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Advancing Behavioral Health Workforce Equity Through Interprofessional Education at a Historically Black College and University: A Mixed-Methods Evaluation of the Center for Interprofessional Collaboration and Education

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Abstract

Interprofessional education (IPE) is a widely recognized strategy for strengthening the behavioral health workforce; however, limited research has examined equity-centered IPE models developed within Historically Black Colleges and Universities (HBCUs). This mixed-methods evaluation examined an HBCU-based interprofessional training initiative designed to strengthen workforce readiness and promote equity-centered, team-based behavioral health practice. Using a convergent mixed-methods design, the study evaluated the Center for Interprofessional Collaboration and Education (C-ICE), a Health Resources and Services Administration (HRSA) Behavioral Health Workforce Education and Training (BHWET)-funded initiative implemented at Clark Atlanta University. Quantitative data included Students' Perceptions of Interprofessional Clinical Education Revised (SPICE-R) survey results and training evaluation data collected between September 2022 and October 2024 (N = 395 responses). Quantitative findings indicated high perceived training value, with 96.12% of respondents (N = 395) reporting satisfaction with training quality and 98.45% indicating they would recommend the training to a colleague. Descriptive SPICE-R2 results indicated notable gains in interprofessional role clarity and understanding of other professionals' training requirements from pre-test (August 2023; n = 24) to post-training (n = 32), including increases in understanding professional roles (from 3.38 at pre-test to 4.66 post-training) and understanding training requirements of other health professionals (from 3.67 to 4.44). There was also high agreement that working with students from different disciplines enhances education (pre M = 4.79, SD = 0.50; post M = 4.66, SD = 0.81) and that health professionals should be educated to establish collaborative relationships (pre M = 4.83, SD = 0.37; post M = 4.84, SD = 0.36). Qualitative data from reflective journals and a May 2024 focus group (n = 7) highlighted immediate transfer of learning to practicum and employment settings and the value of cross-disciplinary collaboration. Findings suggest that culturally grounded IPE models implemented within HBCU contexts may strengthen workforce readiness and support equity-centered collaborative practices in behavioral health.

Keywords: Interprofessional education; behavioral health workforce; health equity; Historically Black Colleges and Universities (HBCUs); Afrocentric practice; cultural humility; mixed-methods evaluation, social work

Introduction

Behavioral health disparities remain among the most persistent inequities in the United States. Black and Brown communities continue to experience barriers to access, structural racism within healthcare systems, and shortages of providers prepared to deliver culturally responsive care [1]. Historically Black Colleges and Universities (HBCUs) serve as critical workforce pipelines by preparing culturally grounded practitioners equipped to navigate social injustice and advocate for equitable care; however, limited empirical research has examined equity-centered interprofessional education models implemented within HBCU training contexts.

In alignment with this role, the Center for Interprofessional Collaboration and Education (C-ICE) is an HBCU-based workforce development initiative supported by the Health Resources and Services Administration (HRSA) through the Behavioral Health Workforce Education and Training (BHWET) program. C-ICE operationalizes interprofessional education (IPE) and team-based learning to strengthen behavioral health workforce preparation. Prior research suggests that IPE can improve role clarity, collaborative

communication, and teamwork skills among healthcare students, reinforcing the relevance of equity-centered interprofessional training models for preparing graduates for collaborative behavioral health practice [2].

C-ICE integrates Afrocentric and interprofessional pedagogies to support workforce preparation grounded in cultural identity, humanistic values, and collaborative practice. By centering culturally responsive training alongside interprofessional competency development, the program frames equity as a core component of team-based behavioral health service delivery. This mixed-method study examines the C-ICE model by assessing fellows' interprofessional competency development and perceptions of program impact across four cohorts. Consistent with best-practice recommendations, the evaluation attends to institutional readiness, curriculum design, and outcome assessment as key components of effective interprofessional education implementation [3].

These commitments are grounded in Afrocentric and humanistic frameworks that emphasize cultural dignity, relational accountability, and ethical responsibility as central to behavioral health workforce preparation. This study was guided by the following research question: What changes were observed in fellows' interprofessional competencies, and how did fellows describe the impact of the C-ICE model on their training experiences across four cohorts?

Theoretical and Conceptual Framework

Afrocentric Perspective and Humanistic Foundations

This mixed-method study is grounded in Afrocentric and humanistic frameworks that position culture, dignity, and relational accountability as essential to effective behavioral health practice and workforce preparation. The Afrocentric Perspective emphasizes collectivism, self-determination, and cultural dignity, with particular attention to how historical context and structural inequities shape community well-being [4, 5]. Afrocentric pedagogy affirms African-centered ways of knowing and supports practitioner development through cultural humility, empathy, and critical consciousness competencies central to culturally responsive service delivery [4, 6]. Complementing Afrocentricity, humanistic values emphasize inherent worth, capacity for growth, and the importance of relational connection in fostering healing at individual and community levels.

These frameworks are operationalized through the Autonomous Social Work Practice Model, an institutional framework rooted in the Atlanta University legacy of social work education. The model asserts that workforce preparation is most effective when professional competence is integrated with humanistic values and culturally affirming approaches, particularly in contexts marked by persistent inequities. Within C-ICE, the Autonomous Model guided program design and implementation by emphasizing three interrelated pillars: autonomous practice, humanistic values, and the Afrocentric Perspective.

Autonomous practice reflects the capacity to exercise professional judgment, ethical decision-making, and leadership in complex service environments while remaining accountable to clients, communities, and professional standards. Together, these pillars provided the conceptual foundation for C-ICE's emphasis on equity-centered interprofessional learning by framing collaboration not only as a technical workforce competency, but also as a culturally grounded and ethically informed practice in behavioral health workforce development.

Conceptual Integration of Afrocentric Values and IPE

Consistent with the Afrocentric and humanistic frameworks outlined above, the Center for Interprofessional Collaboration and Education (C-ICE) was designed at the intersection of equity-centered pedagogy and interprofessional education (IPE). Rather than treating collaboration as a purely technical workforce skill, the program integrated interprofessional learning within a culturally grounded framework that emphasizes relational accountability, collective responsibility, and ethical practice in behavioral health settings.

Within C-ICE, this integration was reflected in program structures that centered fellows lived experiences, supported cross-disciplinary engagement between social work and counseling trainees, and emphasized mentorship and professional socialization as core components of workforce preparation. The Interprofessional Education Collaborative (IPEC) core competencies values and ethics, roles, and responsibilities, interprofessional communication, and teams and teamwork served as the primary conceptual lens for interpreting fellows' interprofessional competency development.

To support replicability and policy relevance, these conceptual commitments were operationalized through aligned program components that balanced structured interprofessional training with applied learning and reflective practice. Consistent with emerging evidence, this approach aligns with research suggesting that interprofessional education models incorporating structured reflection and applied learning may strengthen cultural competence and confidence in collaborative practice [7]. In this evaluation, the IPEC competency domains informed program design and guided the selection of the SPICE-R2 as a quantitative measure of fellows' interprofessional competency perceptions.

Interprofessional Education and Equity

Interprofessional education is widely recognized as a core strategy for preparing behavioral health professionals to collaborate effectively within complex service systems [8]. Consistent with the Interprofessional Education Collaborative (IPEC) Core Competencies for Interprofessional Collaborative Practice [9], C-ICE emphasized four interrelated domains relevant to equity-centered workforce preparation: role clarity, culturally responsive communication, team-based decision-making, and shared accountability for outcomes.

By integrating Afrocentric values with established IPE competency frameworks, C-ICE framed collaborative practice as both a technical workforce of competency and an ethical, culturally grounded responsibility. This approach supports fellows' preparation to engage in interdisciplinary collaboration while maintaining accountability to communities and critically examining practices that reproduce inequities within behavioral health systems.

Methods

Program Context and Evaluation Design

This study reports findings from a mixed-methods evaluation of the Center for Interprofessional Collaboration and Education (C-ICE), a workforce development initiative supported by the Health Resources and Services Administration (HRSA) through the Behavioral Health Workforce Education and Training (BHWET) Program. Implemented from July 2021 through June 2025 at a Historically Black College and University, C-ICE provided equity-centered interprofessional education and community-based training experiences for graduate students in social work and counseling.

A convergent mixed-methods design was used to examine fellows' interprofessional competency development and perceptions of program influence on internship readiness and professional development. Quantitative and qualitative data were collected concurrently and integrated during analysis to provide a comprehensive assessment of program outcomes. This approach aligns with established recommendations for evaluating interprofessional education initiatives using mixed methods designs [2].

Participants and Recruitment

Participants included graduate students enrolled in Clark Atlanta University's Master of Social Work (MSW) program and graduate counseling students enrolled in the School of Education. Across four program years, 132 fellows participated in C-ICE activities. Fellows

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were recruited through internal program communications, faculty referral, and outreach to eligible graduate students. Participation required enrollment in an eligible graduate program and completion of required training activities during the academic year.

Eligibility and Selection Criteria

Fellows were selected through a competitive application process. Eligibility criteria included enrollment in the clinical year of study, a minimum grade point average of 3.2, and submission of a letter of recommendation. These criteria ensured that fellows possessed a foundational practice of readiness and could engage fully in interprofessional training experiences.

Quantitative Analysis

Quantitative data were analyzed using descriptive statistics, including means, standard deviations, frequencies, and percentages. SPICE-R2 findings were summarized at the cohort level and interpreted as descriptive patterns rather than paired individual change scores due to variation in sample sizes across survey administrations. SPICE-R2 items were analyzed at the item level rather than aggregated into domain scores to preserve alignment with interprofessional competency constructs. All quantitative analyses were conducted using IBM SPSS Statistics (Version 29.0.2) to generate descriptive statistics, including means, standard deviations, frequencies, and percentages. Analyses were conducted using an available-case approach; item-level sample sizes varied across survey administrations due to missing responses. Because pre- and post-training surveys were not matched at the individual level and sample sizes varied across administrations, results are interpreted descriptively and no inferential statistical tests were conducted.

Qualitative Analysis

Qualitative analysis followed a thematic synthesis approach. Two members of the evaluation team independently reviewed transcripts and reflection data to generate initial codes, which were organized into a shared codebook. Coding discrepancies were resolved through discussion until consensus was reached. Trustworthiness was enhanced through triangulation across qualitative sources, maintenance of an analytic audit trail, and alignment of qualitative themes with quantitative trends. Trustworthiness was further strengthened through peer debriefing, with members of the evaluation team reviewing and discussing emerging themes to enhance analytic rigor and reduce individual bias.

Results

Quantitative Results

Training evaluation surveys collected between September 2022, and October 2024 yielded 395 responses across interprofessional learning sessions. Overall satisfaction with training quality was high, with 96.12% of respondents reporting they were satisfied or very satisfied. Similarly, 96.90% agreed or strongly agreed that the sessions supported their professional development and/or clinical practice, and 98.45% indicated they would recommend the training to a colleague.

Descriptive SPICE-R2 results further reflected strong perceptions of interprofessional education and collaboration. At pre-test (August 2023; n = 24), fellows reported high agreement that interprofessional learning enhances education (M = 4.79, SD = 0.50) and that health professionals should be educated to establish collaborative relationships (M = 4.83, SD = 0.37). Lower baseline means were observed for understanding professional roles (M = 3.38, SD = 0.95) and training requirements of other disciplines (M = 3.67, SD = 1.25). Post-training SPICE-R2 results (n = 32) reflected higher mean scores across all items compared to pre-test responses, with the largest increases observed in fellows' understanding of professional roles (from 3.38 at pre-test to 4.66 post-training) and understanding of other health professionals' training requirements (from 3.67 to 4.44). Given variation in sample size across administrations, findings are interpreted as descriptive patterns rather than paired individual change scores. Descriptive SPICE-R2 pre- and post-training results are summarized in Table 1, which presents item-level means, standard deviations, and sample sizes across administrations.

SPICE – R2 Question	Pre – Test Mean (SD)	Pre – Test SD	Pre-Test n	Post-Training Mean	Post-Training SD	Post-Training n
1. Working with students from different disciplines enhances my education.	4.79	0.50	24	4.66	0.81	32
2. My role within an interprofessional team is clearly defined.	4.00	0.76	24	4.59	0.65	32
3. Patient/client satisfaction is improved when care is delivered by an interprofessional team.	4.54	0.58	24	4.78	0.48	32
4. Participating in educational experiences with students from different disciplines enhances my ability to work on an interprofessional team.	4.71	0.54	24	4.72	0.51	32
5. I understand the courses taken by and training requirements of other health professionals.	3.67	1.25	24	4.44	0.70	32
6. Healthcare costs are reduced when patients/clients are treated by an interprofessional team.	3.17	1.11	24	4.38	0.70	32
7. Health professionals from different disciplines should be educated to establish collaborative relationships.	4.83	0.37	24	4.84	0.36	32
8. I understand the roles of other health professionals within an interprofessional team.	3.38	0.95	24	4.66	0.54	32
9. Patient/client-centeredness increases when care is delivered by an interprofessional team.	4.08	0.91	24	4.69	0.53	32
10. During their education, health professional students should be involved in teamwork with students from different disciplines to understand their roles.	4.63	0.63	24	4.84	0.36	32

Table 1. Descriptive SPICE-R2 Results for Pre-Test (August 2023) and Post-Training Administrations

Note. Results are descriptive and reflect cohort-level patterns; pre- and post-training samples were not matched.

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Qualitative Results

Qualitative data were drawn from post-session reflections, written journals, program artifacts, and a structured focus group conducted in May 2024 (n = 7). Focus group sessions were conducted using a hybrid format, audio-recorded, transcribed, and analyzed using NVivo software.

Mixed-Methods Integration

Quantitative and qualitative findings were integrated during interpretation to examine convergence and complementarity across data sources. Integration focused on identifying consistencies between self-reported interprofessional competency perceptions and qualitative descriptions of applied learning and professional readiness.

Ethical Considerations

This mixed-method study was conducted as part of a workforce development initiative focused on program evaluation and continuous quality improvement. All evaluation activities prioritized confidentiality and ethical handling of student data, and findings are reported in aggregate to protect participant privacy.

Discussion

This mixed-methods study examined an equity-centered interprofessional education (IPE) model implemented within a HBCU context to support behavioral health workforce readiness. Across quantitative and qualitative data sources, findings indicate that fellows experienced the C-ICE program as a practice-relevant interprofessional training environment that supported collaborative competency development, professional confidence, and applied readiness for team-based behavioral health practice. Taken together, the results suggest that culturally grounded IPE models implemented within minority-serving institutions may contribute meaningfully to strengthening preparation for collaborative behavioral health service delivery.

Interprofessional Competency Development

Quantitative findings demonstrated consistently strong perceptions of interprofessional learning and collaboration among participating fellows. Training evaluation data collected between September 2022, and October 2024 (N = 395 responses) reflected high satisfaction with training quality and strong perceived relevance to professional development and clinical practice. Fellows also reported a high likelihood of applying training content to their clinical experiences and recommending the sessions to colleagues, indicating strong engagement and perceived value across program offerings.

SPICE-R2 findings further contextualized these results by illustrating patterns in fellows' interprofessional competency perceptions at baseline and post-training. In the 2023 cohort pre-test administration (August 2023; n = 24), fellows reported high agreement regarding the value of interprofessional learning and collaborative relationships; however, baseline perceptions were comparatively lower in areas related to role clarity and understanding of other professionals' training requirements. Post-training SPICE-R2 results (n = 32) reflected uniformly strong endorsement across all items, with mean scores in the upper range of the scale and high agreement rates across domains. Together, these findings suggest that C-ICE reinforced interprofessional values and supported perceived readiness for collaborative practice, particularly in domains related to teamwork, communication, and professional role understanding.

Application to Practicum and Emerging Professional Roles

Qualitative findings provided important context for understanding how fellows interpreted and applied interprofessional learning within real-world practice settings. Focus group participants (May 2024; n = 7) consistently described the program as enhancing their ability to translate learning into practice during their clinical year, particularly in environments requiring interdisciplinary coordination, ethical decision-making, and professional communication. Fellows reported applying program content directly within practicum placements and employment contexts, including medical, hospital, and behavioral health systems where interprofessional collaboration was central to service delivery.

Participants emphasized that sessions addressing ethics, mandated reporting, incarceration, maternal health, and interdisciplinary communication were directly relevant to their daily responsibilities and supported increased confidence navigating complex client situations. These qualitative insights align with quantitative findings reflecting strong intent to apply learning to clinical practice, reinforcing the practical relevance of structured interprofessional education during clinical training.

Equity-Centered Interprofessional Education in an HBCU Context

A distinguishing feature of the C-ICE model is its integration of Afrocentric and humanistic values with established interprofessional competency frameworks. Rather than conceptualizing collaboration solely as a technical workforce skill, the program framed interprofessional practice as a relational, ethical, and culturally grounded responsibility. Qualitative findings illustrated how fellows experienced this approach in practice, particularly in relation to understanding client experiences across systems, addressing bias, and engaging respectfully with professionals from other disciplines.

The convergence of quantitative outcomes and qualitative experiences suggests that culturally grounded IPE models implemented within HBCU contexts may be particularly well positioned to address gaps in role clarity and interdisciplinary understanding identified at baseline. By centering cultural identity, collective responsibility, and relational accountability alongside interprofessional competencies, C-ICE contributes to emerging evidence that equity-centered training environments can support both workforce readiness and professional socialization for behavioral health practitioners.

Challenges and Lessons Learned

Implementing an interprofessional behavioral health workforce initiative across multiple cohorts and academic programs presented several challenges that yielded important lessons for replication. One persistent challenge involved coordinating schedules across two graduate programs with distinct academic calendars, internship timelines, and field placement demands. Participation barriers were most pronounced during peak academic periods and internship transitions, underscoring the importance of designing flexible engagement structures that accommodate graduate students' competing responsibilities.

Operational challenges also emerged related to speaker availability, technology limitations, and unanticipated student-level stressors, such as acute personal or academic demands. These disruptions occasionally affected attendance and continuity of engagement, highlighting the need for built-in redundancy within program design. Strategies such as maintaining backup facilitators, recording sessions for asynchronous access, and establishing clear communication protocols supported program continuity and reduced disruptions across cohorts.

A third challenge involved supporting fellows who were new to formal interprofessional learning environments and initially uncertain about professional roles, boundaries, and expectations across disciplines. Early uncertainty reinforced the value of intentional role clarification and guided dialogue within interprofessional training spaces. In response, C-ICE incorporated structured role clarification activities, facilitated cross-disciplinary discussion, and reflective prompts designed to surface assumptions and strengthen mutual understanding. These strategies supported increased collaborative confidence over time.

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Drawing from these experiences, several implementation lessons may inform replication efforts. Institutions seeking to implement similar models may benefit from beginning with a defined pilot period (e.g., 6–8 months) to refine scheduling, delivery formats, and evaluation strategies. Additional recommendations include coordinating calendars across participating disciplines early in the academic year; embedding validated pre- and post-competency measures alongside structured reflection activities; prioritizing hybrid delivery to reduce access barriers for working graduate students; and using dissemination tools such as recorded sessions and social media spotlights to support engagement and accountability. Together, these lessons reflect the importance of balancing evaluation rigor with flexibility to respond to cohort needs and evolving training contexts.

Limitations and Future Directions

This mixed-method study was subject to several limitations. Outcomes relied primarily on self-reported measures of interprofessional competency development, which may be influenced by response bias. Participation varied across sessions due to competing academic and clinical demands, and qualitative findings may reflect the perspectives of more engaged participants. Future research would benefit from incorporating objective measures of interprofessional practice behaviors, comparison groups where feasible, and longitudinal workforce outcomes such as licensure attainment, employment in high-need behavioral health settings, and sustained interdisciplinary collaboration in professional practice.

Implications for Social Work Policy and Practice

Federal and state behavioral health workforce policies increasingly emphasize interprofessional collaboration, workforce diversity, and service delivery in high-need communities; however, limited attention has been given to how training environments shape readiness for equity-centered, team-based practice. Findings from this workforce-focused study suggest that HBCUs represent underutilized policy assets within the behavioral health workforce pipeline, particularly when interprofessional education is aligned with culturally grounded pedagogical frameworks. Programs such as C-ICE demonstrate how federal workforce investments particularly through initiatives such as the Health Resources and Services Administration's Behavioral Health Workforce Education and Training (BHWET) program can support not only workforce expansion, but also preparation for collaborative, culturally responsive practice.

At the workforce training level, findings underscore the importance of embedding structured interprofessional education within graduate-level social work and counseling programs. Baseline competency patterns highlight the need for intentional role clarification and cross-disciplinary learning early in professional preparation. Policy and institutional leaders may consider supporting IPE requirements that move beyond ad hoc workshops toward sustained, competency-aligned training models that reflect real-world behavioral health practice environments.

At the accreditation and professional standards level, stronger alignment between interprofessional competencies and existing accreditation frameworks may further normalize collaborative practice as a core professional expectation. Explicit integration of interprofessional competencies within Council on Social Work Education (CSWE) and Council for Accreditation of Counseling and Related Educational Programs (CACREP) standards may strengthen accountability and reinforce expectations for equity-centered, team-based care.

At the practice and systems level, findings highlight the importance of workforce preparation models that support immediate transfer of learning to clinical and community-based settings. Training models emphasizing applied learning, structured reflection, and interdisciplinary exposure may enhance early-career readiness while strengthening continuity between academic preparation and service delivery in underserved communities. Collectively, these implications highlight the potential for policy-driven investments in interprofessional education to strengthen both workforce capacity and equity outcomes within behavioral health systems.

Conclusion

This mixed-methods study provides evidence that an equity-centered interprofessional education model implemented within an HBCU context can support behavioral health workforce preparation and collaborative practice readiness. Across quantitative and qualitative findings, fellows reported high satisfaction with training quality, strong perceived relevance to professional development and clinical practice, and meaningful opportunities to apply interprofessional learning within practicum and employment settings. Patterns in interprofessional competency perceptions suggest that structured, culturally grounded IPE may be particularly effective in addressing gaps in role clarity and interdisciplinary understanding during clinical training. Together, these findings support the value of integrating culturally grounded frameworks with structured interprofessional education to strengthen workforce readiness and advance equity-centered behavioral health practices.

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