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**ABSTRACT**

Over the last decade, there has been increased momentum to bring the worlds of physical and behavioral health care together. Instead of social work education simply reacting to this change, it is imperative that we be proactive and prepare students to be "multilingual," that is, be able to speak and function in both the worlds of health and mental health so they can move seamlessly into the new world of integrated care. The purpose of this article is to explore curricular and pedagogical strategies needed to prepare graduate social work students for the coming shift in practice toward integrated health and mental health care.

## Introduction

As demonstrated anew, there are few issues in our society that have prompted more passionate discussion and debate than health care. These often contentious deliberations have focused attention on important matters ranging from access to and quality of services, to concerns about the cost of care shouldered by individuals, families, private enterprise, and society as a whole. The spotlight that falls on health policy is not misdirected. Few items impact all phases of the medical world quite like a change in the fiscal landscape. It is for this reason that many wait anxiously as a new administration tackles one of our country's greatest dilemmas: how to increase the access to and quality of care while keeping costs in check—the so-called Triple Aim (Berwick, Nolan, & Whittington, 2008).

Over the last decade, there has been increased momentum toward bringing the worlds of physical and behavioral health care together. As a conceptual matter, integrating care is a logical and rational approach to many of the vexing healthcare challenges that practitioners face every day. However, truly bringing integrated care alive requires alignment at all levels, from policy to direct practice. As many studies attest, it is not easy to do so

(Davis et al., 2013; Durbin, Durbin, Hensel, & Deber, 2016; Grace, Rich, Chin, & Rodriguez, 2016; Padwa et al., 2016; Scharf et al., 2013).

Nonetheless, although the road has not been linear, it would seem that current policy and practice trends suggest that integrated care is the wave of the future, no matter what decisions are made regarding U.S. healthcare reform. Hospital systems continue to expand their scope of services, from wellness and prevention to rehabilitation services. Behavioral health organizations, such as community mental health centers and substance abuse treatment facilities, are now partnering with hospital systems, Federally Qualified Health Centers, and primary care provider networks as never before. Primary care is again touted as the backbone of the healthcare system and the preferred front door for the majority of services a client will need (Blount & Miller, 2009; Bodenheimer, Wagner, & Grumbach, 2002; Coleman, Austin, Brach, & Wagner, 2009; Horevitz & Manoleas, 2013).

Even before serious efforts to integrate physical and behavioral health care were launched, the reality was that more mental health treatment, including prescribing and monitoring psychotropic medication, occurred in primary care settings than in specialty behavioral health programs (Blount & Miller, 2009; Horevitz & Manoleas, 2013). However, more is now expected of integrated services. There is increased demand for those practicing in primary care to routinely and effectively assess and provide at least brief treatment for ubiquitous concerns such as depression, anxiety, and substance misuse issues. In addition, there is a growing expectation that providers take a *biopsychosocial* approach when addressing the increasing number of chronic conditions that people face (Heath, Wise, & Reynolds, 2013; Horevitz & Manoleas, 2013). This demand is based on pragmatics. So many of the leading causes of death today are related to issues such as lifestyle choices, health literacy and behavior, and stress. The failure to address these components of the illness and disease process results in poor treatment outcomes, and by extension, increased direct and indirect costs.

Given that upward of 40% of social workers practice in health and behavioral healthcare programs, these trends have important implications for the profession (Stanhope, Videka, Thorning, & McKay, 2015). Simply put, changes at the policy level, and the resulting reorganization and realignment of health care, will have a direct impact on the scope and nature of social work practice. In many settings, where social workers have been the dominant profession, competition from other disciplines, particularly nursing, can be expected. Contrariwise, social workers may find increased opportunities to practice in primary care offices and other healthcare settings (Mann et al., 2016). In any case it seems certain that there will an increased emphasis on interdisciplinary teamwork in health care; a renewed focus on early identification and treatment of conditions such as substance abuse, anxiety, and depression; and the continued rise of care management

(including client education and self-management) for chronic conditions ranging from asthma and diabetes to schizophrenia.

Thibault (2013) suggested that at times like this there is a natural tendency to predict future workforce needs, focusing on the numbers of professionals needed. However, he also noted,

> At the same time, there is a need to focus more energy on the content and pedagogy of health professions education. Regardless of the number of health professionals required in the future, all health professionals must be trained differently if they are to meet the needs of a changing patient population and are to lead and thrive in a changed health delivery system. (p. 1929)

Hence, the question looms: If the practice world is undergoing a sea change, how will social work education respond? As Stanhope and colleagues (2015) suggested, "We have two challenges; one, to promote our unique contribution to health care reform and two, to prepare the existing and new workforce for the profound shift in their roles" (p. 384). Certainly, the push for interprofessional education is well under way, so how might we best prepare students in our classrooms to respond to this changing environment? To wit, what are the essential skills, and especially the new skills, that students will need to thrive in an integrated care environment? No matter what happens at the policy and organizational levels, the true implementation of any innovation or novel approach to health care rests on the discrete interaction between the client and practitioner, within a practice team. So if the aforementioned trends hold true, it stands to reason that the preparation of social workers must change as well (Horevitz & Manoleas, 2013).

The purpose of this article is to explore the elements needed to prepare our students for this coming shift in practice toward integrated health care. Instead of social work education simply reacting or responding to this forthcoming change, it is imperative that we be proactive and prepare students to be "more multilingual," able to speak and function in both the worlds of health and mental health so that they can move seamlessly into the new world of integrated care. Suggestions for curricular changes are given for curriculum implementation in our graduate schools of social work.

## Integrated behavioral health care

Expanding integrated care is viewed as consistent with efforts to address the noted Triple Aim in health care. Physical and behavioral healthcare challenges are often comorbid. Undetected depression and anxiety, associated with physical healthcare concerns, may negatively impact treatment adherence and recovery. The lack of attention to physical healthcare needs among those with the most severe forms of mental illnesses frequently results in a dramatic reduction in life span. Chronic conditions require self-

management, and often alterations in the home environment and lifestyle, which have not traditionally been the focus of physicians. In both of these examples, failure to address the whole person and consider environmental context in care planning will likely elevate the overall cost of care and simultaneously weaken the effectiveness of the services we offer (Stanhope & Straussner, 2018).

Describing the different models of integrated care is beyond the scope of this article. Yet, regardless of the particular model employed in a given host setting, at the very least it will lead to more routine contact between practitioners in the physical health and the behavioral healthcare worlds. In some arrangements, the linkage between organizations is a function of a binding contract designed to increase the ease of referral between systems and enhance the sharing of information. In the case of colocation, behavioral healthcare professionals are deployed to work in primary health, or in some cases the reverse can occur. In fully integrated care, as Horevitz and Manoleas (2103) noted,

> Mental health services and medical services are co-located, and fully integrated as one system of care where medical providers and behavioral health consultants work together as a team, sharing information about patient care and documenting treatment in the same medical record. (p. 754)

With the present move to integrated health care, new roles are emerging, including those of care manager, patient and family navigator, community health worker, disease manager, and care coordinator (Stanhope et al., 2015). For some seasoned professionals, an enhanced skill set is now needed (Blount & Miller, 2009). O'Donohue, Cummings, and Cummings (2009) have gone one step further by suggesting that integrated care has not taken off as anticipated, either in scope or impact, in part due to the lack of properly trained professionals. They further observed that integrated care is not a matter of simply bringing trained mental health professionals into a medical setting (or the reverse) and having them perform in their customary manner. Roles must be reengineered, for as Grapczynski, Schuurman, Booth, Bambini, and Beel-Bates (2015) argued,

> Health care education is not only about the acquisition of new knowledge and skills; it is also about the acquisition of a new identity—an identity as a health care professional, with competencies in interprofessional collaboration. This new identity comes with rights and responsibilities, including the responsibility to provide professionally competent care based on the knowledge, skills, values, and ethics of one's individual discipline. (p. 113)

## Integrated care practice: Skills and competencies

To be able to proficiently work in an integrated care environment, certain skills are needed. The Substance Abuse and Mental Health Services Administration Center for Integrated Health Solutions has promulgated nine core competencies for all integrated care professionals: interpersonal communication, collaboration and teamwork, screening and assessment, care planning and care coordination, intervention, cultural competence and adaptation, systems-oriented practice, practice-based learning and quality improvement, and informatics (Hoge, Morris, Laraia, Pomerantz, & Farley, 2014). These competencies should thus inform the curriculum of social work and other allied health professions as they develop syllabi, assignments, and practicum opportunities that will translate into real-world skills. However, recent research indicates that social work may not be adequately preparing its students for these roles. Horevitz and Manoleas (2013) conducted a snowball survey with 84 social workers practicing in an integrated care setting, two thirds in primary care. Many social workers in their sample reported that although their MSW program provided a good foundation for their work, learning the necessary skills largely occurred on the job.

Horevitz and Manoleas conducted a review of the literature to determine competencies central to integrated care and then assessed which of these competencies social workers actually deployed in the performance of their jobs. Among these respondents, the most commonly used were knowledge of psychotropic medications (91%), cultural competence (89%), family systems (87%), psychoeducation (83%), motivational interviewing (82%), relaxation training (82%), and team-based care (81%). Items included as competencies, yet endorsed by less than 50% of respondents, were stepped care, functional assessment, problem-solving treatment, and drug assessment/intervention. Other scholars have developed different lists of necessary competencies for practice in integrated care environments. These lists commonly contain practice knowledge, including an understanding of other disciplines; ethical practice; interprofessional practice, including operating as an effective member of an interdisciplinary team; reflection, including role awareness and personal and professional awareness; cultural competence; and client-centered practice (Davis, et, al., 2015; Gordon & Walsh, 2005; Grapczynski et al., 2015; Howarth, Holland, & Grant, 2006; Walsh, Gordon, Marshall, Wilson, & Hunt, 2005).

Specific to social work, we should consider the guidance provided by the Council on Social Work Education (CSWE) derived from its Social Work and Integrated Behavioral Healthcare Project. CSWE (2013) developed a curriculum road map to prepare graduate social work students for the coming increase in integrated behavioral health, which suggests including an intensive course covering both health and mental health conditions,

medications, care planning, screening and structured assessment, skills in motivational interviewing, and sensitivity to cross-cultural issues. CSWE offers sample syllabi on its website for two related courses preparing social work students for integrated care—a clinical social work and a health policy practice course (CSWE, 2017). They also established six required experiences for integrated field placements for social work students involved in the Social Work and Integrated Behavioral Healthcare Project that could be useful for other social work programs to incorporate into their field placements. These experiences include ensuring students observe and conduct comprehensive biopsychosocial assessments that address mental health, substance misuse, trauma, and primary care domains; observe a primary care screening and assessment, and case conference with the primary care physician; co-lead wellness promotion groups; and assist patient care managers with helping clients access services needed (CSWE, 2013).

As we also consider how to calibrate the classroom experience to provide the optimum opportunity to learn and practice the skills most germane to integrated care, it will be wise to consider the difference between competencies and capabilities. Walsh and Gordon (2005) suggested that competencies reflect the knowledge, skills, and behaviors that a person can demonstrate. Capability focuses on the ability to apply, adapt, and synthesize new knowledge in differing contexts. In a similar vein, Sockalingam, Mulsant, and Mylopoulos (2016) argued that students must gain adaptive expertise and learn to respond nimbly to the fast pace and high demand endemic in healthcare environments. Classic clinical pathways may not have the ready answers for novel situations, and this is where professionals may need to stretch their knowledge and skills.

Although the literature contains various competencies for integrated health practice for many types of professionals, including social workers, the challenge to our profession is, how can we best help social work students develop and master these competencies? In short, what can social work educators bring to the classroom to best prepare students for the realities of their future practice?

## The classroom: Where the rubber meets the road

The days of distinct health and mental health concentrations should be coming to a close, and schools need to offer integrated health concentrations instead. To do otherwise will give students the false impression that the health and mental health worlds exist in silos, separate from each other. At the very least, schools that offer separate concentrations for health and mental health should require coursework in both concentrations that will prepare students in both for the integrated healthcare world. Second, and of critical importance, is the recruitment and selection of practicum sites that

are at the cutting edge of the new world of integrated care. Naturally, the translation of classroom knowledge and behavior to the real world of social practice is never certain. For this reason the field practicum is considered as the signature pedagogy, and the litmus test for the preparedness of students to assume professional roles.

To best prepare students for working in integrated care settings, classroom environments must seek to mimic these settings as much as possible. Case studies, exercises, and simulations are encouraged to allow students to interact with the content in as realistic a venue as possible. In this spirit, Blount and Miller (2009) offered a full curriculum designed to prepare students for integrated care, with the use of case examples as the centerpiece. Their notion is to grapple with complex situations, allow opportunities for the diverse perspectives of different disciplines to be shared, and then to work synergistically in formulating a multifaceted view of the presenting challenge. From there the quest is to craft a plan that builds upon the knowledge of all and, of vital importance, will reflect the goals and preferences of the client. Using case studies in class that reflect both health and mental health concerns will improve students' abilities to work in integrated health settings and help them apply all of the skills previously mentioned. Health mentors, and persons with a health condition, also have been used to teach interprofessional teams about understanding and honoring the illness experience (Doucet et al., 2014) and could be effectively incorporated into the social work classroom.

In addition, teamwork skill is essential to interprofessional healthcare practice and should be developed throughout the social work curriculum. Good teamwork depends on the strength of interpersonal relationships, minimization of professional turf protection, basic self-awareness, and a commitment to professional development (Gilbert et al., 2000; Howarth et al., 2006; Walsh et al., 2005). Although classroom exercises on teams and teamwork have been a staple in social work classrooms for years, a focus on interdisciplinary teams must be emphasized in content and simulations (Gilbert et al., 2000). Social work programs can partner with other healthcare disciplines on their campuses to offer interprofessional courses or, at the very least, embed interprofessional activities in their respective courses. These partnerships could also help make available opportunities for using standardized patients who are routinely used in medical and nursing schools to provide a simulation of real-life situations, and they have been demonstrated to improve both clinical and communication skills (Anders et al., 2016; May, Park, & Lee, 2009). Partnering with allied health and mental health disciplines could give social work students access to such resources and promote interprofessional learning in the process.

Along with utilizing the pedagogical methods just noted, specific skills and areas of knowledge should be developed throughout the social work curriculum. The following are important curriculum considerations for preparing students for integrated healthcare practice.

## Preparedness for interprofessional settings

Central to the process of preparing students for the modern integrated healthcare system is providing an interprofessional education environment. Jones and Phillips (2016) said that the goal of such interprofessional education "is for students to become skilled at functioning in an interdisciplinary setting and be able to transfer this experience into their future work as health care professionals" (p. 21). Understanding the perspective of others, dealing with misconceptions and stereotypes of other professions, and recognizing the differences and similarities in functions and boundaries can help facilitate better communication and teamwork among members of difference professions (Grapczynski et al., 2015; MacDonald et al., 2010). Nevertheless, research shows that trust is often a function of familiarity and shared understanding and can be difficult to obtain in interdisciplinary teams (Gilbert et al., 2000). Power also may come into play when those who have held dominant positions in some settings and situations now are expected to work more democratically and share responsibility.

The aforementioned Interprofessional Education Collaborative (2016), comprising organizations representing 15 professions (including social work), recently released a set of competencies for interprofessional education in the healthcare field. These competencies fall into four core areas: values and ethics of interprofessional practice, roles and responsibilities, interprofessional communication, and teams and teamwork. Each of these core areas has subcompetencies and includes both content and skills that need to be acquired in the classroom. Broadly, these competencies state that professionals should be able to work with sister professionals in a mutually respectful manner, use their own role to assess and intervene with patients as well as promote population-level health, communicate responsibly and responsively with everyone involved in the patient's care, and behave in a way that values relationships and team dynamics in order to provide excellence in patient-level and population-level health care.

In the classroom, it is vital that these key content and practice areas are infused throughout the curriculum and tightly linked with internships and practica. Practicum placements should be sought that include opportunities for interdisciplinary collaboration. In tandem, examples given in the classroom should reflect real-world practice, use case studies and groups, and encourage maximum interaction among students to prepare them for work in teams upon graduation (Grapczynski et al., 2015). As noted in a sample of nursing students, they were generally excited during the process of interprofessional education, but enthusiasm could wane if content was not consistently reinforced throughout their student experience (Walsh et al., 2005).

Social work programs may not have far to go to make interprofessional content a central theme of the curriculum. Comer and Rao (2016)

observed that many existing social work classes and group experiences are tailor-made to prepare students to work in interdisciplinary teams and could simply be slightly modified to better prepare students for integrated health practice environments. Current courses in group work could be supplemented by including curricular content that focuses on the role of social work in interprofessional groups, the history of social work in healthcare settings, a discussion of current health and mental healthcare trends, a review of the profession's history of collaboration with other professions, and a reflection on group processes and maintenance while working toward a shared goal.

## Knowledge of treatment modalities applicable to integrated settings

Social work students also need to know which client interventions can be useful in integrated health settings. There are often significant differences between traditional mental health intervention and practices in integrated healthcare settings. Some of these differences may include shorter visits of just 15–30 minutes, often with interruptions to meet other patients, with a warm handoff, a treatment length of stay from one to three visits, frequent consultations with medical providers regarding appropriate assessment and intervention, and working with chronic disease management along with the client's primary medical provider (Horevitz & Manoleas, 2013). This model presents a much different treatment paradigm than what students traditionally envision when thinking about providing mental health services to clients; hence, preparation for this reality is important. This example of therapy is akin to health coaching and has already gained traction in social work (Caspi, 2005; Jost, 2013; Shafer, Keibzak, & Dwoskin, 2003) and is being widely used by other professionals, including those providing telehealth for chronic conditions (Hackshaw et al., 2016; Harter et al., 2016). Health coaching could be a model discussed more intentionally in the classroom to prepare students for the potentially shorter and more goal-focused interactions that often occur in primary care.

There are many therapies that are ideally suited for this type of work and should be taught in social work programs, including motivational interviewing and brief interventions. Motivational interviewing is now infused into multiple settings in health and mental health and is a primary practice currently taught in many social work programs. Stanhope, Tennille, Bohrman, and Hamovitch (2016) argued that social work can take a leadership role in dissemination of motivational interviewing to other professionals, as its techniques can be vital to client engagement and can help remove obstacles to effective self-management in the care of chronic conditions. Although motivational interviewing appears deceptively easy to some, considerable classroom time (and substantial practice opportunities) must

occur before students will likely develop competence beyond just an understanding of its theoretical foundations and what its acronyms mean. Even though many disciplines currently use motivational interviewing, social work could lead the way in understanding both its utility and limitations.

Other brief interventions, such as Screening, Brief Intervention, Referral, and Treatment (SBIRT) should be considered to prepare students for integrated healthcare settings. SBIRT is an evidence-based practice that incorporates an assessment for risky substance use, brief interventions to use in a medical setting, and guidelines for making referrals for more in-depth substance abuse treatment when needed (Babor et al., 2007; McCance-Katz & Satterfield, 2012). Social work students learning to use this or other forms of brief intervention will be better prepared to work in an integrated health and behavioral healthcare environment.

### Health and mental health literacy: Language lessons

Students who plan on entering integrated practice settings must know the basic language and terms of the physical *and* behavioral health worlds. Further, they will need to be versed in the course and symptoms of commons illnesses seen in primary care so that they understand the meaning of the illness to the person and not just what parts of the body it affects. For example, individuals with congestive heart failure will have shortness of breath, may be on oxygen, and will have significant restrictions on their psychosocial functioning in later stages. Understanding how illness disrupts the developmental life cycle is important and critical to helping patients plan for the future and get support for the patient/family to make necessary life adjustments. Understanding common medications for health and mental health conditions (and their side effects) is useful as well. The comorbidities that patients experience in real life also need to be discussed in the classroom; case examples could include a patient with both diabetes and depression, or one with anxiety, Crohn's disease, and recent knee replacement surgery. The interaction between physical and mental health conditions needs to be discussed in depth for students to make appropriate connections between the two, and their combined impact on the quality of life of both the patient and the family. For social workers to have credibility in integrated settings, they also need to be able to walk in the door understanding the language of medical professionals and not rely on other professions, such as nursing, to translate for them. This may require more time on anatomy and physiology, brain neuroscience, pharmacology, an understanding of the course of an illness, and support for a client's self-management strategies—all of which are influenced by their social context (van Houtum, Rijiken, & Groenewegen, 2015).

### Health promotion and disease self-management

Teaching patients self-management skills for monitoring and controlling symptoms of chronic conditions is an important component of integrated health care (Bodenheimer et al., 2002), and social workers can play a role in helping people learn these skills; thus, preparing students for this role is essential. Some of this preparation can be done in field placements and some in the classroom. In the classroom, students can be given case examples of clients with comorbid mental health and physical health conditions and asked to discuss options for facilitating self-management. Many resources, including individualized self-management plans, can be found online (see https://www.nhlbi.nih.gov/files/docs/public/lung/asthma_actplan.pdf for an example of an asthma self-management plan).

Preparation for students in the areas of health promotion and health management also can be done in practicum settings and is encouraged by CSWE. The Council (2013) established expectations for integrated field placements, which include having students lead a health promotion group that might be focused on such topics as nutrition and exercise, substance misuse (including smoking cessation), disease self-management, healthy life-styles, or the role of trauma in managing health and accessing care. This focus further blends the nursing and social work roles as social workers begin to take leadership in areas of health promotion and self-care. Social workers have knowledge regarding how to lead groups but often tend to run groups that are directed toward traditional mental health issues, such as substance abuse, depression, loss and grief, and anxiety. Preparing social workers with information about health promotion, and styles of group leadership for effective psychoeducation, could be helpful to them in integrated health settings.

### Screening and assessment knowledge

Integrated behavioral health "requires a shift from an individual client-based model of care to a population-based model of care" (Horevitz & Manoleas, 2013, p. 755). Screenings of the primary care population for common problems such as insomnia, depression, anxiety, phobias, substance abuse, caregiver stress, dementia, trauma, intimate partner violence, and suicidal ideation are critical to prevention of more serious physical health problems. In primary care settings, all clients may be screened for some health concerns on a regular basis, and these data will need to be tracked over time to help identify trends and the benefits of periodic screening and intervention (Collins & Fund, 2010; Horevitz & Manoleas, 2013). Assessment is more extensive than screening and may involve diagnostic tests, such as mini-mental status exams, biopsychosocial evaluations, or assessments of cultural

factors involved in accessing and benefiting from care. Although social work programs focus on assessment, incorporating both the medical and mental health aspects in greater depth, and understanding how they impact one another, would be important to pursue.

## Comfort with informatics and technology

Technological advances are being made rapidly in health care, and it therefore is essential that students to be prepared to work in technologically advanced practice settings. Technological advances are being made rapidly in health care and is it essential that students be prepared to work in technologically advanced practice settings. For example, mobile phone applications have been developed that help with symptom tracking and disease management of mental health (Donker et al., 2013; Price et al., 2014), substance abuse (Johnson et al., 2016), and physical health conditions (Kamel Boulos, Brewer, Karimkhani, Buller, & Dellavalle, 2014). In the classroom, these apps can be incorporated into case scenarios or demonstrated by the instructor as part of a lecture.

Other ways of helping students interact with technology can be developed via campus partnerships between social work and informatics or computer science departments. Universities are beginning to experiment with using electronic medical records as a teaching tool for interprofessional teamwork (Titzer, Swenty, & Mustata Wilson, 2015). For example, Indiana University recently started using a teaching electronic medical record to promote interprofessional learning for practicum students in geriatric settings through case analysis and real-time interaction with other students. Actual patient records are deidentified (for both patients and providers), but the notes from team members remain and document the flow of a patient moving across systems to access care. Patient records selected for this project were for the older adults who had multiple physical and comorbid mental health conditions. Although this project is in its infancy, the teaching electronic medical record has shown great promise as a way for students to access real patient information and experience the complexity of cases and the interaction (or lack thereof) among interprofessional team members. Students have the opportunity to comment and interact with other students from other disciplines in the medical record as well.

## Conclusion

Integrated care is unquestionably becoming far more prevalent, and schools of social work can improve the transition of new social workers into integrated practice settings by teaching specific curricular content that will enable them to move into this type of practice. Courses must be redesigned

or developed that focus on an integration of health and mental health issues instead of treating them as separate entities. Social work students must be able to speak both the language of health and behavioral health if they are to function effectively as members of interprofessional teams with credibility and impact. If social work is to have a seat at the table in integrated care settings, educators must embrace new practice models that will respond to the complex health and behavioral healthcare needs of patients and find ways to increase interprofessional interaction, communication, and understanding. The time has come to change our curriculum and pedagogical strategies to accommodate the integrated practice environments in which our students will work.

## Disclosure statement

No potential conflict of interest was reported by the authors.

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