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The Integrated Behavioral Health Service Delivery System Model

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Costs and effective management of health care in general, and behavioral health care in particular, have been of primary importance and concern to federal, state, and local governments. With the passage of Health Care Reform (HCR) these concerns will only escalate. Thus, the necessity for the development of innovative, successful, and integrated cost-effective treatments and procedures is evident. The behavioral health care model presented here is proposed to address these needs. The model centers on the composition of effective psychosocial treatment and provides a cost analysis of social work and its services. By defining the problems that need to be addressed in health care management and cost containment, and applying findings of evidence-based studies, this article provides an effective model for health care organizations. It also presents a profile of the behavioral health social worker, defining the requisite abilities for effectiveness in the role and looking at the key impact areas for a behavioral health model. This comprehensive guide will prepare new social workers entering health care organizations as well as provide a valuable reference for existing social workers, academics, and practitioners of behavioral health care.

Keywords: Integrated behavioral health, Health Care Reform

Amid dramatic changes in the health care industry accompanying the implementation of Health Care Reform (HCR) will come major innovation and modification to managed health care as it is now known. This article focuses on three paradigm shifts presently taking place: the effectiveness of health care, the cost efficiency of health care systems, and the service integration of fragmented systems specifically those of health care, substance abuse treatment, and mental health services (Blount et al., 2007; Clancy, 2009; Donaldson et al., 1996; Frank, 2009; Law, 2006; Munsey, 2006; J. S. Wodarski, 2000).

Increased costs and proposed budget cuts are forcing segregated systems into an overall integrated system of delivery (McDaniel & Fogarty, 2009; Meyers, 2006). The model proposed here, the integrated behavioral health service delivery system, employs a change in the policies and procedures that are presently at work in health care systems. The model suggests a progressive approach to service integration through a case-management modality. This modality suggests that the Behavioral Health Social Worker (BHSW) case manager will supervise and control services provided for each client or case. The model provides an integrated cost-effective delivery system
that will provide the needed integrated psychosocial treatment, currently at risk of becoming fragmented as health care programs are revamped (Petterson et al., 2008).

In addition to routine health care needs, the majority of patients receiving services through their health care provider also suffer from psychological and psychosocial problems. In fact, researchers have found “that between 30% and 80% (depending on the study) of all primary care visits are driven in significant part by behavioral health issues” (Bray, 2010, p. 1; Schaible et al., 2004). As these patients typically will only receive medical services from their primary care physician (PCP), they most likely will not receive the psychosocial treatment necessary for overall health. Historically, psychosocial treatment would have been provided exclusively by social work professionals employed through social service agencies. This separation of care causes a major deficit in the collective health of our nation, as most health authorities now believe that major improvements could be effected through lifestyle changes. In fact, certain research indicates that psychosocial variables contribute as much as 70% of the variance of chronic diseases (Leukefeld, 1989; Matthews, 2005; Packard, 2005). Research has also shown that “each illness type has its own specific psychosocial problems, more or less unique stressors that usually emerge with considerable clarity from the constellation of symptoms of a particular illness and the special conditions that characterize its management and treatment” (J. W. Cummings, 1992, p. 77). One could conclude that an emphasis on remedial and preventive health care—now averaging well over $1 billion a day—will result in an increased need for health care practitioners trained in behavioral medicine (Machlin, 2009; Machlin & Kress, 2009; Stoesz, 1986; Ugland, 1989).

In January 2000, the U.S. Surgeon General, Dr. David Satcher, issued the first-ever surgeon general’s report on mental health. His stated intent was to alert the American people that mental illness is a critical public health problem that must be addressed immediately (Satcher, 2000). Dr. Satcher noted that many mental and behavioral illnesses go untreated as a result of the stigma attached to mental disease, and the “lack of parity between insurance coverage for mental health services, substance abuse, and other healthcare services” (p. 33). The bulk of the surgeon general’s report is dedicated to his vision for the future and recommendations to overcome the aforementioned barriers. Included in his recommendations are the following points that relate directly to the needed marriage of basic health care and mental health treatment:

- Improve public awareness of effective treatments
- Ensure the supply of mental health services and providers
- Ensure delivery of state-of-the-art treatments
  - Ensure that mental health services are as universally accessible as other health services in the continuously changing health care delivery system
- Tailor treatment to individuals, acknowledging age, gender, race, and culture
- Facilitate entry into treatment
  - Ensure ready access to appropriate services for people . . . to significantly reduce the need for involuntary care, which is sometimes required in order to prevent behavior that could be harmful
- Reduce financial barriers to treatment (Satcher, 2000)
  - With the passage of HCR law, one decade later, comes the unprecedented mandate for preventive health care

In addition to the basic need to improve availability and affordability of mental health care services, most major health problems facing the United States involve psychological causes, correlates, or consequences. Training in behavioral medicine and interventions, along with competency in assessing psychosocial factors, is therefore a must and should occupy a central position in all levels of education. Solutions and prevention require changes in attitudes, values, behavior, and lifestyles. A few basic examples are
This article outlines the composition of effective psycho-social treatment and presents a cost analysis of social work and its services. It also presents a profile of the BHSW, which defines the abilities of an effective behavioral health social worker. Among the attributes required are (a) the depth of an acceptable knowledge base, (b) the behavioral skills necessary for an intellectual and conceptual understanding of theories of health, and (c) the utilization of techniques necessary to bring about behavioral changes in clinical practice. A foundation for the emerging roles of behavioral intervention in primary care is formed from these characteristics. In addition, the key impact areas for a behavioral health model are delineated. The behavioral interventions provided by the BHSW will ultimately increase the quality of psycho-social health care, while controlling medical costs.

Health care costs and the effective management of health care are of primary importance and concern to federal, state, and local governments. Consequently, it is necessary to develop innovative, successful, and integrated cost-effective treatments and procedures. This article proposes such procedures by defining the problems to be addressed, applying evidence-based research and studies for support, and presenting an innovative model for cost-effective managed health care combined with empirically based psychosocial intervention and prevention.

**BEHAVIORAL HEALTH CARE: THE INTEGRATED SYSTEM**

Historically in American health care, the physician has assumed primary responsibility for an individual’s care during times of illness. The patient passively awaits the doctor’s judgment, perhaps in anticipation of an instantaneous cure. The healthy individual, on the other hand, generally takes his or her physiological state for granted. This reliance on the family physician as primary change agent was reasonable and necessary prior to the 1960s, considering that infectious diseases were the number one health problem in the United States (Sultz & Young, 1997; J. S. Wodarski, 2009; J. S. Wodarski et al., 1991). At the dawn of the age of antibiotics, however, the public health burden shifted to those chronic diseases that have been related to unhealthy lifestyle choices. In fact, according to the Centers for Disease Control, the top 10 leading causes of death, up to 70%, are related to lifestyle or preventable illnesses (Rains & Erickson, 1997; Substance Abuse and Mental Health Services Administration [SAMHSA], 2007). In conjunction with this shift, the illness industry has seen major growth in the United States. Health care expenditures account for nearly 17% of the gross domestic product (Agency for Health Care Research & Quality, 2009; Frank, 2009), whereas federal and state service programs grew 1,760%, or $32.3 billion, from 1960 to 1985 (el-Askari et al., 1998). However, even with this increased funding, many public health problems have continued to increase and health costs are rising 1% annually.

By improving health and quality of life, many agree that a significant reduction in health care cost could be achieved through the prevention of chronic illness. The role that prevention will play in the light of managed care is unclear, as the standard approach to human services places an emphasis on the deficiencies of the individual (el-Askari et al., 1998). This approach undermines a client’s self-worth in addition to decreasing a sense of responsibility for his or her own well being. Although this is an unintended effect of human services programs, it is also a very significant one. Literature suggests that there is a strong association between disempowerment (a lack of social support and weak community involvement) and poor health. Therefore, the traditional approach to health care programs may be contributing to the poor health of individuals by identifying the
problems and attempting to ameliorate them (Agency for Healthcare Research and Quality, 2010; el-Askari et al., 1998).

Key among trends in behavioral medicine is a “growing demand for and use of integrated, comprehensive health services that blend health and behavior, prevention, health promotion, and disease management” (Kersting, 2005b, p. 42). The new field of behavioral medicine seeks to broaden health care to include active client responsibility in the treatment of disease and the maintenance of health. The emphasis is on the alteration of maladaptive behavior patterns that constitute an unhealthy lifestyle (Jeffrey, 1989). Success with behavioral strategies in the treatment of various mental disorders paved the way to the later application of these powerful technologies to medically related problems, such as the stress disorders and obesity (APA Presidential Task Force on Evidence Based Practice, 2006; Thyer & Wodarski, 1998, 2007; L. A. Wodarski & Wodarski, 2004). These intervention procedures with proven successful histories have encouraged the wider acceptance of behavioral treatments by the empirically oriented medical community (Agras, 1982; Blanchard, 1982; Eysenck, 1988; Krantz & Blumethal, 1987; Pinkerton et al., 1982; Pomerleau, 1982).

This article reviews the behavioral medicine paradigm and its implications relevant to social work practice in health care settings. It also focuses on the role of the social worker in the application of behavioral techniques in managed health care settings and elaborates requisite practice principles.

**BEHAVIORAL HEALTH**

Monumental economic and political forces are in the process of reshaping the way health and mental health and substance abuse services will be delivered in the United States. Managed care is simply an initial harbinger of this fundamental paradigm shift, which will involve the reengineering of health care in general in terms of effectiveness, cost, and integration (Bray, 2010; N. Cummings, 1995; Kent & Hersen, 2000; Strosahl, 1994, 1995). Not only will there be an unrelenting focus on developing cost efficient delivery systems, but the watchword in the next generation of health care will be service integration, effectiveness, and prevention. Formerly segregated delivery systems, for example, health and mental health, will be pressured to merge because of growing popularity of capitation, the preferred model for financing health care, and the realization that psychosocial variables affect physical health. “Implementation of managed care principles in the mental health and substance abuse arena has generated much debate, particularly with respect to issues of quality of care” (Sanchez & Turner, 2003, p. 116). As noted by Dr. David Barlow, “in an era of evidence-based practice, psychological treatments have been shown to be the equal of or to be superior to alternative medical or pharmacological treatments” (as cited in Kersting, 2005a, p. 15). The arbitrary division of mind and body will give way to the stark financial reality that health care costs cannot be contained as long as physical health and mental health care are structured as nonoverlapping enterprises.

Although managed care is likely to ratchet down the cost of specific medical mental health and substance abuse procedures, there will be no way to coordinate the utilization of services without integrating the two systems. In other words, such a great proportion of medical care is driven by psychological and psycho-social concerns that the ability of the three systems to contain utilization and cost depends on the provision of appropriate behavioral health services in the general medical setting. (Agency for Research Healthcare and Quality, 2009)

The de facto mental health system in the United States is primary medical care (Rieger et al., 1993). This ascendancy of the primary care physician as the major provider of behavioral health
services is most likely the result of three developments in the field of mental health: (a) the introduction of Selection Serotonin Reuptake Inhibitors (SSRIs), (b) the failure of behavioral health care to meet the needs of mental health consumers, and (c) the increasing recognition of the benefits found in an integrated system of medical and behavioral care (Gray et al., 2005).

The provider constituency in primary care includes a rather bewildering number of physicians (e.g., family practice, general internal medicine, obstetrics-gynecology, pediatrics) and allied health care groups (e.g., physician’s assistants, clinical nurse specialists, registered and licensed nurses, women’s health care specialist), all of whom are providing routine medical care and are likely to encounter patients with mental disorders or significant psychosocial stresses. Indeed, one half of all informal mental health care in the United States has been delivered solely by the above-mentioned providers (Narrow et al., 1993). Other data gathered on this topic stated that approximately “60% of all mental healthcare visits related to mental health are to primary care physicians” (Pace et al., 1995, p. 123). Factors that may have a great influence on this trend of seeking primary care physicians as the sole mental health provider include easier access, confidentiality concerns, social definitions, and public perception/stigmatization of the utilization of mental health services (Pace et al., 1995).

Interestingly, nearly one half of all individuals with a diagnosable mental disorder and substance abuse seek no health care from any professional, but 80% of these individuals will visit their primary care physician at least yearly. Visits are usually very short and of diagnostic nature. For many patients with psychological or psychosocial concerns, medical visits are generated by the physical symptoms of distress (McDaniel & Fogarty, 2009; Smith et al., 1995). For example, a study of the 10 most common physical complaints in primary care revealed that 85% end up with no diagnosable organic etiology during a 3-year follow-up period (Kroenke & Mangelsdor, 1989).

BEHAVIORAL HEALTH, ASSESSMENT INSTRUMENTS, AND HELPING PROFESSIONALS

The stringent standards required by managed health care have changed the way that service is delivered by all human service agencies. The managed care system now requires helping professionals (physicians, psychologists, social workers, etc.) to be accountable for the types of service they provide, the type of clientele that they serve, and the expense, duration, and outcome of the services provided. Part of being an accountable practitioner is working from an empirical basis in relation to interventions, data collection, and treatment process (J. S. Wodarski, 1997; J. S. Wodarski & Hopson, 2011). This emphasis on accountability comes in response to the decreasing federal and state monetary and philosophical support (J. S. Wodarski, 1997). Therefore, professionals are required to work accurately, swiftly, empirically, and in a limited amount of time, while delivering services that are ever more effective and cost-efficient. Levels of involvement in managed care seemed to increase from 1996 to 2001; ratings of specific stresses associated with managed care, such as external constraints on services, managed care paperwork, managed care reimbursements rates, and excessive paperwork, did not increase; and for the most part, sources of satisfaction did not decrease (Baird & Rupert, 2004). (The standardized requirements of managed care have turned the profession toward recreating rapid assessment instruments [RAI] that are easy to administer, score, and complete without losing validity or reliability.) Many instruments exist that are reliable and valid when measuring one aspect of a problem or a particular diagnosis; however, the need is growing for an instrument that can provide the worker with a differential diagnosis for problems related to substance abuse or physical/mental health concerns. This instrument will assist professionals in creating a quicker, more accurate assessment of problems, so that they can refer clients to the appropriate helping agent. RAIs also highlight what areas might have compounded, as well as contributing factors, which often remain unnoticed.
when helping professionals zero in on their own area of expertise. This approach requires a more collaborative and interactive component on the part of helping professionals. There is no reason to doubt the RAIs combined with the interdisciplinary team approach can be an effective way to navigate through managed care systems (Resnick & Tighe, 1997).

The goal of managed care is to alter the treatment process in hopes of reducing the amount of unnecessary health service utilization (Berkman, 1996). The treatment process currently experiences budget, service integration, and utilization constraints. There are financial rewards for service providers who limit services, and preestablishing treatment plan/goals with regular reviews are becoming the norm (J. S. Wodarski et al., 2001). The more powerful role of managed care organizations has also affected the decision making process regarding which services will be provided. In the past, physicians and clients exclusively made these decisions; however, the managed care organization is now the primary decision maker (Raw, 1999).

**RAPID ASSESSMENT**

Rapid assessment inventories (RAIs) have become increasingly popular with practitioners and agencies alike. The trend in using rapid assessment techniques has been associated with the recent demand by funding agencies for evidence that clients are reaching their stated goals and that programs are effective in treating their clients. Practitioners and agencies have realized the contribution of rapid assessment instruments in meeting these two aims. In the managed care arena, there is no doubt that rapid assessment technology would be welcomed.

Social workers who work with children, adults, and multiproblem families need to assess multiple sources of data across and beyond family systems. At the present time, many professionals use clinical interviews, personal judgment, and assumptions to make decisions about services and treatment needs. The danger in this is clear. By utilizing RAI techniques, the BHSW can readily assess psychosocial problems that may affect the individual patient’s physical health. The patient would be assessed simultaneously for alcohol and drug problems, mental illness, family violence, child abuse, housing needs, depression, nutrition, financial problems, and so forth. This information would then be utilized to provide the patient with an integrated individualized treatment plan and appropriate referrals. By utilizing these valid assessments, the social worker increases his or her chance of making an accurate evaluation of all the psychosocial needs that may be affecting the patient’s physical health. No area would be left out, thus making the use of these instruments much more efficient and effective than personal judgment. With appropriate, accurate assessment, the patient would receive only the referrals/services that are indicated.

The information gathered from the rapid assessment instruments would not necessarily be used solely for the primary care physician. Rather, this information, with client consent, could be forwarded to the service agencies where the client would be referred for further treatment. This process would assist the service agencies by providing reliable information about the client’s problems prior to the first meeting. It would also reduce replicated information gathering by the service agencies. Again, efficiency and integration would be increased, thereby decreasing the cost. Two necessary objectives for RAIs are the ability to accurately assess clients’ needs and to evaluate the effectiveness of program interventions.

Social workers have begun to identify the utility of RAIs to collect large quantities of high quality data. Studies consistently have found that these instruments are easily administered, cost-effective, and can provide reliable client data (McMahon, 1984; Rapp-Paglicci et al., 1999; Streever et al., 1984). In addition, these assessment instruments are more objective than a personal interview, in that the personal biases of the worker are reduced, and the subjective nature of assessment, as a whole, is decreased. Flowers et al. (1993) found that clients who were given RAIs throughout treatment made more improvement on their goals, terminated from treatment less often, and were
in general more satisfied with treatment. These instruments have also been noted to gather more information from clients in a shorter amount of time. Consequently, these instruments are more efficient as well as more accurate.

Social workers who work with lifestyle behaviors leading to problematic health must assess multiple sources of data across and beyond family systems. For social workers who work with substance-abusing clients, the need for accurate and reliable information is critical because of the serious decisions that must be made for effective intervention to take place (Thyer & Wodarski, 1998, 2007).

The following measures are personally recommended:

1. Multidimensional Adolescent Assessment Scale
2. The Multi-Problem Screening Inventory
3. Family Assessment Screening Inventory
4. Health Questionnaire.

Each can be computer scored. This list is not exclusive; many others are readily available and might be considered depending on agency needs and resources.

**RAI MODEL FOR DIFFERENTIAL DIAGNOSIS**

The top RAIs found effective for assessing difficulties in the fields of alcohol abuse, mental health, and physical health, are the CAGE (Ewing, 1984) and the GHQ-12 (Goldberg & Williams, 1988). All of these scales can be implemented in a primary care setting and can yield rapid and accurate assessments through computer scoring, allowing for appropriate referrals to a worker on the team in a corresponding discipline. In addition, these instruments can be administered with ease, are simple to score, and are supported by empirical evidence of their validity and reliability.

Numerous findings reveal that primary care physicians often overlook significant mental disorders (Berwick et al., 1991; McDaniel & Fogarty, 2009) and alcohol abuse in their patients (Kessler et al., 2005; Lairson et al., 1992). Liskow et al. (1995) have found that an average of 20% to 30% of clients in clinical settings have alcohol-related problems, and that out of this 20% to 30%, physicians only detect between 10% to 50% of those afflicted. Of the patients with mental disorders, one half or more go undiagnosed and untreated (Berwick et al., 1991). As a result, many of the presenting problems that patients are being treated for may be compounded by mental health and alcohol abuse complications. It is apparent that the utilization of RAIs on the dual diagnosis population would also be beneficial.

**INTERDISCIPLINARY TEAM MODEL**

“Collaborative care can and should take place at all levels of healthcare... Outpatient, inpatient, long-term, emergency, pediatrics, it fits in everywhere” says Dr. Margaret Heldring (as cited in Kersting, 2005a, p. 58). The idea of using an interdisciplinary team approach to provide appropriate client care has become widespread (Clancy, 2009; Farley, 2009; Resnick & Tighe, 1997). The interdisciplinary team generally contains social workers, physicians, physician assistants, psychiatrists, and other paraprofessionals. Utilizing this model leads to more accurate diagnoses, more efficient use of a professional’s time, a decrease in cost, and more appropriate client care (Farley, 2009; Resnick & Tighe, 1997). The interdisciplinary team approach requires that members of the team interact within their area of expertise, maximizing the use of their education. The enhanced function of the role differentiation in this model enables professionals to meet the needs...
of a greater number of clients at a lower cost (Resnick & Tighe, 1997). The cost reductions involved in the utilization of this model allow insurance companies to expand their scope in a greater attempt to achieve nationwide health care.

Unless the complex psycho-social medical needs of patients are recognized and unless a comprehensive package of services is provided based on an interdisciplinary health care model (including social workers), a majority of Americans will be underinsured or forced to pay significant additional fees for uncovered service or supplemental insurance. (Mizrahi, 1993, p. 91)

**BENEFITS**

Despite the role changes for social workers created by managed care, social workers’ expertise and experience is still essential to health care practice. With the finding that 20% to 80% of primary care visits resulted in the medication of presenting problems that were frequently of psychosocial origin (Resnick & Tighe, 1997), it became evident that the strain on physicians’ time for nonmedical problems was inordinate. It was determined that when social workers perform the initial assessments of client needs through RAIs, the entire interdisciplinary team benefits. Social workers would assess and refer, as is indicated, to other more appropriate providers, allowing physicians more time to deal with medical problems. Social workers also would have the ability to flag the psychosocial aspects of ailments, again saving the physician the time needed to screen the client/patient (Resnick & Tighe, 1997). In addition, the social workers can reveal information about a client’s psychosocial problems, which will enable the physician to deliver more comprehensive patient care (Berkman, 1996). Besides helping the physician address the mental health and substance abuse needs of the client, social workers can also work within the primary care setting to address client’s environmental, psychological, and financial concerns. Social workers can work with clients on family issues, financial and resource concerns, mental health issues, behavioral problems, medical noncompliance, and so on (Gross et al., 1983). The assisting role of the social worker allows for service delivery to run smoothly, appropriately, and effectively.

The inclusion of the role of a social worker as a member of the interdisciplinary team can also yield financial rewards to physicians, insurance providers, and other professionals on the team. Collaboration between the medical/behavioral health providers has helped in “identifying optimal billing agents and improved reimbursement rates. Third-party payment for outpatient mental health services increased by 500% in 4 years, replacing state funding as the largest source of payment for outpatient mental health treatment” in a pilot program that integrated medical/behavioral health treatment (Schaible et al., 2004, p. 378). It was recognized that the preventive measures utilized by social workers reduces costs through early detection, early intervention, and decreased use/reuse of hospital services (Berkman, 1996). Further, it was suggested decades ago that potential savings can be achieved through billing on a fee-for-service basis, seeking grants, and consultations (Hooke, 1979). With these observations finally taken into account, it can be assumed that social workers will also benefit from the time constraints required by managed care in that they will be able to serve a greater number of clients in an allotted amount of time, and they are less likely to experience the amount of burnout and replacement that has historically threatened the profession.

Including social workers as members of an interdisciplinary team offers other financial incentives for the primary care physician (Berkman, 1996). For example, Medicare has considered each patient visit as potentially billable, so a physician can “free up valuable billable hours when the social worker has relieved the doctor of the need to spend time providing attention and arranging home care services, family meetings, and the like” (Berkman, 1996, p. 545). In addition to financially serving physicians, the interdisciplinary team approach using RAIs reduces the strain
on medical staff, which enables them to serve more patients/clients at lower rates (Resnick & Tighe, 1997).

Insurance companies stand to benefit from the utilization of social workers as part of the interdisciplinary team. The early detection and intervention of mental health and substance abuse problems by social workers significantly reduces the potential cost of treatment. Research also has found that early detection of mental health and substance abuse problems reduces the likelihood that patients will seek medical attention for psychological problems (Berkman, 1996).

SOCIAL LEARNING TECHNIQUES: THE FOUNDATION FOR BEHAVIORAL HEALTH

One aspect of the service provided by the professional behavioral health social worker includes the application of social learning techniques, which are being used increasingly in the field of preventive medicine. Medical research has accumulated overwhelming evidence that identifies specific lifestyle factors that place an individual at risk for the development of specific types of diseases. Some 43 of chronic medical conditions also have comental health and substance abuse. Breslow and Enstrom (1980) summarize this evidence to isolate seven health practices that extend life:

1. Never smoke cigarettes.
2. Get regular physical activity.
3. Use alcohol moderately or not at all.
4. Get 7 to 8 hours of sleep per night.
5. Maintain proper weight.
6. Eat breakfast.
7. Do not eat between meals.

Social learning techniques can be used to initiate and maintain these practices, thus reducing risk factors and preventing the disease’s development. “Because chronic illness has become our major health problem, its physical, vocational, social, and psychological consequences.” (Taylor, 1999, p. 473) are of increasing significance and indicate the need for behavioral health interventions that work in concert with primary care. Moreover, social learning techniques may be used in the prevention of any disease for which lifestyle risk factors have been identified (Abeles, 1986; Dingfelder, 2006; J. S. Wodarski, 2009).

Perhaps the most important factor contributing to a successful social learning therapy strategy is a complete and individualized assessment of the problem behaviors. The assessment not only specifies the target problem, but also indicates the conditions that constitute a resolution of the problem. Pinkerton et al. (1982) suggested four steps for a comprehensive behavioral assessment.

1. In observable terms, define the target behavior.
2. Specify the antecedent events that elicit or precipitate the problem behavior, and the consequences that maintain the behavior.
3. Quantify the target behavior and related variables in terms of rate, frequency, and duration of occurrence.
4. Specify in quantitative terms the desired goal or outcome.

These steps remain salient today. Self-monitoring is a frequently used behavior assessment method, as it involves the client’s observation and systematic recording of behaviors and their antecedents and consequences. This strategy forces the client to become very aware of the behavior, which in itself often facilitates a certain degree of behavior change. The process renders data that
is also quite useful in the evaluation of treatment effectiveness (Cincirpini & Floreen, 1982; Stuart, 1967; Thyer & Wodarski, 1998, 2007; J. S. Wodarski, 2009).

**TREATMENT OPTIONS RELEVANT TO SOCIAL LEARNING TECHNIQUES**

Inasmuch as environmental factors play an important role in today’s illnesses, the basic learning techniques of respondent and operant conditioning, which operate on environmental influences, are choice treatments in behavioral health (Pinkerton et al., 1982). The basic techniques of social learning theory are grounded in the conditioning theories, which essentially state that learning occurs through prior experiences, and that behavior is usually influenced by its consequences (Bandura, 1977). Departing from the traditional sociobehavioral view, in which behavior is merely controlled by external consequences, it has become clear to social learning theorists that cognitive variables, that is, one’s expectations about the ability of self-change, come into play in the mediation of behavior (J. S. Wodarski, 1985; J. S. Wodarski & Dziegielewski, 2002). Consequently, cognitive strategies are now integrated with most behavioral medicine strategies. Also incorporated into this schema are principles showing that learning that occurs through direct experience can also occur through the observation of others (modeling; Bandura, 1977).

**BEHAVIORAL HEALTH SOCIAL WORK: A MEANS TO A SOLUTION**

The foregoing discussion suggests a new focus on solving health problems, a focus that centers on prevention through theory, assessment, intervention, and outcomes. It is proposed here that behavioral health social work also offers a means for training practitioners to solve some health problems.

Behavioral health social work involves the systematic application of interventions derived from learning theory and supported by empirical evidence to achieve behavior changes in clients that result in better health. The behavioral health social worker must possess theoretical knowledge and an empirical perspective regarding the nature of human behavior and the principles that influence behavioral change. The worker must be capable of translating this knowledge into concrete behavioral operations for practical use in a variety of practice settings. To be an effective practitioner, the behavioral health social worker must therefore possess a solid behavioral science knowledge base, as well as a variety of behavioral skills. Moreover, a thorough grounding in research methodology will enable the behavioral health social worker to evaluate the therapeutic interventions, a necessary requisite of managed care practice. Because the rigorous training of the behavioral health social worker equips her or him to assess and evaluate any intervention procedure that has been instituted, there is continual evaluation that provides corrective feedback to the practitioner. For the behavioral health social worker, theory, practice, and evaluation are all part of one intervention process. The arbitrary division of theory, intervention, and research, which does not facilitate therapeutic effectiveness and improved clinical procedures, is eliminated.

**IMPLICATIONS FOR SOCIAL WORK PRACTICE**

Health Care Reform (HCR) does and will have a profound impact on the way that services are delivered, and on the duration of those services. Although some social workers may view these time limitations as decreasing their role and ability to be effective, they should instead welcome
the opportunity to become educated about empirically validated brief intervention methods and to utilize their assessment skills. While the implementation of managed care has hindered social work provision of long-term service, it has also enhanced social work’s effectiveness in screening and assessing client needs (Thyer & Wodarski, 2007).

The link between mental health and somatic illness has become clear, and it is the social worker who is equipped to deal with the psychosocial and environmental aspects of illness. Social workers have knowledge and training in the recognition and treatment of mental health problems that both medical specialists and physicians most likely lack (Thyer & Wodarski, 1998). Following is a list of roles social workers will play.

- Assess patient/client and family for ability to follow through on treatment plan.
- Support client through assessment, diagnosis, treatment, rehabilitation, stage of change, and so forth.
- Guide clients through the system (what is covered, what is not, and to what extent).
- Educate and inform client and family members about the specific illness, coping techniques, outlook, and so forth.
- Address behavioral, emotional, or mental problems that may hinder decision making around the illness.
- Identify, discuss, and obtain entitlement benefits.
- Identify and facilitate linkages to appropriate nonmedical resources (support groups, emergency food/housing, family/marital/couple/individual counseling, etc.).
- Share knowledge about the client and the family system with the team to ensure their ability to effectively care for the client.
- Advocate for patients who are dissatisfied with their care (J. S. Wodarski, 2009).

PROFILING THE BEHAVIORAL HEALTH SOCIAL WORKER

Behavioral social workers possess theoretical knowledge and conceptual understanding regarding the nature of human behavior and the principles of behavior change. They must also be capable of translating this knowledge and understanding into concrete behavioral operations for practical use in a variety of health care settings. To be an effective practitioner, therefore, the behavioral health social worker must possess a solid knowledge base as well as have a variety of behavioral skills.

In a study surveying graduate program training directors in clinical psychology, counseling psychology, and social work about the training opportunities available for their graduate students, almost 60% of the respondents indicated that they provide some type of service related to managed care (Daniels et al., 2002). This study also pointed out that graduate programs are still behind where they should be in implementing programs that will allow students to participate in managed care settings.

KNOWLEDGE BASE

The body of knowledge that the behavioral social worker must possess to be an effective practitioner should include the following:

- A thorough understanding of the scientifically derived principles and theories of human learning as they relate to human behavior, personality formation, the development and maintenance of interpersonal relationship, and behavior change.
An ability to conceptualize a client’s behavior and to make accurate behavioral assessment based upon the principles and theories so that the appropriate techniques can be developed and effective programs formulated to bring about the desired behavioral acquisitions, modifications, or extinctions of unwanted behaviors for those clients who request such changes.

An ability to understand how these principles of learning and behavior changes can be applied on a broad scale to alleviate social and societal problems.

An understanding of how this knowledge of human behavior and these principles of learning can be utilized in a variety of contexts and settings, for example, with individuals, in groups, among family members, and within large organizations and institutions as well as in naturalistic settings.

The ability to evaluate objectively any treatment procedure and outcome and to formulate new treatment strategies when those formulated originally have been proven ineffective.

**KEY IMPACT AREAS FOR A BEHAVIORAL HEALTH MODEL**

The main influence pushing primary care behavioral integration is the need to control medical costs that directly arise from psychosocial, mental health, or substance abuse factors by providing quality treatment. This means that the activities of the behavioral health clinician need to be focused on achieving four main outcomes:

1. Enhancing the short-term critical outcomes of primary care, health, and mental health and substance abuse interventions for patients with mental health or emotional concerns.
2. Enhancing longer term outcomes in patients who have recurrent, chronic, or progressive medical, substance abuse, or mental health conditions.
3. Controlling medical utilization and costs by providing appropriate behavioral health support to patients who need ongoing social support or who have chronic and treatment resistant mental and medical problems (N. A. Cummings et al., 1996).
4. Provide accurate assessment of the psychosocial aspects of ailments and integration of services.

**EMERGING ROLES FOR BEHAVIORAL INTERVENTIONS IN PRIMARY CARE**

According to Thyer and Wodarski (1998, 2007), there is every reason to believe that behaviorally based interventions can dramatically increase the quality of health care provided in the general medical setting (cf. Strosahl, 1995). First, the behavior therapy model is rich in diagnostically driven treatment approaches. Many behavioral interventions were developed to treat specific mental disorders and only later evolved into generalized behavior change strategies. For example, relaxation training was originally a key strategy in systematic desensitization but is now employed in myriad behaviorally based intervention packages in and out of medical settings.

Second, behavioral interventions have demonstrated clinical effectiveness with a wide range of mental disorders, substance abuse, and psychosocial problems commonly encountered in primary care. Major depression, panic disorder, generalized anxiety disorder, chronic pain, and somatization disorder are common conditions seen in medical practice and can be addressed with empirically supported, time-effective behavior therapies (Thyer & Wodarski, 1998).

Third, the behavioral approach is equally facile at addressing health and illness behaviors (cf. Friedman et al., 1995; Strosahl, 1994). Behavioral interventions are arguably the most effective strategies for promoting health (i.e., myocardial infarction).
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<tr>
<th>Service</th>
<th>Description</th>
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<tr>
<td>1. Behavior health consultation</td>
<td>First visit by a patient for a general evaluation; focus diagnostic and functional evaluation, recommendation for treatment and forming limited behavior change goals; involves assessing patients at risk because of some likely stress event.</td>
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<td>2. Behavior health follow-up</td>
<td>Secondary visits by a patient to support a behavior change plan or treatment started by a provider on the basis of earlier consultation; often in tandem with planned provider visits.</td>
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<td>3. Triage/Liaison</td>
<td>Visit designed to determine appropriate mental health specialty referral outside of primary care setting; usually a single visit.</td>
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<td>4. Compliance enhancement</td>
<td>Visit designed to help patients comply with medication initiated by provider; focus on education, addressing negative beliefs, or strategies for coping with side effects.</td>
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<td>5. Relapse prevention</td>
<td>Visit designed to maintain stable functioning in a patient who has responded to previous treatment; often spaced at long intervals.</td>
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<td>6. Specialty consultation</td>
<td>Visit part of a condensed specialty patient education package conducted by the consultant; visit usually linked to planned provider visits; involves 4 to 6 short sessions; usually reserved for mental conditions such as panic disorder or major depression.</td>
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<td>7. Community resource</td>
<td>Visit designed to educate patient about available community resources in a particular area (i.e., support groups for caregivers).</td>
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<tr>
<td>8. Case management</td>
<td>Visit designed to support functioning in a chronically distressed patient; visit intervals long but continuing; often part of a visit package that is designed to reduce unplanned medical visits.</td>
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<td>9. Behavioral medicine</td>
<td>Visit designed to assess patient in managing a chronic medical condition or to tolerate invasive or uncomfortable medical procedure; focus may be on lifestyle issues or health risk factors among patients at risk (i.e., smoking cessation, weight loss).</td>
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<td>10. Conjoint consultation</td>
<td>Visit with provider and patient designed to address an issue of concern to both; often involves addressing an issue between them.</td>
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<td>11. Provider consultation</td>
<td>Face to face with physician to discuss patient care issues; often involves “curbside” consultation; can include formal case conference with provider and health care team.</td>
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<tr>
<td>12. Team building</td>
<td>Conference with one or more members of health care team to address peer relationships, job stress issues, or process of care concerns.</td>
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<td>13. On demand consultation</td>
<td>Phone or face-to-face contact with provider, usually “emergent”; focus on addressing an immediate care issue.</td>
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<td>14. E-therapy</td>
<td>E-therapy is the use of electronic media and information technologies to provide services to participants in different locations. It is used by skilled and knowledgeable professionals (e.g., counselors, therapists) to address a variety of individual, familial, and social issues. E-therapy can: (a) include a range of services, including screening, assessment, primary treatment, and aftercare; (b) provide more accessible modes of treatment than the traditional ones to those who actively use the recent development of technology (i.e., adolescents and young adults); (c) help people (access treatment services who traditionally could not seek services because of barriers related to geography, shame and guilt, stigma, or other issues); and (d) be provided as a sole treatment modality, or in combination with other treatment modalities like traditional or existing treatments.</td>
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*Note. Provider means any primary caregiver such as a physician, physician’s assistant, clinical nurse specialist, registered nurse, licensed practical nurse, women’s health care specialist.*
Fourth, the behavioral approach can be expanded to fit family or relationship realities just as easily as it can be applied to the individual patient. Pertinent family or relationship reinforcements can be addressed directly within a learning framework. This is important because primary care medicine is not only oriented toward the individual patient, but also emphasizes health and well-being in family living.

Fifth, behavioral technology is easily transferable to the patient, using patient education and self-care models that are already widely employed in the primary care management of chronic diseases, such as diabetes. These models focus on teaching each patient self-management and behavior change skills, while placing more responsibility on the patient for executing these behaviors.

Finally, primary care providers tend to be very pragmatic in their patient interventions, and naturally gravitate to using behavioral techniques (cf. N. S. Robinson et al., 1995; P. Robinson, 1995). Therefore, the overlap between typical physician practice and behavioral strategies makes behavioral interventions very acceptable in the primary care setting (see Table 1 for elucidation of roles).

The health care industry is undergoing unprecedented changes that include a fundamental paradigm shift with far-reaching implications for the effectiveness of health care, the cost-efficiency of health care systems, and the service integration of systems (Masia et al., 1997). These changes are affecting previously segregated delivery systems, specifically those of health and mental health. Increased costs and proposed budget cuts are forcing segregated systems into an overall integrated delivery system with the intent of providing more adequate care (J. S. Wodarski, 2000).

It has been shown increasingly that health care costs and the effective management of health care are of primary importance and concern to federal, state, and local governments. This is necessary to develop innovative, successful, and cost-effective assessments and treatment procedures. This article proposes such procedures by defining the problems to be addressed, applying research and studies for support, and presenting an innovative model for cost-effective and integrated managed health care combined with empirically based psychosocial prevention and intervention.

Finally, a profile of the BHSW was defined describing the abilities of an effective behavioral social worker. Among the required attributes are (a) the depth of an acceptable knowledge base, (b) the behavioral skills necessary for an intellectual and conceptual understanding of theories of human development and learning, and (c) the utilization of techniques necessary to bring about behavioral changes in clinical practice. From these key characteristics, a foundation is established for the emerging roles of behavioral interventions in primary care. These interventions will ultimately increase the quality of psychosocial health care in terms of access and integration while effectively controlling medical costs.

REFERENCES


Packard, E. (2005, December). From basic research to health-care messages: Improved public health is a priority for many APA Div. 8 social psychologists. Monitor on Psychology, 36(11), 84–85.


