



# Innovations in Field Education to Improve Integrated Care for Young People and their Families

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## Abstract

Health care services are rapidly changing, shifting away from traditional models toward integrated approaches relying on team-based care. To meet evolving workforce needs, social workers must be prepared for interprofessional team practice in integrated health settings. Much of students' practical training occurs in field placements. Agencies may not be prepared for integrated and interprofessional practice, presenting a challenge for students in preparing for work in integrated health settings. This article describes how implementation of a student-training model informed the need to more purposefully include the field in training. Specific innovations in field education to improve student and agency preparation to provide integrated care for youth and families are discussed.

*Keywords:* social work education; field education; interprofessional education (IPE); integrated health; behavioral health

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## Introduction

The landscape of health care services and delivery models in the United States is rapidly changing. Health care reform, as supported by the *US Patient Protection and Affordable Care Act* (ACA; Pub L No.111-148), emphasizes a shift away from the traditional medical-based disease model of care and toward integrated approaches that rely on team-based care. The “triple aim” of health care reform (improving patient care, reducing costs, and improving population health outcomes) necessitates the implementation of interprofessional teams, care coordination, chronic disease management, and a renewed focus on prevention (Steketee, Ross, & Wachman, 2017). This rapidly evolving era of health care reform brings with it both challenges and opportunities for the social work profession (Davis et al., 2015). Health care reform has created historic opportunities for innovative models of care, many that specifically consider the needs of poor and medically underserved populations who have traditionally been a key focus of social work practice (Miller et al., 2017). Social work has a vested interest in health care reform and the growth of integrated practice with nearly half of all social workers employed in the health and behavioral health sectors. By 2022 health and behavioral health social work is expected to account for 71% of the social service workforce (Stanhope, Videka, Thorning, & McKay, 2015).

Labor projections suggesting rapid growth of social work employment in health and behavioral health sectors (Bureau of Labor Statistics, 2018) illustrate a workforce challenge for the social work profession. To meet these workforce needs, social workers must be prepared for interprofessional team practice in integrated health settings (Rishel & Hartnett, 2017). Social work in integrated care requires a unique skill set, different from what is needed in traditional health and mental health care models of practice. A shift from individual to group or population-based care requires competency in administration and analysis of screening tools, conducting brief assessments and interventions, and collaborating with interprofessional teams in care coordination (Davis et al., 2015; Horevitz & Manoleas, 2013). New models of social work education and training are needed to meet this need. Emerging work in the field is beginning to review training models for students focused on preparation for integrated and interprofessional practice (e.g., Abu-Rish et al., 2012; Bridges, Davidson, Odegard, Maki, & Tomkowiak, 2011; Davis et al., 2015; Rishel & Hartnett, 2017; Zerden, Jones, Brigham, Kanfer, & Zomordi, 2017). Less work has specifically addressed the need to “train the field” as a vital component of effective student preparation for integrated health care. In social work education, much of students’ practical training occurs at the field placement site(s). If field supervisors and agency settings are not

adequately prepared for integrated and interprofessional practice, it may be difficult for students to implement the concepts and skills learned from coursework into the practice setting. This article describes how implementation of a student training model informed the need to more purposefully include the field in training. Specific innovations in field education, particularly in strengthening the University-field connection, were developed to improve student and agency preparation to provide integrated care for youth and families.

## Literature Review

The goal of integrated health services is to more effectively and efficiently meet the health care needs of a broad-based population group. Interprofessional practice is an inherent component of integrated care. By definition, integration requires collaboration among professionals. This style of practice is very different from the traditional siloed approach in which each professional navigates and delivers a separate set of services, often with little consideration of what other services the patient/client may be receiving. Integrated models of service delivery are relatively new and necessitate innovative approaches in social work field education to adequately prepare students for emerging health care roles.

### Why Integrated Health Care?

*Integrated care* is a term that applies to a continuum of practice models that seek to coordinate physical and behavioral health services utilizing a collaborative approach with communication and coordination among primary and behavioral health care providers (Vogel, Kanzler, Aikens, & Goodie, 2017). A driving force behind the emergence and growth of integrated care approaches is a growing emphasis on prevention and associated efforts to contain rapidly expanding health care costs (Zerden, et al., 2017). Growing recognition that behavioral health (a term now used to encompass both mental health and substance abuse) plays a key role in both the seeking of health care services and health care outcomes has prompted implementation of integrated care approaches aimed at simultaneously addressing both medical and behavioral health care needs (Stanhope et al., 2015).

The rapid growth of integrated care models has changed the landscape of health care delivery. Much of this growth stems from the fact that most behavioral health care is already provided within primary care settings (Vogel et al., 2017). Most people experiencing mental health and substance abuse problems do not seek specialty behavioral health services, but rather rely on the primary care system to meet all health

care needs (Blount & Miller, 2009; Vogel et al., 2017). Primary care has been referred to as the de facto mental health and addictive disorders service system (Regier et al., 1993). Growing recognition of the impact of behavior in determining health outcomes has also contributed to increased emphasis on a more person-centered, holistic approach to health care than the traditional disease-focused model. Moreover, a lack of primary care personnel and expertise along with major shifts in health care policy have prompted the development of integrated behavioral health services as an integral component of primary care services (Vogel et al., 2017).

### **Interprofessional Teams and Integrated Care**

Coordination of services to address both physical and behavioral health care needs relies on effective interprofessional communication and collaboration. Traditional educational and practice models do not promote this type of communication and collaboration among a variety of providers, leading to a gap in preparation of health care professionals for newly emerging models of care. For example, most social work students have historically completed coursework alongside other social work students, rarely having an opportunity to learn with, and alongside, other health professionals (Zerden, Lombardi, Fraser, Jones, & Rico, 2018). This gap has prompted renewed interest and investment in interprofessional education and practice (Zerden et al., 2017). Interprofessional education (IPE) has been defined as members or students of two or more professions learning, with, from, and about each other (Bridges et al., 2011; Sargeant, Loney, & Murphy, 2008). When students are prepared to work interprofessionally, they then enter the workforce ready for collaborative team-based care. This is seen as critical by the World Health Organization (WHO) in order to successfully shift from fragmented health care systems to integrated systems that utilize interprofessional health care teams to provide improved health services and achieve better health outcomes (Gilbert, Yan, & Hoffman, 2010).

The goal of most IPE efforts is to develop and foster effective teamwork skills (Thistlethwaite, 2012). Research examining team effectiveness concludes that contact is not enough to build an effective team. This work suggests that there are five main characteristics of effective interprofessional health care teams, including: understanding and respecting team members' roles; recognizing that teamwork requires work; understanding primary health care; having the practical knowledge to share patient care (e.g., being able to identify and access the right provider); and communication (Sargeant et al., 2008). Interprofessional team communication is considered vital to team success and functioning (Vogel et al., 2017). When preparing students for team-based care, a review of best-practice models for IPE suggests that

common elements of successful models include: assisting students to understand others' professions and their own role on the health care team; helping students to see the impact of interprofessional efforts and reflect on their learning experience; and effective training of mentors and/or faculty so they are confident in implementing the interprofessional curriculum (Bridges et al., 2011).

## **Challenges in Preparing Students for Integrated and Interprofessional Practice**

Behavioral health services have not historically been integrated with other health care services, but rather provided separately through specialty mental health and/or addiction treatment services. Therefore, although social workers comprise the largest group of behavioral health providers in the United States, traditional social work training has not included IPE and preparation for integrated health practice (Zerden et al., 2018). This presents a major challenge for social work educators who strive to develop new curriculum and training models to address the gap in preparation of behavioral health social workers. Previous work examining the preparation of psychology students suggests that "bringing specialty mental health clinicians straight from specialty mental health settings into primary care often results in program failure due to poor skills fit, assumptions about services needed, and routines of practices these clinicians bring from their specialty settings" (Blount & Miller, 2009, p. 113). Without specific training, behavioral health providers will likely duplicate the traditional practice approaches utilized in other settings (Davis et al., 2015). Within the health care field, interprofessional practice is defined as collaboration among multiple service providers of different professions to provide comprehensive health care services (World Health Organization, 2010). For example, social workers providing behavioral health care services in primary care settings may work on an interprofessional team with a primary care physician, nurse, and psychiatrist. To be effective in this collaborative setting, students must be intentionally prepared for integrated and interprofessional practice.

A key challenge for social work programs in interprofessional development is accessing or supporting the role modeling needed in placement settings. Even with a strong curriculum aimed at preparing students for integrated and interprofessional practice, students may not see or experience effective interprofessional teamwork in placement. This discrepancy between what is taught in coursework and what happens in the field can be unsettling and confusing for students (Thistlethwaite, 2012). Recent work indicates that intensive supervision of students in the field placement is a critical component of preparing social workers for primary care behavioral health practice (Davis et al., 2015). Since integrated behavioral health in primary

care is an emerging model, there are few licensed social workers practicing in these settings. Integrated care requires different skills from those of traditionally prepared behavioral health providers and there are few practicing social workers in integrated settings available to supervise students (Davis et al., 2015). This finding is echoed in evaluation findings from another program aimed at preparing social work students for integrated behavioral health practice. Results illustrate that students in the program were often better trained in integrated care approaches than their supervisors and other interprofessional team members who may not have had opportunities for formal integrated behavioral health care education (Zerden et al., 2017).

## **Social Work Roles and Opportunities**

Although there are certainly challenges in preparing students for integrated health practice, this is a time of historic opportunity for social work. Emerging health care service delivery models are geared toward the underserved and vulnerable populations that social work has long avowed to serve (Davis et al., 2015). Moreover, social work is strongly positioned for leadership and employment in the new era of health care (Stanhope et al., 2015). The unique underpinning of social work education (e.g., commitment to social justice and reducing health disparities, person-in-environment perspective, and training in advocacy and collaboration) provides social workers with the foundation needed to meet the behavioral health needs of populations accessing public health services (Davis et al., 2015; Stanhope et al., 2015). Recent federal funding opportunities have provided new resources for social work education programs to develop innovative training models focused on preparing graduates for interprofessional practice in integrated health environments. For example, the Health Resources Service Administration (HRSA) granted awards to 62 social work programs in 2014 and 58 programs in 2017 to support the development of integrated behavioral health training aimed at expanding the behavioral health workforce. This federal funding has served as a “catalyst for promoting the role of social work in integrated care settings” and “has significant implications for the way social work is practiced and taught” (Zerden et al., 2017, p. 59).

Social work needs to take advantage of this evolving era of reform and strengthen our identity as a health profession (Stanhope et al., 2015). To do so, social work education must move beyond the traditional approach of focusing on clinical practice skills and include wide-lens approaches that focus on population, as well as individual, health (Ruth et al., 2017). Social work has long recognized the connection of physical, psychological, and social well-being as illustrated in our biopsychosocial approach to practice. Until recently, this approach has been at odds with the traditional medical

model embraced by the health care system. Evolving integrated models of care, however, embrace a more holistic approach to health services. This shift provides what may be an unprecedented opportunity for social workers to serve as leaders in integrated practice approaches (Andrews, Darnell, McBride, & Gehlert, 2013; Mann et al., 2016; Steketee et al., 2017).

There are multiple new and expanding roles for social workers under health care reform, including roles of patient navigator, care coordinator, case manager, community health worker, and behavioral health consultant (Mann et al., 2016; Stanhope et al., 2015). As members of interprofessional health teams, social workers typically contribute through three primary roles, including the provision of behavioral health interventions, care management, and engagement with external social services on behalf of patients (Zerden et al., 2018). Initial evidence suggests that health care delivered by interprofessional teams that include a social worker results in improved outcomes as compared to usual care (Fraser et al., 2016).

### **Development of Effective Training Efforts**

Preparing students to be successful in rapidly evolving integrated health care roles requires new models of social work education that emphasize a prevention-focused approach and skills needed to work on interprofessional health care teams (Rishel, 2015; Zerden et al., 2017). Specific areas of competency for social workers in integrated health settings include: screening and assessment, brief substance abuse and mental health interventions, and care management (Zerden et al., 2018). Recent work by Stanhope et al. (2015) specifically describes how each of the nine *Core Competencies for Integrated Behavioral Health and Primary Care* developed by the SAMHSA-HRSA Center for Integrated Health Solutions (Hoge, Morris, Lararia, Pomerantz, & Farley, 2014) apply to social work practice. Guidelines regarding interprofessional practice competencies are also available. The Council on Social Work Education (CSWE) recently joined the Interprofessional Education Collaborative (IPEC) and endorsed the *Core Competencies for Interprofessional Collaborative Practice* (IPEC, 2016). The four broad-based IPEC competencies address: Values and Ethics for Interprofessional Practice; Roles and Responsibilities; Interprofessional Communication; and Teams and Teamwork (IPEC, 2016). Social work competency in interprofessional practice is now required by the 2015 CSWE *Educational Policy and Accreditation Standards* (CSWE, 2015). Embracing these competencies will assist social work in collaborating effectively with other health professions (Browne et al., 2017).

In developing social work education models, educators can draw from best practices and recommendations addressing interprofessional education. Interprofessional education (IPE) aims to prepare students as future interprofessional team members (Bridges et al., 2011). Recommendations for IPE suggest that programs provide well-supervised experiences of collaborative practice during training and the early years of professional practice. Students should specifically be prepared for teamwork and encouraged to welcome innovative, flexible, and change-oriented practice (Barr, Freeth, Hammick, Koppel, & Reeves, 2006). Roles as behavioral health specialists and care managers in integrated health settings require a high level of clinical skill (Zerden et al., 2018). Intentional preparation for skills, practice routines, and the primary care approach is critical for effective functioning in integrated health settings (Blount & Miller, 2009).

Shadowing other team members has been identified as particularly helpful in building an effective interprofessional team and improving integrated care (Mann et al., 2016). Several illustrations of shadowing team members are shared in a recent report regarding efforts to integrate social workers as behavioral health providers into existing primary care services. For example, a social worker may shadow a primary care physician and learn that the physician is caring for a number of patients who smoke cigarettes. The social worker can then work with the physician to provide smoking cessation services for these patients. When shadowing another physician, the social worker may learn that the provider has a large group of patients experiencing chronic pain. The social worker can then discuss how behavioral health services could be offered to help patients in addressing this issue (Mann et al., 2016). Finally, pilot programs that have implemented integrated behavioral health training approaches for social work students have recognized particular need to: prepare students to administer substance use screening and assessment tools, provide intensive supervision to students in integrated health placements (Davis et al., 2015), educate field sites about the role of social workers on integrated care teams (Zerden et al., 2017), and prepare students for leadership roles in integrated health practice (Rishel & Hartnett, 2017).

### **Implementation of a Student Training Model**

Responding to the need to prepare social workers for practice in integrated health settings, the West Virginia University School of Social Work developed the *Integrated Mental and Behavioral Health Training Program* (IMBTP) in 2012. Supported via 2012 and 2014 HRSA behavioral health grants, the IMBTP aimed at preparing students for multilevel prevention-focused practice with youth in integrated behavioral health

settings. The program was delivered via a cohort model with selected students from the larger MSW program grouped together for specialized coursework, field instruction, advanced skills workshops, and mentoring.

Students in the training program (also referred to as trainees) completed two specialized 3-credit courses as part of their MSW coursework. The first course on integrated behavioral health care was newly developed for this program. This course was adapted from the *Social Work and Integrated Behavioral Healthcare Project* course on clinical social work practice in integrated health care (CSWE, 2018). The goals of the course are to: familiarize students with integrated behavioral health practice and social work roles, prepare students for interprofessional team-based care approaches, and provide skills-focused preparation in screening, assessment, and brief intervention models commonly used in integrated behavioral health practice. The second course, *Child Mental Health: Promotion, Prevention, and Treatment*, teaches a multilevel approach to youth behavioral health problems (including mental health and substance abuse) with a focus on prevention-focused practice. Specific topics covered include: the three levels of prevention (universal, selective, and indicated); early problem identification and promoting resilience using the risk and protective factor framework; evidence-based prevention and treatment models; models of service delivery that promote prevention efforts (e.g., integrated behavioral health in primary care and school settings); and practice implementing an adolescent SBIRT (Screening, Brief Intervention, and Referral to Treatment) approach for substance abuse prevention and intervention.

The training program also provides students access to specialized advanced field placement sites that include opportunities to experience integrated and interprofessional practice. The focus of field site development has been on health care and school-based settings that allow students to practice with, and learn from, a wide variety of professionals working within a team-based approach. During their advanced field placement, students are grouped together as a training cohort for seminar meetings in which faculty facilitate discussions on opportunities and challenges of integrated and interprofessional practice at their placement sites. Students also work together in small groups to develop a capstone presentation on a specific area of integrated behavioral health practice with youth that they deliver at a statewide social work conference prior to graduation.

Final components of the program include biannual advanced skills workshops and intentional opportunities for mentoring and networking throughout the program. Skills workshops are full-day trainings that focus on specific skill areas for integrated

practice with youth. Topics have included: Motivational Interviewing; SBIRT with Adolescents; Addressing Ethical Challenges in Practice with Youth and Families; and Trauma-Focused Art Directives in Play Therapy. Program faculty provide consistent mentoring and advising throughout students' time in the training program, including intentional fostering of professional networking opportunities and connection with potential employers. Rishel and Hartnett (2017) provide a more detailed description of the training model.

### **Lessons Learned: The Need to Include the Practice Community as a Training Target**

In order to provide a constant feedback loop to the training program, annual evaluation using multiple measures is conducted. For a full description of evaluation methods, see Rishel and Hartnett (2017). An integral component of the evaluation is a free-write and subsequent focus group discussion. Through the free-write and discussion process, trainees are able to provide feedback on how the training has contributed to their knowledge of integrated practice, and aspects of the program that could be improved to enhance their learning or their ability to put learning into practice. It is through this process that it became clear that the trainees were gaining valuable knowledge in the program. They identified several key components of the training program as being most helpful and stated that they were eager to put this knowledge into action. They also indicated that the field was not always equally prepared for integrated practice. This creates a barrier that makes it difficult for the practice community to fully utilize the potential of the social work profession. Zerden et al. (2017, p. 68) spoke to this reality and described it as a "cart before the horse" approach. In other words, perhaps we are training students for a practice world that does not yet fully exist.

Specific feedback from trainees indicates that what is missing in the field is an understanding of integrated practice and, specifically, interprofessional practice and communication. As one trainee stated, "it is more than just placing a social worker in a hospital or on a multi-disciplinary team." These sentiments were also noted by Sargent et al. (2008), who discussed the need to fully incorporate all team members into the process of providing integrated care. Trainees also reported that opportunities for prevention work were limited by misunderstandings of the various levels of prevention practice and the fundamental role prevention plays in integration.

Using these experiences and trainee feedback as a guide, we began a plan for program improvement. Based on evaluation results from multiple cohorts, it was apparent that the field needed to be included as a training target. In order to determine the types of

activities and opportunities to provide, the items the trainees had reported as the most helpful in gaining knowledge regarding integrated care and interprofessional practice, and in learning how to apply this knowledge in practice settings, were examined. The expectation is that this approach will provide the practice community with the requisite skills and knowledge to be able to respond to the changing landscape of service delivery.

The key elements of the training program that trainees consistently note as the most beneficial are: 1) specialized skills workshops, 2) cohort relationships, 3) opportunities for interprofessional communication and exposure, and 4) on-going mentoring (Rishel & Hartnett, 2017). It is important to reiterate here that training opportunities developed emphasize prevention and clinical interventions for youth behavioral health conditions with particular focus on integration with primary care, interprofessional and team-based care approaches, and family and community involvement in prevention and treatment.

### **Innovations in Field Education: Addressing the Gaps**

In developing an enhanced model of field education, we focused on providing training components identified by trainees as the most helpful in preparation for integrated practice and on strengthening the University-field connection. We are currently implementing this new model as supported by a 2017 HRSA behavioral health grant to continue our training program.

#### **Specialized Skills Workshops and Interprofessional Communication**

The trainees consistently comment on the value of focused workshops as an important component of the training program. While they agree that coursework is valuable, the specialized workshops offer the ability to gain concrete skills related to behavioral health practice and provides them with the needed tools for practice. In order to replicate a similar model with the field, we developed a plan to conduct field orientations, monthly lunch and learns, and other opportunities for skill development and interprofessional practice. Under the new model, we provide skills-focused training in two ways: 1) a regularly scheduled mini-workshop series that includes field instructors, agency staff, students, and faculty from across health professions, and 2) a yearly statewide workshop targeting skill development for integrated behavioral health practice. Engagement of field instructors and agency staff is supported by providing free continuing education hours for their participation in the workshops.

The mini-workshop component is a new innovation for this model, as we have only held bi-annual statewide workshops in the past. Previous trainees have reported that these were helpful, but that shorter more frequent “mini-workshops” would better support skill development and build a “network” of professionals with whom to discuss behavioral health practice issues specific to our geographical context. Faculty from various health professions are invited to conduct mini-workshops addressing key issues related to integrated behavioral health and primary care in rural communities. For example, a pharmacist may present on medication management for patients experiencing both mental and physical health problems (e.g., depression and diabetes). At another mini-workshop a primary care physician may present on the most common behavioral health problems seen in his/her rural practice. Program trainees, field instructors, agency staff, and graduate students and faculty from across the health professions attend and engage in interprofessional dialogue. The hope is that this will create a multidisciplinary network of students, faculty, and practitioners who can work together to address the challenges of behavioral health and primary care practice in high-need rural areas. Engaging field instructors and other agency staff as part of this training series allows us to greatly increase our support to field sites in their efforts to integrate behavioral health and primary care services. This component allows for interaction across disciplines, increasing communication and understanding of the various roles each play in providing the best possible care to clients.

The second training component consists of a statewide annual workshop targeting a specific area of skill development for integrated behavioral health practice. The workshop is free of charge to program trainees, field instructors, faculty, and agency staff. The opportunity to receive free continuing education credits is a valuable benefit to field instructors and staff, and assists in the recruitment and retention of quality field instructors and agencies for the program. The annual workshop offers an opportunity to target a particular skill in more depth. Drawing on evaluation results from previous cohorts, these longer workshops focus on skills and models needed for effective integrated and interprofessional practice. Example topic areas include: medical terminology and communication with medical professionals; psychotropic medication; and primary care screening and assessment tools.

## **Mentoring**

A key component of our training program has been on-going mentoring of the trainees by program faculty. The trainees report that this mentoring is essential in developing their knowledge of integrated practice and better understanding the role of the social work profession in interprofessional team-based care. In order to create a

similar process with the field instructors, the two key training program faculty serve as field faculty liaisons for all sites. As a part of this process, we conduct orientations with field placement supervisors and staff at the site to discuss integrated practice and the ways that it can be implemented at that site. We also provide informational packets that include resources appropriate for specific populations and settings, drawing from resources that trainees are provided throughout the training program course curriculum. For example, all trainees are trained in SBIRT for adolescents, including Motivational Interviewing skills to use in a Brief Negotiated Interview (BNI) that is part of the SBIRT implementation process. Explanation of this model (and associated skills) is provided to all sites in which its implementation may be appropriate. Depending on the context of the site, trainees may also supplement field placement staff's learning of this model by sharing information as they receive more in-depth training in the model through their coursework. It is hoped that the initial orientation session and resources provided to the field sites will promote opportunities for continued dialogue and new learning throughout the trainee's placement year, resulting in a strengthened University-field connection as the training program continues. These processes will also help inform us of the challenges faced by the field and provide a feedback loop to inform planning for mini-workshop topics throughout the year.

As a part of the role of field faculty liaison, site visits and seminars with trainees are also conducted. We conduct site visits as a team when possible to provide on-going mentorship to the agency staff. We also hold seminars at agency settings when appropriate to allow agency personnel to interact with trainees and to expose trainees to more of the practice community. This also allows trainees to see different models of integrated care "in practice" and broadens their knowledge and understanding of integrated care with various populations.

### **Build "Cohort" Relationships**

Our evaluation data also suggest that the trainees value the relationships that they are able to build with one another as they complete the program (Rishel, Hartnett, & Davis, 2016). Through these relationships, they are able to help each other solve practice challenges and celebrate successes. We believe that, by providing monthly opportunities for interaction with other providers through the mini-workshop series, a similar "cohort" model can be established among field instructors. It is the hope that these relationships will help the field to continue to respond to the changing landscape of integrated behavioral health practice.

## Assessment

An essential component to our program has been a robust evaluation plan that provides the necessary feedback loop to program implementation and development. As we implement this new model of field education, we will continue this same process of evaluation and program improvement. One of the most valuable aspects of our evaluation methods has been the free-write and focus group discussion process trainees complete each year. We plan to replicate this process with field instructors and agency staff in order to learn what components of our new field education model are most helpful and what could be improved. We anticipate further enhancements to the model as we move forward with this process.

## Conclusion

As we and others continue to learn what is most effective in preparing students and the field for integrated behavioral health care practice, it is essential that on-going assessment accompany any efforts. The importance of including the field in training components has been documented in the literature and corroborated by our evaluation results. Providing the practice community with opportunities similar to those offered to the trainees may serve to help prepare the field to meet the challenges of integrated behavioral health practice. Further research is needed to understand the models that are most effective.

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