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Clinical Social Work in a Public Health Future

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Social and ecological changes after the onset of the COVID-19 pandemic have surfaced the need to change how clinical interventions are administered to extend the reach and impact. The public health prevention approach presents a framework to organize intervention efforts, and clinical social work can benefit from integrating this approach formally into its clinical education programs. This paper presents the current need for a population-based approach to clinical service, a primer for social workers from the public health perspective. It offers key areas to focus on integrating this public health prevention approach more fully into clinical social work practice.

The Need for the Public Health Prevention Approach in Clinical Social Work Practice

The COVID-19 pandemic has increased the general understanding and value of a public health approach to planning and implementing social and health services. Historically, the US has addressed social and public health issues using a treatment model that focuses on assessing and addressing *individual* health problems. A public health approach focuses on the health, safety, and well-being of the whole population, using health promotion and disease prevention interventions to reduce the impact of illness and social problems on the greatest number of people.[1]

The social work perspective rests in ecological systems theory that emphasizes the interconnections between individuals and their environment.[2] When applied to social work, this theory recognizes the profound impact of various systems, from the micro-level (such as families and communities) to the macro-level (including societal and cultural influences) on individuals and their well-being. Social workers employing this perspective strive to understand how these systems interact and shape a person's development, behavior, and access to resources. By comprehending the intricate web of relationships and environments surrounding individuals, social workers can design interventions that address the complex factors affecting their clients, foster resilience, and promote social justice within the broader ecological context.[3]

Within this perspective though, clinical social work training programs often employ the treatment model in their clinical practice curricula and teach how to treat individuals, groups, and families after the onset of a problem. A treatment model can allow customization of intervention planning to clients' needs; however, treating individuals for individual problems can set up the care delivery system in an inefficient way that creates its own access and treatment disparities, on top of the gap related to social, economic, and cultural inequities. The application of treatment for individuals by individual providers can have high variability – and variability in care settings can increase the cost of care and outcomes for service recipients.[4,5] For example, of the estimated 7.7 million children and adolescents with at least one mental health diagnosis, 50% did not receive treatment in 2016.[6] Children

experiencing poverty and those from ethnic and racial minority populations are even less likely to access care, especially after the COVID-19 pandemic[7,8] Furthermore, if children get treatment, they may not receive evidence-based, quality care[9] as a result of the high variability in care.[6]

There is an opportunity for clinical social work to reduce this gap. To best serve recipients of clinical social work services, clinical social work education programs should train students using a public health prevention lens to further align the social work perspective with its populations' pressing needs. This paper outlines the benefits of approaching social work with a public health prevention model and why social work education should more fully integrate this perspective in its training of students. Additionally, methods of integrating this perspective into social work practice and recommendations for social work training and professional development are presented.

Social Work and Public Health

Social work has a history of adopting the prevention framework of public health.[10,11] Natural synergy already occurs between public health and social work, especially within the field of social work itself [10]. Social work houses distinct foci worth mentioning here -clinical and public health social work. Both sub-disciplines play essential roles in addressing the complex issues affecting individuals and communities, with clinical social work attending to immediate personal needs and public health social work addressing systemic issues to create healthier and more equitable societies[11,12]. Both share common understandings of how the systemic forces can impact human behavior and wellbeing and the strategies they use differ because of the level of practice they work in.
Clinical social work and public health social work are complementary branches within the field of social work, each with its unique focus and objectives. Public health social work concentrates on utilizing strategies to improve the health and well-being of entire populations and communities,[10] and these strategies have a top-down approach to change (i.e., strategies at the population level can impact individuals). Public health social workers engage in activities that address social determinants of health, including poverty, education, housing, and access to healthcare. [10,11] They collaborate with community organizations, government agencies, and healthcare providers to develop and implement initiatives aimed at disease prevention, health promotion, and health policy advocacy. [10,11] Public health social workers conduct research, assess community needs, design and evaluate interventions, and engage in community organizing and education. Their efforts are directed towards reducing health disparities, enhancing access to healthcare services, and promoting social justice within the broader population[10, 13].

Clinical social work primarily deals with providing direct services to individuals, families, and small groups using clinical strategies to address personal and psychological challenges. These strategies that aim to improve health and wellness have a bottom-up approach to change (i.e., strategies at the individual level can impact the population). Clinical social workers often work in healthcare settings, mental health clinics, or private practices, providing therapy, counseling, and case management services. They assess clients' emotional, behavioral, and mental health needs, develop treatment plans, and offer individualized support to enhance their overall well-being. Clinical social workers work closely with clients to explore their personal experiences, emotions, and thought patterns, helping them develop coping mechanisms and promoting self-empowerment.[14] Clinical social work interventions are targeted toward promoting mental health, improving relationships, and resolving individual-level challenges.

While clinical social work focuses on individual-level interventions to address personal challenges, public health social work takes a broader perspective, targeting the social, economic, and environmental factors that

influence population health. The prevention approach of public health has had some but minimal documented interest in the social work literature,[10] and a discussion of the public health prevention approach warrants attention.

Public Health Approach: A Primer for Social Workers

The American Public Health Association (APHA) describes public health as "promot[ing] and protect[ing] the health of people and the communities where they live, learn, work and play.[1] Such activities and efforts intended to prevent injury or illness and promote wellness. The public health approach is organized into three levels of prevention: primary, secondary, and tertiary. [1, 15, 16] Multi-tiered efforts to prevent depression illustrate this process.

Primary prevention, commonly known as *universal prevention,* attempts to prevent the onset of clinical risk factors for disease or illness by reducing risk behaviors or risk factors for disease.[15] Universal prevention practices include vaccine programs and school-based efforts to strengthen protective factors (e.g., community connection). Universal prevention occurs before screening or targeting members of a population who could be at risk for a given challenge. It can be implemented at the population level or target the highest-risk groups.[15] Consider the example of depression. Universal prevention programs would aim to prevent individuals from developing risk factors related to depression. Related activities include conducting social-emotional learning curricula in schools for all children, employer health programs that promote physical activity and behavioral activation, and programming for older adults to increase social connectedness.[17] Social workers can actively support such public health efforts by providing education, organizing, and advocating across system levels. Secondary prevention aims to identify and intervene with asymptomatic persons who have developed risk factors for an illness or disease that have not manifested with clinical significance.[16] Its efforts emphasize early and reliable identification, diagnosis, and access to effective and acceptable treatments. Considering depression, social workers could conduct screenings for depression in primary care settings, education settings, or other contexts, like community wellness fairs. For individuals "at-risk" for a depressive disorder, social workers could educate them about lifestyle changes that are not depression-promoting (e.g., social connection, proper sleep hygiene, and nutritional habits), provide brief interventions like behavioral activation planning, and refer to long-term treatment.[18] Secondary prevention begins to resemble more of the treatment-oriented approach in traditional clinical social work.

The third tier of prevention is most similar to the treatment model. Tertiary prevention seeks to interrupt disease progression through disease management, symptom relief, and risk reduction for subsequent events or complications.[19] Activities include pharmacological therapy and outpatient mental health support. With depression, individuals receive treatment if their symptomatology impacts their daily functioning. Social workers could provide cognitive behavioral therapy (CBT) to help identify and challenge thought or behavioral patterns that maintain undesired behavior, or interpersonal therapies to foster relationships that are not depression-promoting. This approach could occur in a traditional outpatient clinic or through work-sponsored Employee Assistance Programs.[20]

Social work can accommodate the *tiers of support* model within its scope of clinical and macro practice, with the challenge of building capacity and attention to universal and selective tiers. The three tiers of prevention can be juxtaposed with social work's *ecological system rings of practice* – micro, mezzo, and macro. Intentional integration of the tiered approach can benefit social work. Public health approaches can improve patients' quality of life and increase life expectancy.[21] For providers, this approach can reduce disparities in treatment outcomes, with fewer patients experiencing the development of

a disease or disorder. For payers, studies show that public health approaches can demonstrate cost-effectiveness.[22] They can bring added public value to the secondary effects on the future functioning of individuals (e.g., contribution to the public good through employment).[23] Social work education needs to become more streamlined to fully integrate the levels of practice and to advance social justice and health equity across these levels of practice. This streamlined approach can help to realize the foundational efforts of the profession that work across sectors and disciplines to improve health and social welfare together.[11]

Roadmap for Social Work Education

Social work is primed to integrate the public health prevention approach more fully. Retooling education can prepare social workers more aptly for a post-COVID-19 world and build capacity for the rapidly expanding social work workforce[11] to meet the increasing demand for clinical services. Three areas organize this new framework: integrating tiered clinical social work skills at a population health level; reconceptualizing intervention by topical and tiered approach; and focusing on dissemination and implementation science.

Clinical Skills at a Population Level

Clinical social workers are being deployed outside the mental health clinic, working in primary care, schools, needle exchange sites, and shelters. Their services must be tailored to each setting, embedding best practices in their work, as the public health approach views health in the context of where people live, work, and play. If clinical social work practice adopts a public health prevention approach, its implementation should be even more embedded in individuals' natural settings and out of the clinic or institutional setting. If clinical social work is taken out of the clinic or the walls of an institution and moved into these natural settings like the home or a park, the social worker can more fully participate in the environment of the person they are helping. Care should be less of a “push” into community treatment facilities and more about a “pull” into the natural settings of clients.

When developing health promotion programs, the environment and resources should be considered. Community-based organizations (CBOs) offer health promotion services where people are. As credible non-stigmatizing presences in a local area, CBOs can help support mental health promotion.[24] Accessibility and community support can increase acceptability and engagement with social services and public health programs. CBOs tend to have fewer structural barriers to participation like insurance status or immigration/citizenship status.[24] Instruction on a common elements approach[25] and understanding how to package these ingredients is an area ripe for improvement. Additionally, training could include consideration of practice in different settings and varying contexts (e.g., primary care).

Reconceptualizing by Problem Area

In social work practice, clinical practice is often taught in a theory-driven manner, an approach that spans practice areas like medical social work, school social work, and mental health/psychotherapy services. Theories of practice are useful as they can be generalizable, but the way clinical social work occurs is problem-based. Our knowledge infrastructure

should be reorganized with problems as the locus and theories informing the approach to the problem. The tiers of intervention model can serve as the organizational tool for clinical skills. Consider our depression example. Instead of focusing our attention on the top tier of intervention (e.g., learning and applying CBT to this problem) why not consider other forms of prevention, like at the population level (e.g., education)? For suicide prevention, why not learn the clinical practice, advocacy, *and* policy skills together to best address the clinical need and influence the ecological factors (e.g., social connection, housing stability, vocational opportunity) that increase suicidality? In clinical education, a multi-tiered approach can organize the application of clinical skills – where CBT can still be learned for the tertiary tier but the application of these skills can be more broadly administered through universal and selective tiers.

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The Role of Dissemination and Implementation Science

In the effort to integrate the public health prevention approach, a systematic approach to understanding the barriers and facilitators to implementation of this practice-based change. A change in practice can have many determinants- such as external factors (e.g., government policy, funding streams) or internal factors (e.g., organizational leadership, staffing patterns of an organization).[26] The scope of dissemination and implementation science can play a role in mapping such change. Dissemination and implementation science investigates the problem of why efficacious practices are not initiated and sustained, or even reach their intended targets.[27] The dissemination and implementation science approach offers fresh possibilities and a basic understanding of these factors that influence the conditions of clinical practice – namely knowing *what* practice to do (*i.e.,* dissemination) and *how* to do it (*i.e.,* implementation). [27] Within research, knowing what works is less of a problem than implementing what is established as effective.[25] Expansive social work policy and research continue to grow, but interventions that work do not reach people.

Dissemination and implementation are related but distinct concepts. Dissemination science carefully distributes information, knowledge, and intervention materials to specific audiences.[28] In contrast, implementation science uses strategies to adopt and integrate research evidence into practice.[16] Implementation science frameworks and behavior change theories articulate the need to consider the opportunities, capabilities, and motivation to change across multiple contexts,[27,29-31] a concept very similar to the person-in-environment and systems approach that defines the social work perspective. Implementation efforts are challenged by organizational contexts, financial resources, provider turnover, support following adoption, and acceptability from providers, also known as *lack of fit*.[32] Implementation studies of global health initiatives show that proper implementation can be cost-efficient compared to initiatives that did not plan for implementation[33]. Intervention setting fit is under-researched as an implementation factor.[32]

Clinical practice instruction should use implementation frameworks, considering the contexts of implementing different tiers of intervention. While dissemination and implementation science are not exclusive to public health, their inclusion with further integration of the public health perspective warrants attention. An implementation lens includes community engagement and organizing approaches. In research and planning, social workers/community partnerships build trust, respect, and understanding of challenges, strengths, and inequities. Through shared goals and innovation, valuable and feasible health and well-being promotion and intervention services can thrive. Continued communication, relationship building, and joint flexibility maximize the utility of collected data and research and help to inform program development and implementation. Clinical work can only be sustained by organizational leaders and managers with an awareness of

organizational factors related to implementation practice.

With our depression example, a dissemination and implementation lens could start a quality improvement project about treatments for depression. The social worker could interview clinicians to understand the current practice in depression treatments at their clinic or conduct focus groups with patients to understand their needs from a mental health clinic to learn if services are tailored to their specific needs. Based on these findings, the social worker can map an implementation blueprint that can incorporate implementation strategies such as training, consultation, fidelity monitoring, giving clinicians reminders, identifying a clinician "champion" for the initiative, or restructuring the work environment (e.g., caseload reassignment, protected time for completing measures). The social worker then serves as a coach for implementation, setting regular intervals for implementation, evaluation, and refinement of the process until the best practice for depression has been sustained in practice.

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Conclusion: Implications for Social Work Education

This paper introduced a path to the cross-pollination of social work and public health disciplines, provided a social work primer on the public health prevention approach, and presented a roadmap for clinical social work education. The public health prevention model aligns with and can be incorporated naturally into social work practice and training. The full integration of the public health prevention perspective in macro and clinical social work education will foster a universal and unified approach in the future social work workforce.[34,35] Existing macro social work curricula on organizational planning, research, and implementation parallel the public health prevention approach. During the initial phases of social work programmatic development, focusing on population outcomes and health promotion and prevention ensures individuals and communities will be served thoughtfully, with efficacy, feasibility, and longevity in mind.

Social work programs should partner with intra-disciplinary departments (e.g., public health, medical, etc.) and community organizations and institutions, building relationships and sharing best practices and knowledge. [34] These collaborations will help align efforts to serve the community best and build resources. Common goals in education, research, and service provision will benefit individuals; support successful clinical social work program development, dissemination, and implementation; strengthen relationships in the community, and have a population impact. There is a natural synergy between social work and public health – it is now time to integrate the prevention approach more fully to advance social welfare and health in the post-COVID, public health-minded world.

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Conflicts of Interest
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Statement of Contributions

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