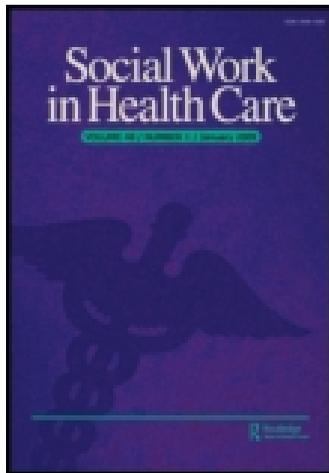


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Professional Competencies and Training Needs of Professional Social Workers in Integrated Behavioral Health in Primary Care

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The Affordable Care Act has led to a widespread movement to integrate behavioral health services into primary care settings. Integrated behavioral health (IBH) holds promise for treating mild to moderate psychiatric disorders in a manner that more fully addresses the biopsychosocial spectrum of needs of individuals and families in primary care, and for reducing disparities in accessing behavioral health care. For behavioral health practitioners, IBH requires a shift to a brief, outcome-driven, and team-based model of care. Despite the fact that social workers comprise the majority of behavioral health providers in IBH settings, little research has been done to assess the extent to which social workers are prepared for effective practice in fast-paced primary care. We conducted a survey of social workers (N = 84) in IBH settings to assess the following: (1) Key competency areas for social work practice in IBH settings and (2) Self-rated preparedness for effective practice in IBH settings. Online snowball sampling methods were used over a period of 1 month. Results indicate that social workers feel prepared for general practice in IBH settings, but would benefit from additional training in IBH-specific competency areas identified in the survey. Findings can help guide social work training to improve workforce preparedness for practice in IBH settings in the wake of health care reform.

KEYWORDS *integrated behavioral health, social work competencies, workforce preparedness, health care reform*

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In June 2012, the Supreme Court of the United States upheld the Patient Protection and Affordable Care Act (ACA) of 2010. A central feature of the ACA is the patient centered medical home (PCMH), which features the integration of behavioral health services into primary care. The characteristics of PCMHs include: a personal physician, a whole person orientation, care that is coordinated and/or integrated across all elements of the complex health care scene, a quality/outcome focus, and evidence-based medicine and clinical decision-support (The American Academy of Family Physicians, 2012). Integration of behavioral health services into primary care (also known as integrated behavioral health, or IBH) is an integral part of the PCMH and is rapidly expanding in primary care clinics across the nation (Roy-Burne, 2013). IBH refers to a team-based model of care that “combines medical and behavioral health services to more fully address the spectrum of problems that patients bring to their primary medical care providers. It allows patients to feel that, for almost any problem, they have come to the right place” (Blount, 1998, p. 1). IBH essentially reconnects the head to the body (Kiser, Lefkowitz, & Kennedy, 2001) and attempts to address the full biopsychosocial spectrum of needs commonly presented by patients in primary care.

Primary Care culture differs from that found in specialty mental health program cultures and training received by most mental health and traditional medical social workers may offer a solid foundation for practice in IBH settings, but not necessarily reflect the specific knowledge and skills needed for IBH practice (O’Donohue, Cummings, & Cummings, 2008). Little of a systematic nature is known about the preparation of clinical social workers for IBH practice and there are currently no systematic studies of competency areas used by social workers in IBH settings or assessments of social work preparedness to enter the IBH workforce. A more thorough understanding of the specific skills and training areas necessary for social work practice in IBH settings is necessary given the landscape of health care reform and the growth of job opportunities for social workers in IBH settings. The current survey of IBH social workers addresses the following questions: (1) What are the primary skills and knowledge used by social workers in IBH settings? and (2) Do social workers feel prepared by their MSW training to work in IBH settings?

BACKGROUND

Need for IBH Services in Primary Care

It has been well established that many individuals with behavioral health concerns seek care through their primary care provider, rather than through specialty mental health (Gray, Brody, & Hart, 2000). Primary care has been called the de-facto system of mental health care in the United States (Blount & Miller, 2009; Gray et al., 2000). Primary care providers manage more

psychotropic medication than the entire psychiatric profession in the United States (Mark, Levit, & Buck, 2009). Moreover, the imminent 2014 expansion of Medicaid coverage to an estimated 16 million new people nationally, one fifth or more of who are likely to have mental illness and/or substance use disorder service needs, underscores the necessity for and promise of IBH, and is a promising disparity reduction strategy for ethnic groups who have traditionally under accessed behavioral health services (Manoleas, 2008; U.S. Department of Health and Human Services, Office of Minority Health, 2011). As a result, clinics across the country are in various stages of integrating health and behavioral health services, and government agencies such as the Agency for Health Care Quality and Research (AHRQ) and the Substance Abuse and Mental Health Service Administration (SAMHSA) are funneling funding to community-based health clinics to support their integration efforts via section 2703 of the ACA (<http://www.samhsa.gov/healthreform/healthhomes/>).

Models of IBH

In practice, IBH programs take on numerous forms, ranging from fully integrated collaborative care to co-location with minimal collaboration between providers (Haas, 2004; Kessler & Stafford, 2008; Schaefer & Davis, 2004). Blount (2003) distinguishes the following continuum of mental health and health services integration: coordinated services, co-located services, and integrated services. In the integrated model, 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. Even within fully integrated settings, there can be a range of behavioral health treatment models. For example, Blount (2003) distinguishes between targeted versus non-targeted services, and specified and unspecified treatment. Targeted services refer to IBH services that are aimed at specific populations (e.g., patients with depression who screen positively for depression) rather than non-targeted services, wherein generalized psychosocial distress identified by the medical provider may trigger a behavioral health referral. Specified treatment refers to behavioral interventions that follow a specific stepped-care model (e.g., cognitive-behavioral therapy, problem solving treatment), whereas un-specified treatment refers to interventions selected by each individual BHC depending on his/her assessment of the problem. The latter is consistent with several evidence-based interventions that emphasize manualized treatment and clinical algorithms (stepped care) for depression and anxiety such as the IMPACT trials and the CALM studies (Areán et al., 2008; Ayalon, Areán, Linkins, Lynch, & Estes, 2007; Katon et al., 1996).

While the majority of the literature emphasizes IBH in primary care, IBH can also refer to bi-directional integration, or reverse co-location (Mauer, 2009). This latter type of integrated setting integrates primary care medical services within specialty mental health settings. The purpose of reverse co-location would be to address physical health conditions such as metabolic syndrome associated with the use of atypical antipsychotic agents, and other physical health disorders encountered by people living with long term, serious mental illness. IBH in primary care involves assessments and brief behavioral interventions at the primary care site, with patients who have most likely not previously received behavioral health services (Collins & Fund, 2010; Mauer, 2009). It is this latter type of service integration that is the most common in practice and to which the majority of the current evidentiary base is dedicated.

Despite the variety in IBH models, in general, treatment for behavioral health issues in IBH settings tends to be shorter-term than in specialty mental health settings. In a majority of settings, patient visits with the behavioral health specialist typically last approximately 30 minutes with an average of 1–10 visits (Blount, 1998; Collins & Fund, 2010; Pomerantz et al., 2010). In the best integrated models, primary care providers and behavioral health specialists work closely together on the patient's treatment plan, and behavioral health information and interventions are jointly charted in the patient's medical record. This differs from traditional referrals from primary care provider to specialty mental health services wherein the patient is referred out for therapy and the patient becomes a client of the therapist with separate records and treatment plan. In addition to shorter terms of treatment and briefer visits, IBH models often involve frequent in-session interruptions wherein the behavioral health specialist may be requested to step out of a scheduled visit to attend to an urgent case or provide a brief intervention for a patient in the medical exam room (called a "warm handoff"); behavioral health consultants may be asked by medical providers to provide a range of behavioral interventions for mental health/substance abuse disorders as well as related to chronic disease management such as diabetes or asthma, or serve in a consultative role to medical providers about behavioral health treatment planning. IBH requires a shift from an individual client-based model of care to a population-based model of care. This approach often involves routine screenings for common behavioral health problems such as depression, anxiety, insomnia, and substance use, as well as the use of outcome metrics such as to track response to treatment overtime, most often in large-scale databases (Blount & Miller, 2009; Collins & Fund, 2010; Hine, Howell, & Yonkers, 2008; Mauer, 2009; Pomerantz et al., 2010).

Although somewhat variable between IBH settings, key conceptual differences between IBH and specialty mental health care models are outlined in Table 1.

TABLE 1 Defining Characteristics of the Primary Care Behavioral Care Versus Specialty Mental Health Treatment Models

Dimension	Primary behavioral health care	Mental health specialty care
Primary Goals	<ul style="list-style-type: none"> • perform appropriate clinical assessments • support medical provider decision making • build on medical provider interventions • teach medical provider “core” mental health skills • educate patient in self management skills through exposure • improve medical provider–patient working relationship • monitor, with medical provider, “at risk” patients • manage chronic patients with medical provider in primary provider role • assist in team building 	<ul style="list-style-type: none"> • deliver primary treatment to resolve/manage condition • reauthorization with Medical Provider • teach patient core self management skills • manage more serious mental disorders over time as primary provider • facilitate recovery • community reintegration
Session Structure	<ul style="list-style-type: none"> • one to three visits in typical case • 15–30-minute visits 	<ul style="list-style-type: none"> • session number variable, related to client condition • “session” definition variable from brief crisis to 50 minute visits to several hour interventions
Intervention Structure	<ul style="list-style-type: none"> • informal, revolves around primary care (medical) provider assessment and goals • less intensity, between session interval longer • relationship generally not primary focus • visits timed around medical provider visits • long-term follow-up rare, reserved for high risk cases 	<ul style="list-style-type: none"> • formal, requires intake assessment, treatment planning • higher intensity, involving more concentrated care • relationship built to last over time • visit structure not related to medical visits • long-term follow-up encouraged for most clients • community interventions
Intervention Methods	<ul style="list-style-type: none"> • limited face to face contact • uses patient education model as primary model • consultation is a technical resource to patient • emphasis on home-based practice to promote change • may involve medical provider in visits with patient 	<ul style="list-style-type: none"> • face to face contact is primary treatment vehicle • education model ancillary • home practice linked back to treatment • medical provider rarely involved in visits with client
Termination/ Follow-Up	<ul style="list-style-type: none"> • responsibility returned to medical provider in toto • medical provider provides relapse prevention or maintenance treatment 	<ul style="list-style-type: none"> • therapist remains person to contact if in need • therapist provides any relapse prevention or maintenance treatment

(Continued)

TABLE 1 (Continued)

Dimension	Primary behavioral health care	Mental health specialty care
Referral Structure	<ul style="list-style-type: none"> • client referred by medical provider only 	<ul style="list-style-type: none"> • client self-refers or is referred by others
Primary Information Products	<ul style="list-style-type: none"> • consultation report to medical provider • consultation report to medical provider • part of the medical record 	<ul style="list-style-type: none"> • specialty treatment notes (i.e., intake or progress notes) • part of a separate mental health record with minimal notation to medical record

(www.ibhp.org)¹

With the rapid expansion of IBH in primary care, one area of particular concern to health care agencies and policymakers is workforce preparedness to meet the demand for behavioral health services (U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality, 2008). Social workers are trained as generalists and approach health and well-being from a biopsychosocial perspective, and thus are well positioned to fill this behavioral health role. Indeed, the majority of IBH practitioners currently practicing in IBH settings are social workers (Kessler & Hunter, 2011). However, given the significant differences between specialty mental health settings or health care settings where social workers are traditionally trained to practice and the IBH practice model, it is important to ensure social workers are adequately prepared for effective IBH practice given the changing landscape of the health care delivery system.

Social Workers as Behavioral Health Specialists

Behavioral health professionals who work in integrated primary care settings go by a variety of names. They are referred to as behavioral health specialists, behavioral consultants, behaviorists, behavioral health therapists, and other titles. They are generally trained in either clinical social work or psychology, and in many states, licensure in one of these professions is required to bill for such services. It is increasingly clear that provision of such services requires special skills not typically provided in traditional mental health training (O'Donohue et al., 2008). Attention has been given to the need for and provision of such specialized training in medicine (Pisani, LeRoux, & Siegel, 2011; Zoberi, Niemeck, & Margolis, 2008), nursing (Interpersonal Education Collaborative Expert Panel, 2011; Weiss, Haber, Horowitz, Stuart, & Wolfe, 2009), and psychology (Blount & Miller, 2009; Masters, Stillman, Browning, & Davis, 2005; Pomerantz, Corson, & Detzer, 2009). There are several certificate programs around the country that emphasize the skills and knowledge needed to work in integrated care settings (see, e.g., IBH certificate programs: Department of Family Medicine and Community Health, University of Massachusetts Medical School; Farleigh Dickinson University;

University of Washington), and at least one university offers a specialized Doctor of Behavioral Health degree (<https://sls.asu.edu/graduate/proginfo/lbvehdbh>). While a variety of psychology programs provide special training in this area (Blount, 2009; Healey, Milbourne, Aaronson, & Errichetti, 2004), most MSW programs have mental health and/or health specializations, neither of which has traditionally captured this new type of practice. We are aware of only a handful of isolated training programs for social workers in primary care (see, e.g., Bilodeau et al., 2010; Damron-Rodriguez, 2008; Healey et al., 2004; Kent, 2011; Rock & Cooper, 2000). The National Association of Deans and Directors of Schools of Social Work (NADD) and the Council on Social Work Education (CSWE) have recently developed a curriculum on competencies and roles of social workers in integrated behavioral health and primary care settings (<http://www.cswe.org/CentersInitiatives/DataStatistics/58020.aspx>). However, little of a systematic nature is known about core competency areas utilized by social workers in IBH settings or the extent to which social workers feel prepared to practice in IBH primary care settings.

Purpose of the Current Study

The purpose of this study is to identify key practice domains for social workers in IBH settings, and to assess the extent to which social workers feel adequately prepared to work in IBH settings. The two main research questions we aim to assess are: (1) What are the primary skills and knowledge used by social workers in IBH settings? And (2) Do professional social workers feel prepared by their MSW training to work in IBH settings?

METHODS

Our survey assessed the primary skills and knowledge social workers in IBH setting viewed as important; where they learned those skills; and how prepared they felt from MSW training to work in IBH settings.

A two stage process was used to identify core competencies to include in the survey instrument. First, we reviewed the current research literature on workforce preparedness and training for behavioral health consultation in primary care. Because the evidentiary base for educational competencies in IBH is nascent, we included recommendations from conference proceedings, training curricula from certification programs as well as psychology graduate and postdoctoral programs in IBH. Second, we conducted key informant interviews with clinical social workers practicing in integrated settings. The key informant methodology of surveying clinical social work practitioners in IBH settings in order to obtain their assessment of key skills is based on the “occupational analysis” methodology employed by several state

licensure boards (http://www.bbs.ca.gov/exams/exam_development.shtml), and is considered to have high face validity, as individuals currently doing such work are presumed competent.

We subsequently identified a list of core competencies necessary for effective practice in primary care settings. For the purposes of this study, we use the definition of competency provided by Hoge, Tondora, and Marrelli (2007): “A competency is a measurable human capability that is required for effective performance. It is comprised of knowledge, a single skill or ability, or personal characteristic—or a cluster of these building blocks of work performance . . .” (p. 517). Once we identified core competency areas, we developed a 99-item survey for pilot testing. The initial survey was piloted among IBH social workers ($N = 8$) to assess content validity and feasibility. The final version of the survey was disseminated on Qualtrics online survey software via relevant e-mail listservs and by posting on professional message boards. Targeted listservs and message boards focused on those programs or groups of individuals known to have IBH practices. Similar online survey sampling methodology has been used previously by other scholars to assess views of other topic areas relevant to social work practice and pedagogy (Rubin & Parrish, 2007).

Data Analysis

Descriptive statistics such as frequency tables and chi-square analyses were used to analyze the survey data. A description of competency areas can be seen in Table 2. For analysis of the final open-ended question, the authors independently reviewed each response to identify emergent themes. Consistent with recommendations for descriptive qualitative research (Sandelowski, 2000) the authors then met to discuss themes and to ensure agreement on key themes in the respondents' answers.

Data Collection

The survey was conducted online and consisted of 99 items (see the Appendix). We used non-probability snowball sampling methodology to distribute the survey. Because there is no database of IBH clinics (i.e., no known population) (Selm & Jankowski, 2006), links to the survey were sent out to IBH listservs and posted on professional message boards such as www.cfha.net, part of the Collaborative Family Health Care Association, a national professional organization dedicated integrated care. Key contacts at the National Association of Social Workers and IBH colleagues were asked to forward the survey link to potential respondents. Participants were also asked to send the link to the survey on to relevant listservs and/or colleagues working as behavioral health practitioners in IBH settings.

TABLE 2 Competency Definitions

Competency	Definition
Functional Assessment	This is used to assess current level of functioning including both strengths of functioning and functional impairments in a variety of domains.
Warm Handoff	This is a referral in which the medical care provider directly introduces the client to the behavioral health provider at the time of the client's medical visit. The reason behind the "warm hand-off" is both to establish an initial face-to-face contact between the client and the behavioral counselor and to confer the trust and rapport the client has developed with the provider to the behavioral counselor.
Behavioral Activation	This is a brief evidence-based intervention for depression that focuses on activation and on processes that inhibit activation, such as escape and avoidance behaviors and ruminative thinking.
Motivational Interviewing	This is an intervention technique defined as: "a collaborative, person-centered form of guiding to elicit and strengthen motivation for change" in clients.
Problem Solving Treatment (PST)	Problem-solving treatment is a brief psychological intervention that has been shown to be effective in the treatment of major depression and for patients with a broad range of emotional disorders that have not resolved with simple measures. The treatment derives from cognitive-behavioral principles.
Cognitive Behavioral Therapy in Primary Care	This intervention is based on the traditional foundations of Cognitive Behavioral Therapy (CBT) but has been modified to be used for a variety of disorders (depression, anxiety, substance use, trauma) in as few as 4–6 sessions. In primary care settings, it is sometimes referred to as CBT-PC (Cognitive Behavioral Therapy in Primary Care).
Relaxation Training	This refers to a variety of techniques including teaching clients diaphragmatic breathing, mindfulness, and visualizations. It is often used to treat anxiety.
Team-Based Care	This refers to the ability to work effectively on an interdisciplinary or multidisciplinary team to enhance client care.
Chronic Disease Management	Refers to understanding the psychosocial implications and supporting the management of chronic physical conditions (such as diabetes, asthma, heart disease, etc.).
Psychotropic Medication	Refers to knowledge of psychotropic medication (including but not limited to familiarity with current medications, side-effects, and primary usage).
Alcohol and Drug (AOD) Brief Assessment and Intervention	Refers to the ability to assess and engage in brief intervention or referral related to AOD disorders. The CAGE, MAST, Brief MAST, TICS, or other screening tool are often used to complete AOD assessments.
Psychoeducation	Refers to the education offered to people who live with a psychological disturbance. It is often also offered to patients' families.
Curbside Consultation	This refers to the practice of brief, impromptu consultation with patients' medical providers to help inform patient treatment.

(Continued)

TABLE 2 (Continued)

Competency	Definition
Stepped Care	Refers to use of behavioral health algorithms for depression, anxiety and other behavioral conditions commonly seen in primary care settings.
Family Systems	This refers to knowledge of family systems theory and the role that families play in impacting health and well-being.
Case Management	Case management is a collaborative process of assessment, planning, facilitation, care coordination, evaluation, and advocacy for options and services to meet an individual's and family's comprehensive health needs through communication and available resources to promote quality cost-effective outcomes.
Cultural Competence	Cultural and linguistic competence is a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enables effective work in cross-cultural situations. "Culture" refers to integrated patterns of human behavior that include the language, thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups. "Competence" implies having the capacity to function effectively as an individual and an organization within the context of the cultural beliefs, behaviors, and needs presented by consumers and their communities. (Adapted from Cross, 1989).
Standardized Outcome Metrics	This refers to using standardized outcome measures to inform treatment decisions. Common outcome metrics include the Patient Health Questionnaire for depression (PHQ-9); the GAD-7 for anxiety; and so on.
Patient Centered Medical Home	This refers to knowledge about the PCMH as an approach to providing comprehensive, coordinated primary care for children, youth and adults. The PCMH is a health care setting that facilitates partnerships between individual patients, and their personal physicians, and when appropriate, the patient's family (www.ppcc.net).

¹Table adapted from: "Primary Behavioral Health Care Services Practice Manual 2.0, U.S. Air Force Medical Operations Agency, 2002".

The first several survey items captured demographic data, including educational information, description of IBH setting, number of patients seen per-day and amount of time spent with patients. The second set of questions asked participants a set of four questions about each of the 19 competency areas (Table 2): (1) Have you heard of this competency area?; (2) Do you use this competency at your current job?; (3) Where did you learn the most about this competency area?; (4) How important is this competency area in your job? When participants answered "no" to questions 1 or 2, they moved through a "skip sequence" and were directed to the next competency area. After assessing their skills in the various competency areas, participants were asked to rate their overall preparedness for practice in IBH settings and to identify the major source of their learning (e.g., MSW program, on the job,

training program). The final question in the survey was open-ended, and asked participants to provide more detailed information on factors they felt were important for social work preparedness for practice in IBH settings.

Sample and Response Rate

The study population included MSW-level social workers who identified as being employed in an IBH setting. The initial sampling frame included all persons (regardless of degree) who identified as being employed as a behavioral health specialist in an IBH setting. Because of the use of online snowball sampling methodology, we were unable to assess the total response rate for this survey. Over the course of one month, we collected 141 initial responses to the survey, and of those, 104 completed the entire survey (a completion rate of 73%), although only 54 participants answered the final open-ended question. Of those who completed the entire survey, 84 had MSWs and were included in the final analysis for this study. The other 57 respondents had other degrees (in psychology or counseling) or non-master's-level social work degrees (e.g., BSW) and were not included in the final analysis for this study because of our research questions' emphasis on MSW-level training.

RESULTS

Characteristics of Respondents

The majority of respondents ($N = 84$) were female (82%), non-Hispanic White (70%), and resided in California (63%). Other states represented by the remaining survey participants included Michigan, Arizona, Colorado, Indiana, Kansas, Missouri, New York, Oregon, Pennsylvania, Texas, Washington, and West Virginia. Fifty-six percent of respondents selected "Mental Health" as their primary MSW concentration area, with health concentrators being the next most commonly represented in this sample (20%). Nearly half (46%) of respondents graduated from their MSW programs within the past 10 years. Three of the MSW respondents also had PhDs in social work or related fields.

IBH Practice Context

The majority of respondents (67%) work in a primary care clinic with co-located or integrated behavioral health services. Approximately 16% of respondents work in a mental health setting with integrated or co-located primary care services, and the remainder of respondents works in some other form of IBH setting. Nearly half of the respondents (42%) are relatively new in their positions, having been in their current position between 1–3 years. In their capacity as behavioral health clinicians in IBH settings, just over a

third of respondents (37%) report seeing 3–5 patients in face-to-face visits per day, while 26% see 6–8 patients per day in face-to-face visits. Almost half (45%) of respondents report seeing individual patients for periods of 30–50 minutes.

Competencies and Training for IBH Practice

FAMILIARITY WITH KEY COMPETENCY AREAS

As can be seen in Table 3, the majority of respondents had typically heard of the competency areas in the survey. However, less than half had heard of stepped care (44%) or behavioral activation (48%).

SOURCE OF TRAINING IN KEY COMPETENCY AREAS

With the exception of cultural competence, knowledge of family systems, motivational interviewing, and relaxation training, the majority of respondents reported learning the other 15 IBH competency areas on the job.

TABLE 3 Competencies and Training

	Heard of?		Learned at school		Learned on job		Use on job?		Important?	
	<i>n</i>	%	<i>n</i>	%	<i>n</i>	&	<i>n</i>	%	<i>n</i>	%
Functional Assessment	65	77	11	13	27	32	39	46	35	42
Warm Handoff	66	79	7	8	50	60	60	71	57	68
Behavioral Activation	40	48	8	10	14	17	33	40	31	37
Motivational Interviewing*	76	91	22	26	13	17	69	82	63	76
Problem-Solving Treatment	50	60	8	10	14	17	40	48	36	43
CBT-PC	71	85	18	21	24	29	56	67	50	60
Relaxation Training**	75	89	15	18	17	20	69	82	52	74
Team-Based Care	71	84	14	17	54	64	68	81	68	81
Chronic Illness	72	86	9	10	54	64	64	76	70	83
Psychotropic Medication	77	92	14	17	45	54	76	91	72	86
AOD	57	68	9	11	25	30	33	39	29	35
Psychoeducation	72	86	25	30	40	48	70	83	68	81
Curbside Consultation	61	72	2	2	54	64	57	68	57	68
Stepped Care	37	44	3	4	16	19	16	50	16	19
Family Systems	77	92	65	77	5	6	73	87	64	76
Case Management	77	92	31	37	42	50	64	76	59	70
Cultural Competence	76	91	46	56	14	17	74	88	73	87
Standardized Outcome Measures	65	77	8	10	44	52	53	63	48	57
PCMH	57	68	2	2	45	54	50	60	52	44

(Important = very important + important).

*The majority (33%, *n* = 28) learned MI at a training;

**the majority (25%, *n* = 21) learned relaxation training via self-teaching.

The two major competency areas participants reported learning in their MSW programs were cultural competence and knowledge of family systems. The majority of participants with knowledge of motivational interviewing reported learning it at training. The majority of participants with knowledge of relaxation training endorsed learning this via self-teaching (i.e., reading a book about it).

COMPETENCIES USED ON THE JOB

The competency areas most commonly endorsed as being used on the job were: knowledge of psychotropic medications (91%), followed by cultural competence (88%), knowledge of family systems (87%), psychoeducation (83%), motivational interviewing (82%), relaxation training (82%), and team-based care (81%). Less than 50% report using functional assessment, problem-solving treatment or alcohol and drug assessment/intervention on the job.

IMPORTANCE OF COMPETENCY AREAS

Over 80% of respondents rated knowledge of psychosocial sequela of chronic illness, knowledge about psychotropic medication, skills in team-based care, cultural competence, and psychoeducation as important or very important competency areas at their job. Less than half endorsed functional assessment, problem solving treatment, alcohol and drug assessment and intervention, stepped care (clinical algorithms), or knowledge of the patient-centered medical home as important on-the-job competency areas for effective IBH practice.

Preparedness for IBH Practice

On the whole participants felt that they learned the majority of skills and competencies necessary for IBH practice on the job (66%), with only 10% endorsing MSW training as the main source of training for IBH practice. However, when asked about overall sense of preparedness based on MSW training, a combined 46% of respondents endorsed feeling “extremely prepared” or “prepared.” In this sample differences between years on the job and date of graduation were not significant predictors of self-rated preparedness in chi square analysis. MSW concentration was also not a significant predictor of self-rated preparedness in chi square analysis.

The final question asked, in open-ended phrasing, about other factors important for effective IBH practice. Participants consistently commented that MSW training provided a solid foundation for IBH practice, but that additional training specific to IBH would be helpful. In addition to increased

training related to specific interventions or increased knowledge related to psychopharmacology and chronic disease management, improved training to work as members of an interdisciplinary medical team also emerged as a key theme among respondents:

I think it is important for social workers going into health settings to have some understanding of the culture of medical education and what physicians do and do not learn in medical school. I think it is also important for social workers to have some knowledge about the dynamics of a patient physician relationship. In addition I also think it would be helpful for social workers to have seen how the medical model compares to the psychosocial approach to treating patients and the challenges/benefits of working in an interdisciplinary team.

To be familiar with common chronic health issues as well as mental health issues. It is important to have a working knowledge of psych meds as well as other medications used in a health care setting. You need to be able to advocate for your patients when you are working with doctors, nurses etc. who may have a different view or philosophy than social workers.

Additionally, some respondents described the importance of working in cross-cultural and multilingual settings:

We consistently see shortage of bilingual mental health practitioners. Fully half of clients at the primary care clinic where I work are Hispanic. This reflects changing demographics in state, and MSW students should know importance of speaking and developing their language competence. Only LCSWs can work at FQHCs, MSW-trained counselors have huge advantage over MFTs in this respect. I may be biased but I always thought MSW training was best course and it has served me well, I got my MSW in 1982 and have been able to move with the changing tides in mental health.

DISCUSSION

This survey examined key competency areas utilized by social workers in IBH settings, and assessed the extent to which social workers currently employed in IBH settings felt prepared for IBH practice by their MSW program versus other sources of learning (e.g., learning on the job, attending trainings). In sum, we found a “both and” effect of MSW training. That is, MSW training *both* affords social workers a general sense of preparedness for IBH practice *and* social workers still require additional training in many competency areas required in IBH practice settings.

Overall, social workers feel prepared to work in integrated care settings by their MSW training. However, while it is reassuring that MSW programs lay a foundation for social workers to enter the IBH workforce, the overwhelming majority of specific competency areas necessary for IBH practice (in particular in primary care) are learned by social workers on the job. Thus, while generalist training afforded to MSW students is clearly an excellent starting point for entry into IBH practice, additional training opportunities for social work students in IBH competency areas will increasingly be required for social workers to maintain a competitive edge for IBH positions. This is especially true given that other allied professions such as psychology and marriage and family therapy programs are in the process of creating or modifying curriculum allowing students to specialize in primary care practice.

With regard to IBH competency areas, our findings confirmed the importance of many of the competency areas found from our review of the extant literature on IBH practice. In fact, all but four of the competency areas were used by over half the survey participants on the job. In particular, knowledge of psychotropic medication, interdisciplinary (team) collaboration, psychoeducation, knowledge of chronic illness and cultural competence were overwhelmingly endorsed as important on-the-job competencies. Additionally, motivational interviewing, relaxation training, curbside consultation with medical providers were also highly ranked as commonly-used interventions for IBH practice. It is interesting to note that in our review of the literature on training and competency areas, very few mention cultural competence or cultural humility, which may be a reflection that social workers bring with them an acute awareness of the need for this competency area in IBH practice.

Less than half of the participants endorsed problem solving treatment or stepped care algorithms as important on the job. This is particularly interesting in light of the movement toward evidence based interventions such as IMPACT that utilize problem solving treatment and stepped care algorithms for depression, anxiety and other conditions in primary care. This may be an indication that many integrated settings have yet to incorporate these evidence-based interventions into practice. Thus, we would urge caution when interpreting the importance rankings of these competency areas, especially given the growing emphasis on the use of evidence-based practices (EBPs) in IBH settings. We would imagine that over time, IBH settings will increasingly be turning toward such stepped-care EBPs. Alcohol and other drug assessment and intervention and knowledge of the patient centered medical home were also only ranked important by less than half of participants. Given the increased attention to substance use disorders as part of behavioral health treatment (see, e.g., SAMHSA), we would also expect that social workers will increasingly be required to utilize AOD assessment

and intervention increasingly in IBH settings. Similarly, contextual knowledge of PCMH and the policy landscape of ACA will also be important knowledge areas for effective IBH practice.

STUDY LIMITATIONS

There are several limitations to this study. First, generalizability to all IBH social workers is not possible due to non-probability sampling. This survey is based on an overwhelmingly California-based sample. This not only biases the results toward the demographics of California patients, but also toward prevailing service models found in California.

Second, some competency definitions may have suffered from social desirability bias. Because cultural competence is such an important part of MSW education, it is possible that social workers would endorse this competency area and its importance on the job. More specificity in this area will lead to more discriminatory power for the item, and allow a deeper understanding of this domain. For example, Tervalon and Murray-Garcia (1998) describe the concept of “cultural humility,” which places the clinician in a fundamentally different juxtaposition with the patient. This is particularly important because according to the California Pan-Ethnic Health Network (2009), more than half those eligible for subsidies or Medi-Cal under the ACA are people of color, and 32–51% of adults in these groups speak English less than well.

Third, this study mainly looked at practitioners working in only one direction of the “bi-directional” integration paradigm (IBH in primary care settings). These clinical social workers serve the cohort of patients found in primary care clinics, and assess and address their behavioral health needs. A minority of participants in our sample reported working in reverse co-located settings (specialty behavioral health settings with co-located or integrated primary care). This study did not account for additional skills or competency areas required for such settings. A separate examination of the skills and knowledge needed by those working in reverse co-located is warranted, as clients in these settings are known to suffer from serious and persistent mental illness, co-morbid substance abuse, periodic homelessness, and multi-system involvement.

Finally, there are many models of integration of behavioral health services into primary care. The items in this survey placed heavy emphasis on one model. Moreover, we did not assess the extent of integration in any of the settings (i.e., co-location versus actual integration). Related to this limitation is one associated with the necessary limitations of language. Any profession or emerging practice area has esoteric language, or jargon. The possibility exists for a disconnect between practice activities and the

commonly accepted language that describes that activity. For example, a practitioner may be practicing “curbside consultation” without actually being familiar with the term.

IMPLICATIONS FOR SOCIAL WORK

Despite the limitations of our study design, our findings suggest that MSW training is useful for social workers in IBH practice, but that additional training in practice techniques specific to IBH settings is important for social workers. In addition to family systems and cultural competence (two of the competency areas that respondents overwhelmingly attributed to MSW training), it seems likely that MSW training in systems, person-in-environment, and biopsychosocial theories make social workers particularly well-suited to IBH practice. However, while MSW training provides a good starting point, survey respondents overwhelmingly noted they had learned needed skills “on the job.” Given the rapid expansion of IBH practice settings, and the proliferation of IBH certificate programs and primary care specializations in psychology and other allied professions, social workers will be more competitive on the IBH job market with additional IBH relevant competencies.

Future curricular research should take a special look at field education, and examine the types of internships available via various MSW programs. For example, it seems clear that interdisciplinary training and IBH field placements are crucial to advance MSW’s preparedness to enter the IBH workforce. This is especially pertinent given the emphasis on behavioral health specialist’s role as *consultant*, not only to the patient, but also to members of the medical team. There is much literature available on effective models of interdisciplinary training from social work and other allied disciplines.

While we would argue that the traditional separation of health and mental health concentrations may soon become obsolete and unnecessarily reify antiquated separations between fields of practice (indeed, as our findings indicate, intimate knowledge of both physical and mental health and related systems are key for IBH practice), we recognize that drastic changes to curricula may take time. Nonetheless, there are several competency areas that could easily be incorporated into practice courses in multiple concentrations (including, for example, gerontology). Namely: motivational interviewing, relaxation training (mindfulness), use of a variety of screening and outcome measurement tools, psychoeducation, and psychotropic medication. While many schools of social work teach some or all of these components, it will be increasingly important to teach these competency areas in the context of health care reform. Social workers will also be at an advantage if they exit MSW training with knowledge of the emerging evidence-based interventions

used in primary care such as how to use stepped care treatment algorithms, problem solving treatment, and brief AOD assessment and interventions.

CONCLUSION

Our study has contributed to the nascent literature on social work preparedness for practice in IBH settings, and highlighted key competency areas for social work practice in these settings. While our study points to important competency areas to include in MSW training, it will take more than simply incorporating a list of competency areas to existing MSW classes to adequately address the IBH workforce needs. Future practice-based research should examine additional competency areas, and parse out the specifics of each. For example, what aspects of, say, psychoeducation are important for IBH practice? What are components of effective psychoeducation? How should social work skills on providing psychoeducation be assessed? How will social workers be deemed *competent* in this area? (Such questions should be examined for each IBH competency area.) Findings from our survey can help guide these and other efforts to build on the current strengths of social work training and prepare the next generation of IBH social workers to be leaders in the field.

REFERENCES

- American Academy of Family Physicians. (2012). Retrieved from <http://www.aafp.org/online/en/home/membership/initiatives/pcmh.html>
- Areán, P.A., Ayalon, L., Jin, C., McCulloch, C.E., Linkins, K., Chen, H., . . . Estes, C. (2008). Integrated specialty mental health care among older minorities improves access but not outcomes: Results of the PRISMe study. *International Journal of Geriatric Psychiatry, 23*(10), 1086–1092.
- Ayalon, L., Areán, P.A., Linkins, K., Lynch, M., & Estes, C.L. (2007). Integration of mental health services into primary care overcomes ethnic disparities in access to mental health services between black and white elderly. *American Journal of Geriatric Psychiatry, 15*(10), 906–912.
- Bilodeau, A., Dumont, S., Hagan, L., Paré, L., Razmpoosh, M., Houle, N., . . . Iloko-Fundi, M. (2010). Interprofessional education at Laval University: Building an integrated curriculum for patient-centred practice. *Journal of Interprofessional Care, 24*(5), 524–535. doi:10.3109/13561821003724026
- Blount, A. E. (1998). *Integrated primary care: The future of medical and mental health collaboration*. New York, NY: W.W. Norton & Co.
- Blount, A., Schoenbaum, M., Kathol, R., Rollman, B. L., Thomas, M., O'Donohue, W., & Peek, C. J. (2007). The economics of behavioral health services in medical settings: A summary of the evidence. *Professional Psychology: Research and Practice, 38*(3), 290–297. doi:10.1037/0735-7028.38.3.290

- Blount, F.A., & Miller, B.F. (2009). Addressing the workforce crisis in integrated primary care. *Journal of Clinical Psychology in Medical Settings*, 16(1), 113–119.
- Butler, M., Kane, R. L., McAlpine, D., et al. (2008, October). Integration of Mental Health/Substance Abuse and Primary Care. (Evidence Reports/Technology Assessments, No. 173.). Rockville, MD: Agency for Healthcare Research and Quality (US); Retrieved from <http://www.ncbi.nlm.nih.gov/books/NBK38632/>
- Collins, C., & Fund, M. M. (2010). *Evolving models of behavioral health integration in primary care*. Milbank Memorial Fund. Retrieved from http://searchpdfdownload.com/pdf/download/www__milbank__org-reports-10430-EvolvingCare-EvolvingCare.pdf
- Damron-Rodriguez, J. (2008). Developing competence for nurses and social workers. *Journal of Social Work Education*, 44, 27–37.
- Ell, K., & Vourlekis, B. (2008). Social work in health care in 2025: The landscape and paths of transformation. *Advances in Social Work*, 6(1), 182–192.
- Gray, G. V., Brody, D. S., & Hart, M. T. (2000). Primary care and the de facto mental health care system: Improving care where it counts. *Managed Care Interface*, 13(3), 62–65.
- Haas, L. J. (2004). *Handbook of primary care psychology*. Oxford University Press U.S.
- Healey, K., Milbourne, G., Aaronson, W.E., & Errichetti, A.M. (2004). Innovative training for integrated primary health care teams: Creating simulated/standardized patient training in an international context. *Families, Systems & Health: The Journal of Collaborative Family HealthCare*, 22(3), 368–375.
- Hine, C.E., Howell, H.B., & Yonkers, K.A. (2008). Integration of medical and psychological treatment within the primary health care setting. *Social Work in Health Care*, 47(2), 122.
- Hoge, M. A., Tondora, J., & Marrelli, A. F. (2005). The fundamentals of workforce competency: Implications for behavioral health. *Administration and Policy in Mental Health and Mental Health Services Research*, 32(5), 509–531. doi:10.1007/s10488-005-3263-1
- Interpersonal Education Collaborative Expert Panel. (2011). *Core Competencies for Interprofessional Collaborative Practice: Report of an Expert Panel*. Washington, DC: Interprofessional Education Collaborative.
- Katon, W., Robinson, P., Von Korff, M., Lin, E., Bush, T., Ludman, E., . . . Walker, E. (1996). A Multifaceted Intervention to Improve Treatment of Depression in Primary Care. *Arch Gen Psychiatry*, 53(10), 924–932. doi:10.1001/archpsyc.1996.01830100072009
- Kent, B. (2011). Personal e-mail communication. Course taught at Farleigh Dickinson University School of Social Work on social work in integrated primary care.
- Kessler, R., & Stafford, D. (2008). *Collaborative medicine case studies: Evidence in practice*. New York, NY: Springer.
- Kessler, R., & Hunter, C. (2011). *On Science, Metrics & Outcomes: Is Collaborative Care an Evidence Based Practice?* Presentation at the Collaborative Family Health Care Association Annual Conference, Philadelphia, PA, October 27–29, 2011.
- Kiser L.J., Lefkowitz P.M., & Kennedy L.L. (eds.). (2001). *The Integrated Behavioral Health Continuum: Theory and Practice*. Washington, DC: American Psychiatric Press.

- Manoleas, P. (2008). Integrated primary care and behavioral health services for Latinos: A blueprint and research agenda. *Social Work in Health Care, 47*(4), 438–454.
- Masters, K.S., Stillman, A.M., Browning, A.D., & Davis, J.W. (2005). Primary care psychology training on campus: Collaboration within a student health center. *Professional Psychology, Research & Practice, 36*(2), 144–150.
- Mark, T., Levit, K., & Buck, J. (2009). Datapoints: Psychotropic drug prescriptions by medical specialty. *Psychiatric Services, 60*(9), 1167.
- Mauer, B. (2009). *Behavioral Health/Primary Care Integration and the Person-Centered Healthcare Home*. Washington, DC: National Council for Community Behavioral Healthcare.
- O'Donohue, W.T., Cummings, N.A., & Cummings, J.L. (2008). The unmet educational agenda in integrated care. *Journal of Clinical Psychology in Medical Settings, 16*(1), 94–100. doi:10.1007/s10880-008-9138-3
- Pisani, A.R., LeRoux, P., & Siegel, D.M. (2011). Educating residents in behavioral health care and collaboration: Integrated clinical training of pediatric residents and psychology fellows. *Academic Medicine, 2011 Feb, 86*(2), 166–173.
- Pomerantz, A.S., Corson, J.A., & Detzer, M.J. (2009). The challenge of integrated care for mental health: Leaving the 50 minute hour and other sacred things. *Journal of Clinical Psychology in Medical Settings, 16*(1), 40–46.
- Pomerantz, A. S., Shiner, B., Watts, B. V., Detzer, M. J., Kutter, C., Street, B., & Scott, D. (2010). The White River model of colocated collaborative care: A platform for mental and behavioral health care in the medical home. *Families, Systems, & Health, 28*(2), 114.
- Rock, B.D., & Cooper, M. (2000). Social work in primary care: A demonstration student unit utilizing practice research. *Social Work in Health Care, 31*(1), 1–17.
- Roy-Byrne, P. (2013). Collaborative care at the crossroads. *The British Journal of Psychiatry, 203*(2), 86–87. doi:10.1192/bjp.bp.113.128728
- Roy-Byrne, P. P., Craske, M. G., Stein, M. B., Sullivan, G., Bystritsky, A., Katon, W., . . . Sherbourne, C. D. (2005). A randomized effectiveness trial of cognitive-behavioral therapy and medication for primary care panic disorder. *Archives of General Psychiatry, 62*(3), 290.
- Rubin, A., & Parrish, D. (2007). Views of evidence-based practice among faculty in master of social work programs: A national survey. *Research on Social Work Practice, 17*(1), 110–122. doi:10.1177/1049731506293059
- Sandelowski, M. (2000). Focus on research methods – Whatever happened to qualitative description? *Research in Nursing and Health, 23*(4), 334–340.
- Schaefer, J., & Davis, C. (2004). Case management and the chronic care model: A multidisciplinary role. *Professional Case Management, 9*(2), 96.
- Selm, M.V., & Jankowski, N.W. (2006). Conducting online surveys. *Quality and Quantity, 40*(3), 435–456. doi:10.1007/s11135-005-8081-8
- Tervalon, M., & Murray-Garcia, J. (1998). Cultural humility versus cultural competence: A critical distinction in defining physician training outcomes in multicultural education. *Journal of Health Care for the Poor and Underserved, 9*(2), 117–125.
- U.S. Air Force Medical Operations Agency. (2002). *Primary Behavioral Health Care Services Practice Manual 2.0*. Lackland AFB, Texas. Retrieved from <http://>

old.thenationalcouncil.org/galleries/business-practice%20files/2011%20BHOP%20Manual%20-%20PDF,%207.28%20updates.pdf

- U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality. (2008). *Evidence Report/Technology Assessment Number 173, Integration of Mental Health/Substance Abuse and Primary Care*. Rockville, MD.
- U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration. (1998). *Interprofessional Health Care Services in Primary Care Settings: Implications for the Education and Training of Psychologists*. Rockville, MD: Substance Abuse and Mental Health Services Administration.
- Weiss, S.J., Haber, J., Horowitz, J.A., Stuart, G.W., & Wolfe, B. (2009). The inextricable nature of mental and physical health: Implications for integrative care. *Journal of the American Psychiatric Nurses Association*, 15(6), 371–382.
- Zoberi, K., Niemec, R.M., & Margolis, R.B. (2008). Teaching integrated behavioral health in a primary care clerkship. *Medical Teacher*, 30(7), 218–223.

APPENDIX : SURVEY ITEMS

Please select your gender

- Male
- Female

Please select your primary ethnicity

- Latino/a
- African American
- Asian
- Non-Hispanic White
- Native American/Indigenous Peoples
- Mixed
- Other

In what state do you currently reside?

Please write in your age in years

Please select the highest degree you have earned to date

- Associate's Degree (AA)
- Bachelor's Degree
- Master's Degree
- Doctoral Degree

Please enter the year you graduated from the institution where you earned your highest degree

What kind of bachelor's degree did you earn?

- BA
- BS
- BSW

What kind of master's degree did you earn?

- MSW
- MFT
- Master's in Counseling
- Other

Please name the type of Master's Degree you earned

In what area did you earn your doctoral degree?

- Social Work/Welfare
- Psychology
- Counseling
- Other

Please name the area in which you earned your doctoral degree:

Please select your primary area of concentration (or the closest approximation)

- Health
- Mental Health
- Children and Families
- Gerontology
- Management and Planning
- Other

Are you currently licensed as a mental health professional?

- Yes
- No

What is your current job title?

Please select the type of practice setting where you currently work

- Primary care clinic with co-located or integrated behavioral health services
- Specialty mental health clinic with co-located or integrated primary care services
- Substance abuse center that also offers medical services
- Other

Do you work for the VA?

- Yes
- No

Please describe the type of integrated/co-located health/behavioral health site where you work:

How many years have you been in your current job?

- 0
- 1-3
- 4-6
- 8-10
- 11+

During an average work-day, how many clients do you see for face-to-face visits?

- 0-2
- 3-5
- 6-8
- 8-10
- 11+

On average, how much time (in minutes) do you spend with your clients in your setting? (Face-to-face clinical time).

- 5-15
- 15-30
- 30-50
- 50+

The following are some activities or information that you may or may not use in your daily practice. Please answer each question to the best of your ability:

FUNCTIONAL ASSESSMENT is used to assess current level of functioning including both strengths of functioning and functional impairments in a variety of domains.

Have you heard of this before?

- Yes
- No

Where did you learn the most about Functional Assessment?

- MSW program
- Other graduate program
- On-the-job
- Attended a training
- Self-taught (e.g., read about it on your own, sought information from others, etc)
- I have not learned about this (only heard about it)

Have you done a functional assessment at your current job?

- Yes
- No

Please rate the importance of functional assessment in your current job

- Extremely Important
- Important
- Neither Important nor Unimportant
- Unimportant
- Not at all Important

WARM HANDOFF: a referral in which the medical care provider directly introduces the client to the behavioral health provider at the time of the client's medical visit. The reason behind the "warm hand-off" is both to establish an initial face-to-face contact between the client and the behavioral counselor and to confer the trust and rapport the client has developed with the provider to the behavioral counselor.

Have you heard of this before?

- » Yes
- » No

Where did you learn the most about the Warm Handoff?

- » MSW program
- » Other graduate program
- » On-the-job
- » Attended a training
- » Self-taught (e.g., read about it on your own, sought information from others, etc)
- » I have not learned about this (only heard about it)

Do you use the warm handoff at your current job?

- Yes
- No

Please rate the importance of warm handoff referrals at your current job

- » Extremely Important
- » Important
- » Neither Important nor Unimportant
- » Unimportant
- » Not at all Important

Behavioral Activation: This is a brief evidence-based intervention for depression that focuses on activation and on processes that inhibit activation, such as escape and avoidance behaviors and ruminative thinking.

Have you heard of behavioral activation before?

- Yes
- No

Where did you learn the most about behavioral activation?

- » MSW program
- » Other graduate program
- » On-the-job
- » Attended a training
- » Self-taught (e.g., read about it on your own, sought information from others, etc)
- » I have not learned about this (only heard about it)

Have you used behavioral activation at your current job?

- Yes
- No

Please rate the importance of Behavioral Activation in your current job

- » Extremely Important
- » Important
- » Neither Important nor Unimportant
- » Unimportant
- » Not at all Important

Motivational Interviewing: This is an intervention technique defined as: "a collaborative, person-centered form of guiding to elicit and strengthen motivation for change" in clients.

Have you heard of Motivational Interviewing before?

- Yes
- No

Where did you learn the most about Motivational Interviewing?

- » MSW program
- » Other graduate program
- » On-the-job
- » Attended a training
- » Self-taught (e.g., read about it on your own, sought information from others, etc)
- » I have not learned about this (only heard about it)

Have you used Motivational Interviewing at your current job?

- Yes
- No

Please rate the importance of motivational interviewing at your current job:

- » Extremely Important
- » Important
- » Neither Important nor Unimportant
- » Unimportant
- » Not at all Important

Problem Solving Treatment (PST): Problem-solving treatment is a brief psychological intervention that has been shown to be effective in the treatment of major depression and for patients with a broad range of emotional disorders that have not resolved with simple measures. The treatment derives from cognitive-behavioural principles.

Have you heard of Problem Solving Treatment before?

- Yes
- No

Where did you learn the most about Problem Solving Treatment?

- » MSW program
- » Other graduate program
- » On-the-job
- » Attended a training
- » Self-taught (e.g., read about it on your own, sought information from others, etc)
- » I have not learned about this (only heard about it)

Do you use Problem Solving Treatment at your current job?

- Yes
- No

Please rate the importance of Problem Solving Treatment at your current job

- » Extremely Important
- » Important
- » Neither Important nor Unimportant
- » Unimportant
- » Not at all Important

Brief Cognitive Behavioral Therapy: This intervention is based on the traditional foundations of Cognitive Behavioral Therapy (CBT) but has been modified to be used for a variety of disorders (depression, anxiety, substance use, trauma) in as few as 4-6 sessions. In primary care settings, it is sometimes referred to as CBT-PC (Cognitive Behavioral Therapy in Primary Care).

Have you heard of Brief Cognitive Behavioral Therapy or CBT-PC before?

- Yes
- No

Where did you learn the most about Brief Cognitive Behavioral Therapy or CBT-PC?

- » MSW program
- » Other graduate program
- » On-the-job
- » Attended a training
- » Self-taught (e.g., read about it on your own, sought information from others, etc)
- » I have not learned about this (only heard about it)

Do you use Brief Cognitive Behavioral Therapy or CBT-PC?

- Yes
- No

How important is Brief Cognitive Behavioral Therapy or CBT-PC in your current practice setting?

- » Extremely Important
- » Important
- » Neither Important nor Unimportant
- » Unimportant
- » Not at all Important

Relaxation training: This refers to a variety of techniques including teaching clients diaphragmatic breathing, mindfulness, and visualizations. It is often used to treat anxiety.

Have you heard of relaxation training before?

- Yes
- No

Where did you learn the most about relaxation training?

- » MSW program
- » Other graduate program
- » On-the-job
- » Attended a training
- » Self-taught (e.g., read about it on your own, sought information from others, etc)
- » I have not learned about this (only heard about it)

Do you use relaxation training at your current job?

- Yes
- No

Please rate the importance of relaxation training at your current job

- » Extremely Important
- » Important
- » Neither Important nor Unimportant
- » Unimportant
- » Not at all Important

Team-based care: This refers to the ability to work effectively on an interdisciplinary or multi-disciplinary teams to enhance client care.

Have you heard of team-based care before?

- Yes
- No

Where did you learn the most about team-based care?

- » MSW program
- » Other graduate program
- » On-the-job
- » Attended a training
- » Self-taught (e.g., read about it on your own, sought information from others, etc)
- » I have not learned about this (only heard about it)

Do you currently engage in team-based care?

- Yes
- No

How important is team-based care in your current practice setting?

- » Extremely Important
- » Important
- » Neither Important nor Unimportant
- » Unimportant
- » Not at all Important

Have you heard about the psychosocial implications and management of chronic physical conditions (such as diabetes, asthma, heart disease, etc) before?

- Yes
- No

Where did you learn the most about the psychosocial implications and management of chronic physical conditions (such as diabetes, asthma, heart disease, etc).

- » MSW program
- » Other graduate program
- » On-the-job
- » Attended a training
- » Self-taught (e.g., read about it on your own, sought information from others, etc)
- » I have not learned about this (only heard about it)

Do you implement your knowledge of psychosocial implications and management of chronic physical conditions (such as diabetes, asthma, heart disease, etc) in your current job?

- Yes
- No

Please rate the importance of knowing about psychosocial implications and management of chronic physical conditions at your current job:

- » Extremely Important
- » Important
- » Neither Important nor Unimportant
- » Unimportant

- » Not at all Important

Have you learned about psychotropic medication (including but not limited to familiarity with current medications, side-effects, and primary usage) before?

- Yes
- No

Where did you learn the most about psychotropic medication?

- » MSW program
- » Other graduate program
- » On-the-job
- » Attended a training
- » Self-taught (e.g., read about it on your own, sought information from others, etc)
- » I have not learned about this (only heard about it)

Do you utilize your knowledge about psychotropic medications at your current job?

- Yes
- No

Please rate the importance of knowing about psychotropic medications at your current job:

- » Extremely Important
- » Important
- » Neither Important nor Unimportant
- » Unimportant
- » Not at all Important

Alcohol and Other Drug (AOD) Assessment and brief intervention: The CAGE, MAST, Brief MAST, TICS, or other screening tool are often used to complete AOD assessments.

Are you familiar with AOD assessment and intervention?

- Yes
- No

Where did you learn the most about brief AOD assessment and intervention?

- » MSW program
- » Other graduate program
- » On-the-job
- » Attended a training
- » Self-taught (e.g., read about it on your own, sought information from others, etc)
- » I have not learned about this (only heard about it)

Do you use AOD assessment and intervention at your current job?

- Yes
- No

Please rate the importance of AOD assessment and intervention at your current job:

- » Extremely Important
- » Important
- » Neither Important nor Unimportant
- » Unimportant
- » Not at all Important

Psychoeducation: Refers to the education offered to people who live with a psychological disturbance. It is often also offered to patients' families.

Have you heard of psychoeducation before?

- Yes
- No

Where did you learn the most about psychoeducation?

- » MSW program
- » Other graduate program
- » On-the-job
- » Attended a training
- » Self-taught (e.g., read about it on your own, sought information from others, etc)
- » I have not learned about this (only heard about it)

Do you use psychoeducation in your current job?

- Yes
- No

Please rate the importance of psychoeducation at your current job

- » Extremely Important
- » Important
- » Neither Important nor Unimportant
- » Unimportant
- » Not at all Important

Curbside consultation with medical providers: This refers to the practice of brief, impromptu consultation with patients' medical providers to help inform patient treatment.

Have you heard of curbside consultation before?

- Yes
- No

Where did you learn the most about curbside consultation

- » MSW program
- » Other graduate program
- » On-the-job
- » Attended a training
- » Self-taught (e.g., read about it on your own, sought information from others, etc)
- » I have not learned about this (only heard about it)

Do you use curbside consultation at your job?

- Yes
- No

Please rate the importance of curbside consultation at your job

- » Extremely Important
- » Important
- » Neither Important nor Unimportant
- » Unimportant
- » Not at all Important

Stepped-care or other behavioral health algorithms for depression, anxiety and other behavioral conditions commonly seen in primary care settings.

Have you heard of stepped care or algorithms for behavioral health before?

- Yes
- No

Where did you learn the most about stepped care behavioral health care?

- » MSW program
- » Other graduate program
- » On-the-job
- » Attended a training
- » Self-taught (e.g., read about it on your own, sought information from others, etc)
- » I have not learned about this (only heard about it)

Do you use stepped-care or behavioral health algorithms in your current work setting?

- Yes
- No

Please rate the importance of stepped care at your current work setting.

- » Extremely Important
- » Important
- » Neither Important nor Unimportant

- » Unimportant
- » Not at all Important

Family systems: this refers to family systems theory and the role that families play in impacting health and well-being.

Have you heard of family systems theory before?

- Yes
- No

Where did you learn the most about family systems and health?

- » MSW program
- » Other graduate program
- » On-the-job
- » Attended a training
- » Self-taught (e.g., read about it on your own, sought information from others, etc)
- » I have not learned about this (only heard about it)

Do you use your knowledge of family systems and health at your current job?

- Yes
- No

Please rate the importance of knowing about family systems and health at your current job

- » Extremely Important
- » Important
- » Neither Important nor Unimportant
- » Unimportant
- » Not at all Important

Case management: Case management is a collaborative process of assessment, planning, facilitation, care coordination, evaluation, and advocacy for options and services to meet an individual's and family's comprehensive health needs through communication and available resources to promote quality costeffective outcomes

Have you heard of case management before?

- Yes
- No

Where did you learn the most about case management

- » MSW program
- » Other graduate program
- » On-the-job
- » Attended a training
- » Self-taught (e.g., read about it on your own, sought information from others, etc)
- » I have not learned about this (only heard about it)

Do you engage in case management at your current job?

- Yes
- No

Please rate the importance of case management at your current job

- » Extremely Important
- » Important
- » Neither Important nor Unimportant
- » Unimportant
- » Not at all Important

Cultural competence: Cultural and linguistic competence is a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enables effective work in cross-cultural situations. 'Culture' refers to integrated patterns of human behavior that include the language, thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups. 'Competence' implies having the capacity to function effectively as an individual and an organization within the context of the cultural beliefs, behaviors, and needs presented by consumers and their communities. (Adapted from Cross, 1989).

Have you heard of cultural competence?

- Yes
- No

Where did you learn the most about cultural competence?

- » MSW program
- » Other graduate program
- » On-the-job
- » Attended a training
- » Self-taught (e.g., read about it on your own, sought information from others, etc)
- » I have not learned about this (only heard about it)

Do you utilize cultural competence at your current job?

- Yes
- No

Please rate the importance of cultural competence at your current job

- » Extremely Important
- » Important
- » Neither Important nor Unimportant
- » Unimportant
- » Not at all Important

Use of standardized outcome measures to inform treatment: Common outcome metrics include the Patient Health Questionnaire for depression (PHQ-9); the GAD-7 for anxiety; etc.

Have you heard of using standardized outcome measures to inform treatment decisions before?

- Yes
- No

Where did you learn the most about using standardized outcome measures to inform treatment decisions?

- » MSW program
- » Other graduate program
- » On-the-job
- » Attended a training
- » Self-taught (e.g., read about it on your own, sought information from others, etc)
- » I have not learned about this (only heard about it)

Do you use standardized outcome measures to inform treatment decisions at your current job?

- Yes
- No

Please rate the importance of using standardized outcome measures to inform treatment decisions at your current job

- » Extremely Important
- » Important
- » Neither Important nor Unimportant
- » Unimportant
- » Not at all Important

The patient centered medical home is an approach to providing comprehensive primary care for children, youth and adults. The PCMH is a health care setting that facilitates partnerships between individual patients, and their personal physicians, and when appropriate, the patient's family.

Have you heard of the patient-centered medical home before?

- Yes
- No

Where did you learn the most about the patient-centered medical home?

- » MSW program
- » Other graduate program
- » On-the-job
- » Attended a training
- » Self-taught (e.g., read about it on your own, sought information from others, etc)
- » I have not learned about this (only heard about it)

Do you use your knowledge of the patient-centered medical home at your current job?

- Yes
- No

Please rate the importance of knowing about the patient-centered medical home at your current job

- » Extremely Important
- » Important
- » Neither Important nor Unimportant
- » Unimportant
- » Not at all Important

Considering the skills and knowledge that you use on a day-to-day basis, how much did your MSW training prepare you to work in your current setting?

- Extremely prepared
- Prepared
- Neither prepared nor unprepared
- Not prepared
- Extremely unprepared

Considering the sum total of skills and knowledge you use on a day-to-day basis, where did you obtain the majority of your preparation?

- MSW Program
- Other graduate program
- On-the-job
- Attended a training
- Self-taught (e.g., read about it on your own, sought help from others)

In the box below, please share any skills or knowledge that you believe are important for social work practice in integrated behavioral health/primary care settings: