WHY INTEGRATED CARE?
Mental health problems can cause, worsen or limit recovery from illness. Clinics and hospitals are adopting “integrated care” – holistic care wherein mental health providers, such as counselors, serve on multi-disciplinary, multi-specialty patient care teams.

Integrated care is under development or operational nationwide (Crowley & Kirshner, 2015)

WHY INTERNSHIPS IN INTEGRATED CARE?
• Medical practices and hospitals prefer mental health clinicians with integrated care experience
• Counselor educators have the opportunity to help shape workforce training in this nascent field

INTERNSHIP PROGRAM DEVELOPMENT

CRITICAL PROCESS ROADMAP IN INTEGRATED CARE INTERNSHIP PROGRAM DEVELOPMENT: Lessons from integrating three new internship sites

MEDICAL PRACTICE
• Integrated care physician champion(s), or physicians who are willing to become champions
• Physician specialty: training, values, approach to patient care, views on mental health
• Practice structure and operations: types of providers and scope of practice, support staff, workflow and tools

PATIENT POPULATION
• Medical and mental health concerns and their intersectionality; emotional impact of diagnoses
• Social determinants of health, the health risks and benefits arising from social factors
• Cultural factors, e.g. ethnicity, gender identity, socioeconomic status, religion/spirituality, family and community systems and values
• Likely acceptance of and experience with mental health providers

TRAINING AND EDUCATION
• Operational factors: co-location with medical providers in “pod”; alerting providers to availability (prior day email); participation in daily rounds and huddles; provider effectiveness in offering mental health care to patients with “warm hand-off”; brief, intentional communication; access to and documentation in health records
• Practice factors: effective theoretical approach; session location private but in clinical area; session content – intro, confidentiality as medical team member, rapport-building, screening/assessment, brief intervention, goals; time with patient 10-30 minutes; follow-up and treatment plans

SUPERVISION
• Onsite: counselor identity, as onsite supervisors are often from social work, marriage/ family therapy, or psychology; more frequent supervision may be warranted depending on site (vicarious trauma, intensity of needs)
• Program: potential lack of supervisor knowledge and experience, with bias against non-traditional counseling; negotiating recording requirements (audio only, short sessions)

DATA
• Clinical use: development of registries for identifying patients with mental health needs, tracking clinical outcomes, and sharing knowledge with patients
• Research use: documenting encounters and collecting outcomes data from health records system to demonstrate efficacy and effectiveness

RESOURCES