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This paper explores the new challenges that interdisciplinary health care training clinics have experienced for the respective disciplines of counseling and psychology amid the COVID-19 pandemic. Previous challenges among these disciplines has always included the differences in specialty areas, ethical codes; and practicum and internship requirements. This current qualitative self-review identified three emergent themes from a training/service delivery perspective: Cessation of In-person Training; Cessation of In-person Assessments and Therapy; and Certification Requirements for Telehealth. Each theme is discussed from both a benefit lens and a challenge lens considering a possible future time where these modifications may need to be adopted again.

Keywords: pandemic, COVID, training, interdisciplinary training

Interdisciplinary health care teams have evolved over the years and have provided models for how healthcare professionals can deliver not only beneficial healthcare, but also quality training that provides education blended with real world clinical interactions. These interdisciplinary teams can provide training to an array of professionals from different disciplines and offer coordinated services by an integrated team of professionals. These integrated teams are, at times, embedded at the heart of university health science center's training programs. These interdisciplinary training program experiences expose healthcare students to the roles of other healthcare providers, interprofessional collaboration, and breaks down barriers and stereotypes.

However, the COVID pandemic provided challenges and areas for growth for many university training programs, internship programs, healthcare systems, and government agencies. This required that many programs focus on discipline specific issues, such as university accreditation requirements, training requirements, and logistical nuances. Additionally, many systems had to reevaluate specific requirements for telehealth and related privacy laws. Then, programs could possibly reintegrate as an interdisciplinary team to move forward providing mental health care in a manner in which many had never done before.

The authors deliberately use the general terms of student, trainee, and intern interchangeably to recognize that individuals are a variety of educational levels during this unprecedented educational opportunity. These terms, therefore, represent the full range of all trainees including those who may be beginning their graduate field experience as a practicum student; interns, at the master's level or doctoral level; and post-graduate. Additionally, the authors recognized that while others use the terms multi- and interdisciplinary interchangeably, we are purposely using the term interdisciplinary to best represent the true meaning and intent of the integrative practice of mental health professionals, allied health professionals, medical professional, etc.

While there have always been challenges to interdisciplinary training, the purpose of

this qualitative self-review was to expand upon typical training challenges with a focus on behavioral health service delivery for the respective disciplines of counseling and psychology amid the COVID-19 pandemic. This new set of circumstances presented unique concerns and forced interdisciplinary problem solving to ensure a new best practice of interdisciplinary behavioral health services to best match the situation. This review attempts to bring the reader from the history and benefit of interdisciplinary training to what could be regarded as current best practices under these unprecedented circumstances for both the delivery and training of interdisciplinary health care services. Finally, this template for interdisciplinary training may find itself again useful should the community, nation, or world find itself in yet another unfortunate situation similar to the one that has recently occurred.

History and Benefit of Interdisciplinary Training

Interdisciplinary healthcare teams appear to have originated during World War II with the appearance of multidisciplinary medical and surgical teams (Baldwin, 2007). Previously, healthcare was only provided in what is now known as traditional disciplinary models where professionals simply worked alone without interaction or consultation with other disciplines. There is evidence that a similar style of teaming entered into the mental health practice in the United States because of the summative efforts from the Kennedy and Johnson presidential administrations. It was during that time when significant reforms de-institutionalized both the patient and stigma of mental health disease by transferring services to community based mental health teams. Eventually this notion of multidisciplinary teaming would find itself in educational circles as well with the 1975 passage of Public Law 94 – 142, the Education for All Handicapped Children Act, which required that a child must be evaluated by a multidisciplinary team in all areas of suspected disability and the evaluation must consist of more than one procedure for either planning or placement purposes. The term inter-disciplinary does not appear in this legislation until it became re-authorized in 1990.

While teaming may have been inevitable in hindsight, it certainly evolved slowly. In a seminal article, Stember (1991) posited three areas of arguments promoting the logic of interdisciplinary teaming. These areas were categorized as intellectual, practical, and pedagogical arguments. From the intellectual argument, it stands to reason that ideas in any discipline are enriched by theories, concepts, and methods from other disciplines. The practical argument for interdisciplinary practice forces all to admit that the problems of the world are not conveniently packaged according to professional disciplines. Finally, the pedagogical argument highlights how fragmented curricula does not facilitate learning that is representative of real world mental health practices.

While the terms multidisciplinary and interdisciplinary are often used interchangeably, teaming purists argued a sharp distinction. Stemper (1991) created the uniform terminology that is still referenced today describing the professional models across the continuum of service delivery. The most basic model of the continuum was intradisciplinary,

which has a professional only viewing a problem and solutions from their disciplinary perspective. The next level higher was defined as crossdisciplinary, which incorporated the viewing of another discipline from one's own discipline perspective. Pursuant to that level was multidisciplinary, which utilized the perspective of several disciplines on the same problem or concern. Higher yet was interdisciplinary which for the first time required the interaction and integration of the discipline perspectives to create a more holistic representation of the problem or concern. Finally, transdisciplinary sat atop this service delivery continuum, which theoretically unified all of the discipline perspectives such that the blending removed the clear identification of any single contribution from any individual discipline.

Building upon existing definitions, DeGraw et al. (1996) broadly defined interdisciplinary team training as the education and training of an array of professionals from different disciplines in the provision of coordinated services by an integrated team of professionals. The authors stressed the importance of conveying an understanding and appreciation of the unique perspectives, knowledge, skills, values, and purposes of each discipline represented on the team. Additionally, the over-arching goal was to learn how to work interdependently and collaboratively with other members of the team.

While there are many benefits to interdisciplinary training, there are, however some continued challenges. Gale (2012) identified various concerns regarding interdisciplinary training, specifically the different licensing boards with different policies and procedures; this became particularly challenging during the early days of the pandemic. Not surprisingly, there can be many inconsistencies between mental health disciplines and their related university training programs, licensing boards, etc. A major discrepancy is the different ethical codes that each discipline must follow. Additionally, training programs may begin and end at different times throughout the year, thus creating differing trainee turnover rates, which may be problematic for clinical care and training coordination.

Traditional Challenges for Interdisciplinary Training in Behavioral Health

When considering interdisciplinary clinical training, a site must consider the unique training needs of each discipline. For example, each discipline may have different lengths of their respective university programs, ethical codes, and liabilities. In this vein, the disciplines of psychology and counseling have different specialty areas, entry-level degrees, and finally, practicum and internship requirements. The next section will explore the different training requirements across these disciplines for both practicum and internship. While there are many similarities, there are also substantial differences.

Counseling

The Council for Accreditation of Counseling and Related Educational Programs (CACREP, 2016) provides standards for both Entry Level (master's degree) and Doctoral level programs (https://www.cacrep.org/for-programs/2016-cacrep-standards/). Interestingly, when compared to psychology, the master's degree is regarded

as the entry-level for practice whereby graduates are prepared in one of the eight specialty areas: Addiction Counseling; Career Counseling; Clinical Mental Health Counseling; Clinical Rehabilitation Counseling; College Counseling and Student Affairs; Marriage, Couple, and Family Counseling; School Counseling; and Rehabilitation Counseling. Doctoral-level graduates are prepared for counselor education, supervision, and practice. Therefore, for the purpose of this discussion, only the 2016 CACREP Standards for the Entry Level (master's degree) will be outlined since they address the entry-level for practice.

Regarding practica and internships, the 2016 CACREP Standards required that students complete supervised counseling practicum experiences that total a minimum of 100 clock hours and 600 hours, respectively, over a full academic term that is a minimum of 10 weeks. Supervision must occur weekly with a supervisor that averages one hour per week of individual and/or triadic supervision throughout the practicum by a counselor education program faculty member, a student supervisor who is under the supervision of a counselor education program faculty member, or a site supervisor who is working in consultation on a regular schedule with a counselor education program faculty member in accordance with the supervision agreement. Regardless of mental health discipline, the site supervisor must have knowledge of the program's expectations, requirements, and evaluation procedures for students; and relevant training in counseling supervision. Therefore, practicum students must participate in an average of 1.5 hours per week of group supervision on a regular schedule throughout the practicum. Group supervision must be provided by a counselor education program faculty member or a student supervisor who is under the supervision of a counselor education program faculty member.

Psychology

The American Psychology Association (APA) only provided standards of accreditation for doctoral level programs to what it defined as Health Service Psychology. More specifically, these only included the specialty areas of Clinical, Counseling, and School Psychology. As a result, other specialty programs, for example Cognitive, Developmental, Social, or Sport Psychology had no professional educational standards. Similarly, the APA has no accreditation standards for terminal master degree programs (APA, 2015). Therefore, for the purpose of this discussion, the current APA Standards of Accreditation for Health Service Psychology (2015) will be addressed.

The APA standards stressed that the programs must provide opportunities for all of their students to achieve and demonstrate each required profession-wide competency. Additionally, since science is at the core of health service psychology, programs must demonstrate that they rely on the current evidence-base when training students. Therefore, the programs must ensure that the specific practicum and internship sites allow for the competent demonstration of most, if not all of these following areas: Research; Ethical and Legal Standards; Individual and Cultural Diversity; Professional Values, Attitudes, and Behaviors; Communication and

Interpersonal Skills; Assessment; Intervention; Supervision; and Consultation and Interprofessional/Interdisciplinary Skills.

Regarding practicum, the APA Standards require that sites must include supervised experience working with diverse individuals with a variety of presenting problems, diagnoses, and issues. The purpose of practica was to develop the requisite knowledge and skills to demonstrate the competencies. According these APA Standards, the programs needed to provide individual training plans appropriate to the student's current skills and ability, to ensure that the student has attained the requisite levels of competency to apply for internship. While, internships require supervision by a licensed psychologist, practica supervision can be provided by any appropriately trained and credentialed individual. The APA standards failed to indicate any minimal level of hours to be attained during any singular practicum or totaling across all practica by a student.

Regarding internship, these same APA Standards dictated only that students complete a one-year full-time or two year part-time internship if the internship was also APA accredited. If the student completed a non-accredited internship, then the program must provide evidence demonstrating the quality and adequacy of the internship in terms of the following: The nature and appropriateness of the training activities; frequency and quality of supervision; credentials of the supervisors; how the internship evaluates the intern's performance; how interns demonstrate competency at the appropriate levels; documentation of the evaluation of the intern in its student files. Unlike practicum, internships that are accredited by the APA are recognized as meeting the Association of Psychology Postdoctoral and Internship Centers (APPIC) doctoral membership criteria. It is in these APPIC internship criteria that stipulate a minimum of 1500 documented hours that must be completed in no less than 9 months and no more than 24 months.

Results of Qualitative Self-Review: Emergent Themes from the Pandemic

The on-going monitoring of traditional intra- and interdisciplinary training requirements according to these respective accrediting bodies (i.e., CACREP and APA, respectively) provided a useful stepping-off point to sharply identify distinct themes brought forth by the pandemic to produce meaningful and ethical responses. Ironically, these emergent themes had with them both benefits and challenges. Therefore, the identified emergent themes from this qualitative self-review were the following: Cessation of In-person Training; Cessation of In-person Assessments and Therapy; and Certification Requirements for Telehealth. Each are now presented and then discussed with both a benefit lens and a challenge lens.

Cessation of In-person Training

Traditional CACREP accreditation addresses areas such as: institutional settings, program missions and objectives, content, experiences, advising, qualified faculty, evaluation processes, etc. As part of the counseling accreditation, students must participate in an approved practicum and internship training (requirements discussed above) that included the use of audio/video or live supervision of student's interactions with clients. Certain internships may include interdisciplinary

training, which Schmidt (2021) recommended embrace "opportunities for students to understand their roles on these teams, effectively describe and implement counseling services and uphold the culture of interdisciplinary care" (p. 45). Additionally, these interdisciplinary training sites often offered practicum and internship interactions that provided face to face in an approved setting prior to the pandemic.

However, in early 2020, the COVID-19 pandemic interrupted the traditional in-person training of many interdisciplinary sites that hosted practicum and internship students across the United States. The pandemic shutdown much of the United Stated in March 2020, many interdisciplinary and university training programs transitioned to remote learning and stopped all direct patient care training services until policies and procedures for telehealth could be explored or developed. Bell, et al (2020) recognized that there were several factors that must be considered by the university training programs to address internships during the pandemic, including: public interest (continued care), clinical training sites, university related issues (integrity of training), and individuals (trainees, faculty, and other's wellbeing). While considering these factors, Bell et al. noted that many training programs struggled to develop policies that respected accrediting bodies, institutional guidance, national, state and local regulations—many of which were not clearly defined or aligned in the early spring of 2020. Such example was CACREP's notation that flexibility may be necessary for programs while noting "the potential consequences for students in the long-term including credentialing, portability, and future employment" (CACREP, 2020). CACREP encouraged innovation and flexibility while being mindful of the Professional Practice section of the standards. Once programs developed appropriate policies and procedures, many programs then allowed continued remote learning and telehealth services at willing and appropriate clinical sites with approved site supervisors.

Benefits of telehealth training

While site supervisors were used to being onsite with their interns, telehealth and social distancing practices disallowed such face-to-face interactions for many site supervisors, much less a larger interdisciplinary team. Supervisors were faced with the legal, ethical and professional obligations to serve clients, while considering the practicality of such services. As Hames, et al. (2020) pointed out, many psychology training programs were forced to consider whether they would cease training or rapidly switch to telehealth due to state and local stay at home orders.

Telehealth benefits for students in training included access to supervisors and interdisciplinary teams with specialization, certifications, or clientele not previously available in their local community. Additionally, students who trained at interdisciplinary sites gained experiences such as: working within a team, integrating counseling theory into practice, exploring ethical dilemmas from a counseling perspective, and improved care (Schmidt, 2021). These interdisciplinary training programs also had greater ability to provide services outside of traditional business hours with reduced travel or commuting

times creating an increase in flexibility when offering telehealth services.

Additionally, students reported positive telesupervisory experiences (Tarlow et al., 2020). Their study surveyed a small sample of interns who transitioned to telehealth during the early stage of the pandemic and found in-person supervision had similar outcomes to telesupervision. Additionally, when exploring supervision satisfaction and the supervisory working alliance, there was little decrease in satisfaction. While this small sample cannot be generalized across all supervisory relationships, it does support future telesupervision education, training, and research.

Challenges to telehealth training

Supervisors are traditionally in person in the same clinic with their trainee, therefore able to observe body language, waiting room interactions, professionalism, etc. Over telehealth, the supervisor and/or interdisciplinary team are able to observe sessions, recordings, and participate in supervision, but may rarely see the trainee between sessions in the "office". However, some supervisors work in clinical settings that require "well-controlled clinic environment with on-site access to a supervisor" (Hames, et al., 2020). Other interdisciplinary training challenges included supervisors who may simply be uncomfortable allowing services in new and unfamiliar ways, whether due to physical location differences or new technology.

When the decision to provide interdisciplinary training, telehealth, and remote supervision was contemplated, a myriad of other issues also had to be considered. The supervisor and interdisciplinary training team must consider each student's ability to provide telehealth services on multiple levels: university requirements, telehealth training, competency, licensing board rules/regulations, and if liability insurance covers such services. These requirements may be similar for disciplines, but have unique university or professional requirements. Clinical sites were asked to review and agree to revised contracts or site agreements. Additionally, supervisors must contemplate how they would share or transfer both client/patient information as well as student evaluations—considering both HIPPA and FERPA considerations. Site staffing may have been revised and provided remotely to all professionals. Thus, considerations for confidentiality and privacy across multiple remote locations required additional attention previously not required.

In the spring of 2020, interns had varied experiences: some were nearing graduation with almost a full year of clinical experience; some were in beginning stages of practicum while others were exploring options for future practicum site with no clinical experience. Some interns were interested in interdisciplinary healthcare and telehealth services prior to the shutdown. Other university programs had students with no interdisciplinary education, much less training in telehealth. Universities worked with students to increase knowledge, skills, and exposure to telehealth. Some professional organizations sponsored low to no cost trainings for their members.

Overall, interns at interdisciplinary sites experienced a variety of challenges when not experiencing in person internship training. Interns may lack opportunities to join other clinical team member's sessions

(due to the planning required for telehealth), observations of other clinicians, and professional exchanges that typically happen in offices or agencies. In traditional in person internship programs, interns may have had opportunities to participate in spontaneous case consultations that now may not occur as frequently via telehealth. Schineider, et al. (2020) recommended that university-based training programs recognize interns' mental health, training needs, received support and desired support. Furthermore, Schineider, et al. recognized that interns might be especially challenged by the lack of communication from university programs and internship sites. Therefore, strongly recommended communication that is regular, that provides updates, discussed policy and procedure changes, and incorporates feedback.

Certification Requirements for Telehealth

Different states required different trainings for telehealth certification prior to the pandemic. For example, in the State of Louisiana, counselors were required nine hours of live telehealth training, while psychologist were required to have none. However, some counselors did not hold such trainings or certification prior to the onset of the pandemic since they provided services in a traditional in person format. Therefore, it was possible that the supervisors within these interdisciplinary teams were attempting to gain telehealth education to provide mental health services within the scope of their individual practice. Psychologists on the other hand were advised that telehealth (i.e., telepsychology) is not a separate specialty and were only encouraged to maintain competence in this area via appropriate continuing education.

Quickly, the State of Louisiana rescinded the nine hours of live telehealth training requirements for Licensed Professional Counselors to practice telehealth in the spring of 2020 due to the pandemic. This allowed counselors to practice without the previous required live nine hours of telehealth training, which most would have been unable to acquire due to social distancing requirements across the state. However, clients were then without mental health services in some instances for two to three weeks while clinical sites worked to provide appropriate, legal, and ethical telehealth services. Students at some universities disallowed internship training until policies and procedures could be established. CACREP released guidance statements and amendments to the traditional training requirements during the spring semester of 2020. Such movements allowed many counselors to begin providing clinical services via telehealth, telesupervision, and participate in remote trainings. However, this left interdisciplinary sites with the extra step of then working through policies and procedures that would again allow for interdisciplinary education, experiences, and collaboration via telehealth.

Cessation of In-person Assessments and Therapy

The rapid growth of telehealth availability during the pandemic permitted patients to access to a wider pool of clinicians, as patients were able to see interdisciplinary teams outside of their hometown. Telehealth may have offered new opportunities for those in rural areas to access a wider pool of providers, including

those certified in evidenced based treatments for the client's presenting issue. While these interdisciplinary teams offering telehealth services encountered some barriers, many modifications or mediations have been recommended.

When these teams offered evidenced based treatments that required access to protocol materials, Ralston, et al (2020) believed that some barriers, such as lack of access to protocol materials, could be mediated. For example, Ralston, et al., recommended that clinicians consider utilizing videoconferencing with shared screens, mail, or securely emailed materials. Many electronic medical record sites such as Therapy Notes or Simple Practice allowed uploading of documents for patient access. Additionally, regulations and telehealth certification requirements were rescinded by professional organizations and licensing boards to allow for continued services with a reduction of harm model in mind. This allowed telehealth platforms to be utilized that may not have previously met industry standards.

Mental health professionals were also faced with utilizing assessments in a modified fashion. Hames (2020) cautioned that trainees should be trained in methods that are secure and standardized before allowing modifications. If modifications are necessary, the supervisor should ensure that the trainee is made aware of the rationalization, legal, and ethical standards surrounding such practices (Hames, 2020). Additionally, Ralston, et al. (2020) proposed that supervisors promote flexibility within fidelity. They acknowledged that adjusting traditionally manualized treatment protocols for telehealth without modifying to the point of becoming ineffective or compromising treatment fidelity was important during the pandemic. Ralston, et al. acknowledged that flexibility and fidelity allows clients in rural areas access to evidence-based treatments. However, one must still consider how these modifications would be made while still training and/or educating interns.

Conclusion

The COVID pandemic brought many challenges to the field of mental healthcare, but also benefits. Meeting challenges with benefits, many interdisciplinary training programs rose to meet the needs of their populations. University training programs quickly moved to remote education and faculty supervision while considering their professional standards (APA, CACREP, etc.) and the legal requirements of FERPA and HIPPA. Site supervisors explored telehealth training, telehealth supervision, electronic medical records, telehealth platforms, and possible modifications to treatment or assessment protocols. Sites were also challenged to consider how they would provide supervision and staffing across disciplines, exploring access to HIPPA protected medical records, confidential video conferencing platforms, etc. Additionally, licensing boards, state and federal regulating bodies, and specialized certification programs were tasked with providing guidance on best practices during an unprecedented time.

Trainees at multiple levels were exposed to telehealth and remote learning at the same time as many of their faculty and site supervisors. This was a unique situation for many interns to find themselves. Trainees reported a multitude of varied experiences, satisfaction with supervision, and interdisciplinary training.

However, many programs continued to offer education, supervision, and patient care.

Pandemic research outcomes continue on an array of levels including: interdisciplinary training, supervision, remote learning, telehealth, and telesupervision. As research guides practice in a variety of clinical sittings, training should be no different. University and clinical training programs must assess what worked and areas of growth during remote learning and training. Moving forward, university training programs should preemptively incorporate telehealth training; expose graduate students to remote interdisciplinary trainings, and clinical supervision.

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