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In Pursuit of Excellence: Developing Competencies for Delivery of Brief Interventions

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Abstract

In traditional work settings and in the emerging Patient Centered Medical Home team, social workers are faced with the challenge of providing brief intervention services to larger groups of people in need. Social workers need to learn a new model of service delivery and to gain competency in providing brief interventions to clients of all ages. This article introduces Population-based Care and the Primary Care Behavioral Health model as conceptual and methodological tools for social workers to use in mindfully meeting these challenges. Additionally, this article offers the Brief Intervention Competency Assessment Tool (BI-CAT) and demonstrates its use as a career development tool in a case example.

In Pursuit of Excellence: Developing Competencies for Delivery of Brief Interventions

Social workers deliver services to a broad range of clients in many settings. The number of children, families and adults of all ages in need of social work services is increasing faster than the rate of available resources and social work values suggest the importance of the principle of "the greatest good" in directing practice. In community mental health, primary care and other practice settings such as correctional facilities, hospitals and hospice care, there is an increasing demand for social workers to revise their practice toward a brief intervention model in order to provide more services to more people at the time of need. The introduction of managed care into behavioral health has also asked social workers to revise their practice and to see more clients in less time with better results (Aaronwitz, 2012).

All too often, academic training in social work school at the master's level does not prepare clinicians for the challenges of today's health care world. Most newly graduated social workers receive a "crash course" in the realities of clinical work during their field placement or at their first employment. It is at this point that many social workers identify gaps between their graduate preparation and practice setting demands. The experienced social worker may also struggle with discrepancies between their perspective and practice habits that worked well for many years and but less well now in today's world of health care. Preparation gaps, in combination with high caseloads and higher productivity standards, many social workers come to experience job dissatisfaction and without further skill training become vulnerable to burnout.

On-going competency training is an integral part of career development (Boyd-Franklin, 1998, 2003). Competency in brief intervention work, in particular, is fundamental to social worker success. Social workers who takes a systematic approach to learning brief intervention skills are more likely to form a strong and enduring connection to the values that led to their choice of social work as a career. With a strong value connection, social workers exude passion for their work and a strong sense of hope. This empowers clients to also experience great hope and stamina in pursuing more meaningful lives, even with substantial challenges such as poor health and financial problems. A commitment to learning naturally brings us together into communities and these communities promoting self care (an ethical responsibility for social workers) (Hunter and Schofield, 2006). In writing this chapter, our intention was to assist social workers with planning career development activities that enhance success in health care work, improve resilience and strengthen connection to the larger social work community.

We offer readers a tool for enhancing understanding and developing a broad range of skills supportive of excellence in brief practice. The Brief Intervention Competency Assessment Tool, or "BI-CAT", asks social workers to self-assess level of competence in 20 areas. Along with the BI-CAT, we present behavioral anchors to help readers better understand levels of low, adequate and exceptional competency. After reading this chapter, we hope that our readers can (1) use the BI-CAT for self-assessment with confidence, (2) select specific areas for improving competence and (3) recruit colleagues with greater competence in brief work to provide

assistance through modeling and coaching. Indeed, it is with being "watched" and guided by an exceptional brief clinician that the new exceptional brief intervention social worker evolves.

In concluding our chapter, we present a case example of a social worker struggling to meet the challenges of working briefly. Mary uses the BI-CAT as a career development tool. A co-worker introduces her to Focused Acceptance and Commitment Therapy (FACT). She achieves greater job satisfaction and develops a more rewarding connection with other social workers. We encourage our readers to study the chapter in this book that introduces FACT, as it offers many useful clinical strategies for brief work.

Prior to launching into the BI-CAT, we briefly describe the population-based care perspective, as it contrasts with the case perspective that social workers often learn first. The case perspective typically suggests a focus on members of a caseload, and this for social workers often means the most vulnerable members of the community. We will also introduce the Primary Care Behavioral Health (PCBH) model, which provides direction for social workers who are moving into work settings that require a population-based care perspective. The PCBH model describes a new role for social workers, providing tools for brief intervention work in a team treatment context. While the PCBH model was specifically developed to guide delivery of behavioral health services in the primary care setting, many of its features apply equally well to other settings where social workers need to practice briefly.

The Population-Based Care Perspective

Population-based health care suggests that much is to be gained in clinical and cost outcomes when we focus resources on helping all people maintain optimal health as long as possible, rather than attending exclusively to people in acute need of services. When we focus interventions on all members of a population, we are able to prevent development and progression of disease and overtime reduce the number of people who become substantially disabled and require very expensive care. Population-based care also suggests that we may realize better outcomes by changing the way we care for people who are most disabled by health problems. Providing disease management programs to members of this small but costly group involves offering evidence-based interventions that support of development of self-management skills, emotional health, a social support base and in general a higher quality of life. In saving money spent in caring for the most vulnerable, we create a pot of money for intervening with members of the population who are still healthy or less impaired by disorder and disease than most severely impaired members.

Principles of population-based health apply to people of all ages and may be addressed in almost any health care delivery venue. For example, a primary care clinic might develop a program that targets parents of infants with the intention of providing information about the time and course of colic behaviors and strategies for intervening should these occur. The idea would be to prevent secondary problems associated with uninformed parental responses to this somewhat common problem (such as more frequent medical visits, decline in parent functioning due to sleep and mood problems, increased conflict between parents, and, in a worst case scenario, parental harm to the infant). Another example could be the decision of a mental health service to target healthy weight and healthy lifestyle behaviors among clients taking

psychotropic medications that cause weight gain by initiating on-going class and telephone support to members of this group. In both examples, developers of the population-based health program would define outcomes, measure them over time and revise the program as indicated by outcomes.

Over the past two decades, population-based care principles have been applied increasing to the primary care setting. This trend created a positive environment for re-design of delivery of health care, both medical and mental, in the primary care setting. With this we have seen the development of the Patient Centered Medical Home (PCMH) and the Primary Care Behavioral Health (PCBH) model. The PCMH attempts to deliver services needed to the patient at the time of need, including those enhancing development of skills necessary to maintain health and prevent disease as long as possible. The PCBH model describes procedural details for implementing, maintaining and evaluating delivery of behavioral health services in primary care.

The Primary Care Behavioral Health (PCBH) Model

The Primary Care Behavioral Health (PCBH) model (Robinson & Reiter, 2007; Strosahl, 1994a, 1994b) evolved from early randomized control trials demonstrating improved clinical, satisfaction and cost outcomes for integrated behavioral health care relative to the usual practice of primary care providers referring clients to outpatient mental health clinics (see for example, e.g., Katon, Robinson, Von Korff, Lin, Bush, et al., 1996). Large health care organizations, such as the United States Air Force, and numerous Federally Qualified Health Centers have implemented this model. A procedural manual is fundamental to PCBH dissemination efforts and to realization of anticipated outcomes. With increasing frequency, research findings indicate that behavioral health services delivered in the context of the PCBH model result in improved symptoms, better quality of life and higher life satisfaction for most clients; that most clients benefit from an average of four or less visits; that gains made by clients are maintained for several years, and that clients and primary care providers prefer this model to usual care (Bryan, Corso, Corso, Morrow, Kanzler, et al., 2012; Bryan, Morrow, & Appolonio, 2008; Cigrang, Dobmeyer, Becknell, Roa-Navarrete, & Yerian, 2006; Corso, Bryan, Corso, Kanzler, Houghton, et al., 2012; Ray-Sannerud, Dolan, Morrow, Corso, Kanzler, et al., 2012; Simon, Katon, Rutter, VonKorff, Lin, Robinson, et al., 1998; Smith, Rost, & Kashner, 1995). Numerous resources are now available to support behavioral health and primary care providers in implementing the model (Hunter, Goodie, Oordt, & Dobmeyer, 2009;; O'Donohue, Byrd, Cummings, & Henderson, 2005; Oordt & Gatchel, 2003; Robinson, 1996; Robinson, Del Vento, & Wischman, 1998; Robinson, Gould, & Strosahl, 2010; Robinson & Reiter, 2007; Robinson, Wischman, & Del Vento, 1996; Runyan, Fonseca, & Hunter, 2003; Rowan & Runyan, 2005; Strosahl, 1997; Strosahl, Robinson, & Gustavvson, 2012).

The PCBH model describes the role and responsibilities of primary care behavioral health providers, primary care providers (PCP) and nursing staff working together in the context of the PCMH. Typically, the term Behavioral Health Consultant (BHC) is used to describe the services of the primary care behavioral health provider working in the PCBH model. The BHC functions as a consultant to clients and providers and delivers brief intervention services and PCBH

pathway services. The BHC offers brief intervention services to children, youth and adults, often on the same day of the client's visit with the referring PCP or nurse. The BHC uses evidence-based interventions adapted to the brief context of primary care (see for example, Robinson, 2005; 2008; Robinson, Bush, Von Korff, Katon, Lin, et al., 1995; Goodie, Isler, Hunter, & Peterson, 2009) and translates these to even briefer versions that BHCs can teach PCP and nurse members of the team. This allows the PCP, the BHC's primary customer, to support client efforts to practice new strategies and skills over time and in this way sustain gains in functioning. The BHC is considered to be a primary care provider rather than a specialist and charts in the medical record rather than a separate mental health record. The BHC does not have a caseload, does not "open" or "close" cases and is easily accessed by clients and family members on an intermittent basis over the course of their lifetime.

BHC pathway services involve consistent involvement of the BHC with specific members of a specific client population. Clinics develop PCBH pathways in order to improve outcomes to high impact client groups. The targeted group may be that of a healthy population (such as children coming for well child visits) and the focus may be primary prevention (for example, identifying parent-child relationship problems and providing brief, same-day interventions to improve relating skills). Alternatively, pathway services may target clients with mental and/or physical health problems (such as depression, diabetes or chronic pain) and the focus is on teaching self-management skills. Whatever the target, the goal of pathway services is to increase the healthy lifespan of members of the targeted group by consistently adding the expertise of the BHC to client care. Specific BHC pathway services may include assessment and intervention visits in individual, family or group contexts. In some cases, services may involve delivery of monthly group services to clients (for example those with chronic disease) for as long as they receive care at the clinic.

Brief Intervention - Competency Assessment Tool

We developed the Brief-Intervention - Competency Assessment Tool (BI-CAT) (see Figure 1) with the intention of providing social workers a feasible method for self-assessing knowledge and skill levels in daily practice of activities that support working briefly with clients. The BI-CAT is a brief tool and not intended to be comprehensive but instead to suggest 20 fundamental competencies for brief practice in a broad range of settings where social workers provide service, ranging from inpatient units and jails to mental health clinics and primary care settings. The BI-CAT taps into competencies in four domains: Practice Context, Intervention Design, Intervention Delivery, and Outcomes-based Practice. In constructing the BI-CAT, we did not assume that social workers would use only one psychotherapeutic approach but that they would draw from an array of evidence-based interventions. Workers with greater training in brief psychotherapies (such as Solution Focused Therapy and Focused Acceptance and Commitment Therapy) are likely to have higher competence in Intervention Design and Delivery and Outcomes-based Practice Domains, and workers with training in brief therapies and the Primary Care Behavioral Health model are likely to have higher competencies in all four domains.

BI-CAT Behavioral Anchors

In the following section, we offer descriptions for each of the competencies, along with three behavioral anchors defining low, adequate and exceptional levels of competence. The BI-CAT asks respondents to use a scale of 0-10 in self-assessing confidence. Low competence ratings are scores of 0-3, adequate rating are associated with scores of 4-6 and exceptional levels of competence with scores of 7-10. The behavioral anchors describe both knowledge and skill competencies. We recommend that social workers use this tool to self-assess and to strategically plan activities to develop stronger levels of competence in identified areas of weakness. We encourage social workers that are new to brief work to go beyond reading and seek training from colleagues and/or coworkers with higher levels of competence for brief work. Such input will likely include skill training through modeling, observation, guided rehearsal, and on-going coaching in the context of daily practice. Increasingly, organizations will need to identify providers who have strong competencies for brief work and create protocols to guide their provision of mentoring services for staff new to brief treatment.

Domain 1: Practice Context. This domains taps into knowledge and skills related to applying brief interventions tailored to the social worker's practice context. Skill application of brief interventions involves understanding the population you serve so that you are able to reach out to them, address barriers to their use of services, provide transparent interventions amenable to support by non-social worker colleagues, and change routine practices to improve services to clients. Table 1 provides a description of low, adequate and exceptional competency levels for the four areas in this domain.

Table 1. BI-CAT Practice Context Domain Items and Behavioral Anchors for Low, Adequate and High Competence

1. Understand the most common problems of clients in your setting and promote their access to your services for these problems	
Low	Has no have specific information about potential and actual clients' most common complaints; unable to use this information as a basis for outreach
Adequate	Has information about top 5 problems / requests / diagnoses and knowledge of how to address these
High	Has information about top 5 problems / requests / diagnoses and action plan for outreach plan that describes these services to potential and actual clients
2. Address barriers to client access of your service (e.g., minimize stigma, select optimal location)	
Low	Cannot identify specific barriers clients often experience in attempts to access services

Adequate	Can describe specific access barriers clients experience and attempts to address some of these on a case-by-case basis (e.g., attempts to lessen stigma, provides bus tokens)
High	Periodically surveys clients about access barriers and feasible strategies for addressing these; makes changes to routine practices to lessen experience of barriers (e.g., moves practice to more accessible location; offers services at preferred times, etc.)
3.Work to share your skills with other members of your team so that they can support your interventions	
Low	Attends all staff meetings but does not report on any specific brief intervention activities beyond linkage and referral activities and does this only when requested to
Adequate	Attends all staff meetings; reports on resources and linkage activities as requested; attends workshops on evidence-based brief interventions and provides brief summary of learnings at staff meetings
High	Adapts brief interventions for use by team members who have less time with clients (e.g., adapting 5 minute breathing exercise to a 2-minuter version) and teaches these through half-page handouts and presentations at staff meetings; creates 1-page client education handouts and makes these available to other team members
4. Define the demands of your practice setting and make necessary adjustments to your practice (e.g., numerous clients and limited providers / shorten visit times)	
Low	Continues to ask clients to attend 1-hour initial and 1-hour follow-up appointments, even when evidence for such is lacking and other clients receive no services and continue without care on long waiting lists
Adequate	Tracks number of days that clients wait for service and attempts to provide same-day service for acute clients and service for non-acute clients within 1 week; makes changes to appointment length as needed to reach access standards
High	Tracks number of days that clients wait for service and attempts to provide same-day service for all clients requesting such, by adjusting appointment time to what is required to service clients (averaging 30 minutes per client)

Domain 2: Intervention Design. This area suggests competency levels for designing interventions supportive of brief work with clients, beginning with providing a standard introduction that suggests that the client may benefit from a single appointment. Table 2 provides behavioral descriptors for low, adequate and high competence on each of the 9 areas in this important domain.

Table 2. BI-CAT Intervention Design Domain Items and Behavioral Anchors for Low, Adequate and High Competence

5. Introduce yourself and your services in ways that promote change (e.g., My job is to help you help yourself, I may only see you once; we will come up with one or more strategies to help you today)	
Low	Introduction suggests that the focus on the initial visit will be limited to assessment
Adequate	Introduction suggests that the initial visit will include assessment and recommendations regarding behavior change
High	Introduction suggests that the initial visit will include assessment, behavior change recommendations and skill training and that many clients benefit from a single appointment
6. Target problem of concern to client at time of visit	
Low	Obtains lengthy psychosocial history in initial visit
Adequate	Obtains brief psychosocial history and inquires about problem concerning client at time of visit
High	Obtains psychosocial information in 5 minutes and focusses assessment and brief intervention on problem of concern to client at time of visit
7. Identify and use client strengths in intervention design	
Low	Does not routinely asks questions that help identify client strengths to use in intervention design; focus of assessment is on client weaknesses, deficits and pathological symptoms; designs intervention to reduce or eliminate symptoms
Adequate	Assessment includes questions that help identify client strengths and weaknesses; focus of assessment is on identifying client skill deficits and remediation strategies, as well as reducing symptoms
High	Assessment includes questions that help identify client strengths and weaknesses; conceptualizes intervention design in terms of client strengths, including ability to identify and accept current symptoms / problems as signals of the need for behavior change and willingness to learn new skills
8. Normalize the client's problem or avoid pathology explanations of the problem	
Low	Routinely works to establish a specific diagnosis, communicates diagnosis to client and then sees client through the lens of a "diagnosed" person
Adequate	While understanding and being guided by a client's diagnosis, communicates understanding of the context of client's diagnostic symptoms and expresses view that symptoms emerge in a biological, psychological and social context
High	While understanding a client's diagnosis and using it as needed by billing purposes, communicates to client that problem or symptoms are understandable in the client's life context and that change in that context is possible

9. Completes assessment prior to beginning behavior change planning	
Low	Blends assessment and behavior change planning, often returning to assessment after development of a behavior change plan
Adequate	Attempts to complete assessment prior to beginning behavior change planning
High	Consistently completes assessment and summarizes assessment findings to client prior to beginning behavior change planning
10.Offers client a case conceptualization in a problem summary statement	
Low	Does not provide a problem summary statement with a case conceptualization
Adequate	Provides problem summary statement weak (or no) case conceptualization in it
High	Provides problem summary statement with strong case conceptualization ("So, you've been staying in your room more and you notice thoughts about "failing" more. Staying in your room doesn't change those thoughts and you notice that your mood worsens when you don't go out, so some change in that behavior might make sense?")

11. Focus on small changes ("one step at a time")	
Low	Works from extensive treatment plan with multiple goals
Adequate	Targets client's priority among treatment plan goals
High	Targets client's target problem and specific change plans designed to improve that problem
12. Frame intervention as "an experiment to see what happens" (i.e., create permission to fail)	
Low	Frames behavior change as a request ("Will you do X?")
Adequate	Frames behavior change as a plan ("So our plan is X?")
High	Frames behavior change as an experiment ("So our plan is X and we both agree that this is just an experiment to see what happens, right? If it doesn't work, we'll know we need to try something different")
13. Assess confidence in behavior change plan at all visits	
Low	Does not ask about client's level of confidence in behavior change plan
Adequate	Asks about client's level of confidence in behavior change plan ("How confident are you in our plan?")
High	Ask about client's level of confidence in behavior change plan at all visits, using a rating scale question ("On a scale of 1 to 10, where 1 is "not confident" and 10 is "very confident", how confident are you in our plan?)

High	Identifies and addresses barriers to client's follow-up, acknowledges and addresses these (e.g., "So you went to the park and saw your friends and forgot that you planned not to drink at the park . . . I have an idea about how to help you learn to stay more aware in situations like that . . . want to hear about that?"
14. Identify and address barriers to client's follow through with behavior change plans?	
Low	Expresses concern that client did not follow through on a change plan and attributes this to a lack of motivation, requests that s/he try plan again
Adequate	Identifies barriers to client's follow-up, sees barriers as challenges, encourages continued effort
High	Normalizes lack of compliance, is curious about barriers, sees barriers as an opportunity for clinician and client to learn. Also inquires about behavior changes client made other than the planned change that had a positive impact on client status. Attributes positive outcomes to client's ability to be aware, choose, and take action ("Awesome. You did the plan and parts of it worked for you and you found some other things that are helpful, too")
15. Encourage client to take ownership of behavior changes	
Low	Focuses on client compliance ("So, you did follow through with our plan this time")
Adequate	Focuses on client compliance and acknowledges client's role in following through with behavior change plans ("Good for you; you followed through. How did it work for you?")
High	Focuses on client compliance and inquires about behavior changes beyond the planned change that might have had an impact on client status; attributes positive outcomes to client's ability to be aware, choose, and take action ("Awesome. You did the plan and parts of it worked for you and you found some other things that are helpful, too")

Domain 3: Intervention Delivery. These competencies tap into skills involved in visit-by-visit delivery of brief interventions. They guide social workers into greater adoption of the population-based care perspective described earlier in this chapter and by so doing empower workers to serve more clients. Table 3 provides behavioral anchor descriptions for the two items in this domain.

Table 3. BI-CAT Intervention Delivery Domain Items and Behavioral Anchors for Low, Adequate and High Competence

16. Establish a care pathway (or routine procedure) for consistent delivery of acceptable, effective interventions for common client problems (e.g., skill groups for clients with depression, lifestyle problems or chronic disease; workshops for clients with high stress, parenting concerns or sleep problems)	
Low	Does not understand the concept of a care pathway

Adequate	Understands what a care pathway is and works with colleagues to develop an initial care pathway to improve multiple outcomes (e.g., client or provider satisfaction, clinical outcomes, more optimal use of resources)
High	Implements and evaluates multiple care pathways that improve outcomes and participates in revisions to pathways as suggested by outcome information
17. Offer open access groups to clients to enhance access to skill practice and social / emotional support	
Low	Does not offer group or class services
Adequate	Offers closed group services to a select group of clients (e.g., a 7-session class for depressed clients)
High	Offers open access groups and workshops with topics that are relevant to clients with a variety of problems (e.g, a 5-session "Life Satisfaction" class that teaches a variety of strategies that are relevant to clients with many different kinds of problems, with each class as a stand alone unit open to client self-referral)

Domain 4: Outcomes-based Practice. Use of feasible outcomes to plan, evaluate and make intervention plan changes provides a strong foundation for brief intervention work. Data needs to guide case-by-case work as well as overall effectiveness of a social worker's (or clinic's) brief intervention practice. Skills in this domain apply to deliver of serves to all units, including individuals, families and groups. Table 4 describes the behavioral anchors for these three competencies.

Table 4. BI-CAT Outcomes-based Practice Domain Items and Behavioral Anchors for Low, Adequate and High Competence

18. Use outcomes tailored to delivery of brief interventions (e.g., problem severity rating)	
Low	Does not collect / ask outcome information
Adequate	Collects outcome information at beginning and end of treatment
High	Collects outcome information at all visits (e.g., "On a scale of 1 to 10, where 1 is "not a problem" and 10 is "a very big problem, how big of a problem is . . . parenting your son at this point in time, . . . or managing your diabetes, . . . or doing what you choose to do when you feel anxious?")
19. Demonstrate willingness and ability to change intervention based on assessment results (e.g., confidence rating)	
Low	Tends to encourage client to implement behavior change plan even when client seems uninterested or under-committed to it

Adequate	When client indicates a lack of confidence, makes an effort to change behavior change plan (e.g., "Let's take this plan off the list; you didn't seem interested in that one. Okay?")
High	When client indicates a confidence level of 6 or less, asks client what changes can be made to the behavior change plan to increase client confidence and then makes these changes
20. Use outcomes in aggregate to evaluate the effectiveness of your practice (e.g., client change in mental health or health-related quality of life scores from initial to last follow-up visits)	
Low	Does not have aggregate outcome information to help with evaluating practice effectiveness or is not interested in available information
Adequate	Reviews available aggregate information and participates in discussions about data with other team members
High	Actively uses available aggregate information to plan and make changes to service delivery

BI-CAT Evaluation

Our evaluation of the BI-CAT is preliminary. We have results from a survey of 20 behavioral health clinicians. All clinicians worked in a setting that encouraged them to complete treatment with clients in six or less contacts and all were trained in Acceptance and Commitment Therapy, as well as other cognitive behavioral approaches. Clinicians varied in level of competency and those with higher competence tended to see clients more briefly. All clinicians made gains in average competency ratings after a 1-day training in Focused Acceptance and Commitment Therapy (Strosahl, Robinson, & Gustavvson, 2012) and use of techniques from *Real Behavior Change in Primary Care: Improving Outcomes and Increasing Job Satisfaction* (Robinson, Gould, & Strosahl, 2011). In the future, we plan more systematic evaluation of the BI-CAT, including collection of survey, observation and behavioral event interview data.

Case Example: Mary

Mary is a 27-year old licensed master social worker and Behavioral Health Consultant (BHC). She is working in her home state. She graduated from a state university two years ago. A large part of her social work training in graduate school emphasized long-term clinical work. She's been frustrated with the results of her attempts to employ the long-term therapy strategies to the brief intervention worked required of her as a member of the Patient Centered Medical Home (PCMH). She became worried when she noticed that she was less excited about going to work, spent more time day dreaming during visits with clients and became easily irritated by colleagues. Mary even wondered if she had chosen the wrong career.

Mary went to her supervisor and asked for help. She explained that she wanted to learn whatever she could in order to provide better BHC services and that she desperately wanted to feel more effective. Her supervisor introduced her to the BI-CAT and suggested that she use it as a self-assessment tool. Once Mary completed her ratings, she and her supervisor mapped out a career development plan. This plan included Mary's reading more about brief intervention work in primary care (see for example, Robinson & Reiter, 2013) and reviewing what she had learned in graduate school about Solution Focused Therapy (Miller, ?). Her supervisor also arranged for her to go to another clinic to shadow a more experienced BHC.

About 6 months later, a colleague from graduate school told Mary that he'd attended several trainings on Acceptance and Commitment Therapy (ACT) and found its trans-diagnostic approach supportive of working briefly with clients. Mary decided to attend the Association for Contextual and Behavioral Sciences (ACBS) world conference with her friend. At the conference, Mary attended a workshop of using ACT in primary care (Robinson, Gould, & Strosahl, 2010) and applying the principles of Focused Acceptance and Commitment (FACT) (Strosahl, Robinson, & Gustavvson, 2012) to the context of brief intervention work. She was impressed by the strong evidence base for ACT interventions. Upon returning from the conference, Mary incorporated "workabililty questions" and values clarification exercises into her clinical work and noted better client engagement immediately.

Mary joined one of the many ACBS listservs (see contextualpsychology.or) and spearheaded a learning cohort for aPCMH workers. She continued to use her BI-CAT results to develop her skill set and administered a survey to her PC colleagues in an effort to identify a population for development of a PCBH pathway. Results suggested that improved treatment of chronic pain was a top priority. With a small group of colleagues, Mary developed a pathway pilot that relied on use of the primary care Bulls Eye Plan to improve psychological flexibility and quality of life for clients with chronic pain (for instructions, see http://www.newharbingeronline.com/real-behavior-change-in-primary-care.html). In order to meet the needs of this large group of clients, Mary started several monthly groups to serve them. Outcomes from the chronic pain class include improved satisfaction with care for clients and for primary care providers and nurses as well. Scaled scores on the Duke Health Profile (Parkerson, Broadhead, & Tse, 1990) suggest improvement in social health among group participants. Mary is planning a series of 5-10 minute presentations on the Bulls Eye Plan at provider and nursing meetings. She continues to meet monthly with the small group of staff who are evaluating the chronic pain pathway.

Mary is on her way to developing exceptional competencies in delivery of brief interventions in several areas where her initial ratings were low. She is no completing 10 client visits per day and her outcome data suggest that most clients are improving. Several of her colleagues have asked to come and shadow her individual work with clients and her group work with clients with chronic pain. She suggested that they read this chapter and complete the BI-CAT before their visit to her clinic, so that they would be better able to see ways to address identified skill gaps.

Conclusion

The BI-CAT offers readers an opportunity to better describe their strengths and weaknesses in relation to providing brief interventions. With vigilance and with the support of others, the BI-CAT is a useful career development tool that can help new and experienced professionals develop fundamental skills for succeeding in today's health care world. When social workers demonstrate adequate and exceptional skill levels in brief intervention work and apply interventions consistent with FACT, they are likely to experience greater job satisfaction as well as better outcomes with clients.

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Figure 1. Brief Intervention Competency Assessment Tool (BI-CAT)

Competency means "adequacy; possession of required skill, knowledge, qualification or capacity". This tool is designed to help you assess your competence in skills involved in effective delivery of brief interventions. Specific competencies are grouped in four domains: Practice Context, Intervention Design, Intervention Delivery, and Outcomes-Based Practice. Use this scale to assign a "rating" to your competence level at this time. Use results to formulate a career development plan.

0 = not adequate 5 = adequate 10 = exemplary*

PRACTICE CONTEXT. This area concerns your ability to consistently promote optimal behavior change opportunities for your clients in the setting where you work. Do you . . .

Competency	*Rating*
1. Understand the most common problems of clients in your setting and promote their access to your services for these problems?	
2. Address barriers to client access of your service (e.g., minimize stigma, select optimal location)?	
3. Work to share your skills with other members of your team so that they can support your interventions?	
4. Define the demands of your practice setting and make necessary adjustments to your practice (e.g., numerous clients and limited providers / shorten visit times)?	

INTERVENTION DESIGN. This area concerns your ability to design strong brief interventions. Do you . . .

Competency	*Rating*
5. Introduce yourself and your services in ways that promote change (e.g., My job is to help you help yourself, I may only see you once; we will come up with one or more strategies to help you today)?	
6. Target problem of concern to client at time of visit?	
7. Identify and use client strengths in intervention design?	
8. Normalize the client's problem or avoid pathology explanations of the problem?	
9. Complete assessment prior to beginning behavior change planning	
10. Offer client a case conceptualization in a problem summary statement	
11. Focus on small changes ("one step at a time")?	
12. Frame intervention as "an experiment to see what happens" (i.e., create permission to fail)?	
13. Assess confidence in behavior change plan at all visits	
14. Identify and address barriers to client's follow through with behavior change plans?	
15. Encourage client to take ownership of behavior changes?	

INTERVENTION DELIVERY. This area concerns your ability to integrate brief interventions into your system of care, so that more clients benefit from your brief services. Do you . . .

Competency	*Rating*
16. Establish a care pathway (or routine procedure) for consistent delivery of acceptable, effective interventions for common client problems (e.g., skill groups for clients with depression, lifestyle problems or chronic disease; workshops for clients with high stress, parenting concerns, or sleep problems)?	
17. Offer open access groups to clients to enhance access to skill practice and social / emotional support?	

OUTCOMES-BASED PRACTICE. This area concerns your ability to use outcomes to plan and evaluate treatment. Do you . . .

Competency	*Rating*
18. Use outcomes tailored to delivery of brief interventions (e.g., problem severity rating)?	
19. Demonstrate willingness and ability to change intervention based on assessment results (e.g., confidence rating)?	
20. Use outcomes in aggregate to evaluate the effectiveness of your practice (e.g., client change in mental health or health-related quality of life scores from initial to last follow-up visits)?	

*In evaluating your scores in relation to the behavioral anchors for each item described in this chapter, we recommend that you see scores of 0-3 as “low”, 4-6 as “adequate” and 7-10 as “exceptional”