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INTEGRATING COMPLEMENTARY AND ALTERNATIVE MEDICINE INTO THE CURRICULUM

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Integrating Complementary and Alternative Medicine into the Curriculum

Complementary and alternative medicine (CAM) approaches, referred to as integrative health services (IHS), are used by a cross section of populations that intersect socioeconomic status, gender, race, religion and age. These approaches to health care include a variety of methods and approaches to relieve chronic and acute disabling conditions. HIS approaches to health care are gaining popularity and credibility both within and outside of the academy. According to Gant, Benn, Gioia, Seabury (2009), it is time for social work educators to integrate IHS into the curriculum along with traditional behavioral and cognitive approaches to social work practice. Rationales and pedagogical models for integrating IHS into the curriculum are offered, linking these with social work professional ethics and core competencies.

Key Words:

Complementary and alternative medicine (CAM)

Integrative Health Services (IHS)

Social Work Curriculum

Core Competencies

Educational Policies and Accreditation Standards (EPAS)

NASW Code of Ethics

BACKGROUND

Social workers continue to provide the bulk of mental health services in the U.S. (Block, 2006). A significant number of persons seeking services expect their health care providers to be aware and knowledgeable about alternatives and complements to western medical approaches for symptom relief and healing when their health is disrupted and/or compromised (Gehlert & Browne, 2006). An ever increasing number of people are seeking complementary and alternative medicine (CAM), here to forth referred to as integrated health care (IHC) to address health/mental health issues (National Center for Complementary and Alternative Medicine (NCCAM), 2012; Shapiro, Cook, Davydow, Ottaviani, Leuchter, & Abrams, 2007; McCaffrey, Eisenberg, Legedza, Davis, & Phillips 2004). IHC is the common acronym being used in health and mental health care services in western societies (NCCAM, 2012). Not only are people receptive to IHC, they are also requesting their health care providers to explore diverse approaches that go beyond medications and psychotherapy to address their overall health concerns (Kliger, 2000; Mann, Gaylord, & Norton, 2001). The medical community is responding with innovative approaches to integrating IHC with traditional health/mental health care (Faas, 2001). IHC is requested by consumers and many will expect their social worker to have some level of knowledge about various forms of IHC (Tindel, Phillips & Eisenberg (2005).

A generally accepted description of IHC/CAM among a wide range of social scientists is that “CAM is a broad domain of resources that encompasses health systems, modalities, and practices and their accompanying theories and beliefs, other than those intrinsic to the dominant health system of a particular society or culture in a given historical period” (Gant, et. al., 2009, p. 407). It is important to acknowledge that some

social workers and/or clients may not consider various types of practices labeled as IHC as alternative or complementary. They readily access these types of interventions before seeking pharmacological and psychotherapies and consider these resources to be essential components of their approaches to health/mental health care. Interventions and remedies that some cultures and populations consider conventional, others view as alternative and what some clients assess as successful outcomes, the medical community and/or social workers may not concur.

With the rising costs of medications and the increasing lack of health insurance, many adults are seeking alternatives for their health/mental health care (Ananth & Martin, 2006). Factors, such as cultural norms, religious beliefs and familial distrust of seeking help from “outsiders,” creates skepticism for utilizing interventions that western medicine takes for granted as legitimate and credible (Mann, Gaylord & Norton, 2004, Wylie, 2004). The myriad of reasons why diverse populations seek IHC when addressing their health care needs is being investigated (NCCAM, 2012; Coulter & Willis, 2007). Also, the National Institute of Health (NIH) (2012), the Institute of Medicine (2005), and the Center for Disease Control (CDC) (2005) are studying the efficacy and legitimacy of IHC approaches to health and mental health care. Data from these research institutions indicate that providing a variety of complementary/integrative and conventional interventions are valuable and effective (NCCAM, 2012; D’Eramo, Papp & Rose, 2001; Hill, Smith, Fearn, Rydberg & Oliphant, 2007).

GLOBAL RECOGNITION OF THE VALUE OF IHC

According to the World Health Organization (WHO) an IHC approach is needed for effective and efficient health/ mental health delivery systems (WHO, 2008). They

define IHC “as the organization and management of health services so that people get the care they need, when they need it, in ways that are user-friendly, achieve the desired results and provide value for the money” (WHO, 2008, p. 1). The following benefits of IHC are listed, which provide guidance for Social Work programs when approaching IHC education from a holistic, integrated system of learning (WHO, 2008).

- Integration is about practical questions on how to deliver services.
- It is a continuum involving discussions about the organization of various tasks which need to be performed in order to provide a population with quality health care; this can look differently for different populations.
- Not all services have to be integrated into one package, but rather to avoid disjointed services and strive to link all health care into connected services that can be navigated by consumers.
- Changing the way health care is provided may require a mix of political, technical, and administrative collaboration, with input from all stakeholders.

Integrating IHC into the social work curriculum involves revisiting the implicit and explicit curricula for areas where it makes sense to incorporate IHC into current educational practices and structures for a particular program and its environment.

In order to be perceived as credible, many clients will expect their social workers to be aware of IHC approaches to health and mental health care. The multitude of complementary approaches to maintaining health are vast and it is unrealistic for students to be informed and knowledgeable about all of them, but it is expected that students will be aware of the predominant practices and methods being used among the populations they are serving. Just as important, social work students need to be instilled with a respect

for clients' authority in determining the best method to treat their illness or malady when there are no indications of harm to self and/or others (NASW, Code of Ethics, 2008). Knowing how to integrate empirically tested and validated medical interventions, along with indigenous approaches preserved for generations, may well be the future of health/mental health care in western industrial societies (Block, 2006).

CHALLENGES FOR INTEGRATING IHC INTO THE CURRICULUM

Many social work educators are aware of the rapidly expanding utilization of IHC approaches for health/mental health care and that clients and patients are seeking an integrated approach with traditional health care strategies (Gehlert & Browne, 2006). The immediate and long term challenges for social work educators are how to equip and prepare students with an integrated experience that infuses the profession's signature person in environment (PIE) framework (Hutchison, 2011) and professional values when incorporating IHC in the curriculum (Grant, Benn, Giola & Seabury, 2009).

Simply offering an elective IHC course once a year may not be meeting the needs of both social work students and the people they will serve (Grant, Benn, Giola & Seabury, 2009). What would be more responsive to the demands of both consumers and students is the development of core competencies as a protocol for measuring and assessing the prerequisite knowledge, skills, and values needed for responsible social work practice, as well as familiarizing students with studies that demonstrate the effectiveness of IHC models of social work practice that are valid and reliable.

When reading the literature on IHC it becomes paramount that there is a need for social work programs to collaborate with other professional disciplines to develop curricula that is responsive to the marketplace (Gant, Benn, Gioia, Seabury (2009).

Schools of Medicine, Nursing and Allied Health are legitimate and essential partners with Social Work in both teaching the next wave of health/mental health care providers and creating research teams that employ both PIE (Hutchison, 2011) and participatory action research (PAR) principles (Stringer, 1999). Basic integrative approaches to educating social work students with other health care professions about IHC considers empirical data that support the rationale for including and integrating IHC education throughout the curriculum. The overlaps between medical model approaches, with its emphases on medications and behavioral therapies, and IHC approaches can inform and support each other when studied and researched in a multidisciplinary environment (NCCAM, 2012).

Applying an integrative, multidisciplinary approach to educating social work students, recognizes that the social worker and the client possess expertise in managing their health care (Stringer, 1999). Knowledge is mutually respected and shared when determining which interventions are best suited for a particular person and his/her environmental factors. “While non-conventional models are not identical, they tend to share common principles. A holistic view is inclusive and considers the healing needs unique to each individual’s presenting problem, history, other medical conditions, environment, preferences and lifestyle” (McBee, 2008, p. 9).

CONCEPTUAL ORGANIZING FRAME

The curricular guidelines and models for IHC (Mann, Gaylord, & Norton, 2004) require a theoretical foundation based upon empirical research findings, as well as anecdotal testimonies from people who can attest to both the efficacy and applicability of various types of IHC. Both theory and outcome measures based upon empirical research designs will drive the infusion of IHC into the social work curriculum (Gant, Benn, Giola

& Seabury, 2009). Linking practice with theory is imperative for being effective when serving individuals and communities (Turner, 1996). The theories we hold within our professional disciplines deeply influences how we interpret data, explain behavior, and design our interventions (Guba & Lincoln, 1986). In order to integrate IHC education into the social work curriculum a theoretical premise needs to be established, which informs practice and research. For social work education this approach is systems theory (Robbins, Chatterjee, Canda, 1998) “Over the past two decades, systems theories have become widely used in social work practice, and both systems theory and the ecosystems perspective have been proposed as meta theories for social work practice” (p. 48). Systems theory recognizes that all relationships are dynamic and take place within an interconnecting environment and that the social worker is aware of multiple aspects of the person and his/her environment and how each is influencing the other (Thyer, 2001).

RESEARCH METHODS AND INTERPRETING IHC DATA

Within professional health care, interpretations of the effectiveness of IHC vary immensely (Mann, Gaylord , & Norton, 2004; Institute of Medicine, 2005; National Center for CAM, 2012). Some researchers are challenging conventional empirical methods of testing the effectiveness of IHC interventions and resources: “CAM is not simply a new array of therapeutic tools that needs to be evaluated; it presents other ways to think about disease and therapeutics, and consequently new ideas about how research should be strategically developed” (Fonnebo et. al., 2007, p. 5). These researchers suggest that looking at a therapeutic intervention without really understanding the cultural context in which it is being practiced does not allow researchers to analyze data outcomes at their fullest capacity and a more complex approach to research is needed.

Other researchers point to the inadequacies of current research methodologies in capturing the effects of IHC interventions (Block & Jonas, 2006; Boon et. al., 2006; Coulter, 2006). Issues are raised when researchers are dependent upon participants accurately reporting and fully disclosing both the type and quantity of IHC they are utilizing. One of many challenges for social work educators who are engaging in IHC research and are currently teaching IHC is how to present valid and reliable data when integrating IHC into the core curriculum. (Jonas, Beckner & Coulter, 2006).

When researching measurable outcomes and the effects of IHC interventions with particular individuals and populations it is critical to take into consideration this person/population's particular strengths that he/she identify within his/her cultural and religious environments. Incorporating strength's perspective when gathering and analyzing data, researchers must closely examine how participants are portrayed and represented (Saleebey, 1997). This approach is aligned with participatory action research methods (PAR) (Wolcott, 1994; Stringer, 1999), which recognizes participants as having authority and expert knowledge in interpreting their experiences and that historically marginalized populations often are misrepresented by dominant authorities in society (Kemmis & McTaggart, 2000; Wolcott, 1994).

There is a healthy tension between professional interpretations of the effects of IHC and the ambiguities that exist among the multiple interpretations from the people who utilize IHC. Multiple perspectives need to be considered when assessing the credibility of health care outcomes. Both the practitioner and the client have something valuable to contribute to the science and art of introducing IHC to assessment and treatment plans (Stringer, 2007). This PAR approach to research and practice when

applied to IHC education, includes the voices of both clients who self-report benefits from utilizing IHC along with IHC practitioners who are practicing IHC in the field.

INITIAL PHASE OF INTEGRATING IHC ACROSS THE CURRICULUM

The starting point for integrating IHC into the curriculum is employing systems theory and PIE (Hutchison, 2011), along with PAR (Stringer, 2009) frameworks to both teaching and researching IHC. The complexities of persons interacting with their environments, and vast array of non-traditional approaches to health and mental health care being accessed by diverse individuals and populations are significantly influenced by the cultural environment in which students will be practicing. Recognizing the expertise and authority of the client(s) are essential components when approaching IHC.

NCCAM (2012) research is assisting social workers in gaining a richer, fuller understanding of ways in which adults maintain health and the reasons they select various alternatives for their health care. Social work educators will need to be aware and sensitive to these emerging trends in IHC practice and research that are significantly informed by cultural contexts. (Richardson & Barusch, 2006).

Linking IHC content across the curriculum, utilizing the core competencies established by the Council on Social Work Education (CSWE) (2008), can assist in organizing and conceptualizing this dynamic process of integrating IHC into the social work curriculum. “The need to reframe EPAS [Educational Policy & Accreditation Standards] to a focus on student outcomes based in practice behaviors, that is, what a student must learn and be able to do, lead to a competency-based education approach. Competency-based education is an outcome performance approach to curriculum design” (CSWE, Advanced Gero- Social Work Education, 2010, p. 1).

A precedent for this process is the collaboration between the Hartford-funded CSWE Gero-Ed Center and the Association for Gerontology Education in Social Work, (CSWE, *Advanced Gero Social Work Practice*, 2010). Another model for this process is the *Advanced Social Work Practice in the Prevention of Substance Use Disorders* (CSWE, 2008) and the most recent collaboration is the *Advanced Social Work Practice in Trauma* (CSWE, 2012). All are models “for social work programs to use in the development of concentrations specific to an area for the 2008 EPAS” (CSWE, *Advanced Gero Social Work Practice*, 2010, p. 2). Just as competencies regarding treatment for older adults, substance abuse, and trauma have been developed by CSWE, there appears to be a clear mandate for integrating IHC approaches to social work practice within the curriculum (Gant, et. al., 2009).

Using competencies outlined in EPAS as the standard for integrating IHC into the social work curriculum will require guidelines that are flexible enough to adapt to meet the regional and cultural needs that are specific to social work programs, their students and constituents. Each IHC competency that could be used to integrate IHC across the social work curriculum is presented in the appendix and the authors offer this framework as a platform that could begin the process of dialogue within CSWE and among Schools and Departments of Social Work of the need for integrated health/mental health care material to be included in the curriculum for competency based social work practice

MODELS FOR INCORPORATING IHC ACROSS THE CURRICULUM

When teaching best practices in IHC education, innovative and well-tested forms of interventions are needed that take into consideration a holistic perspective of the person (Cook, Becvar, & Pontious, 2000). These best practices recognize that multiple

environmental variables operate in a person's life that contributes to his/her overall health (Koenig, McCullough & Larson, 2000; Strozier & Carpenter, 2008). This holistic approach to health/mental health care is an approach that incorporates the bio-psycho-social-spiritual dimensions of a person and/or a population, increasing the possibilities for achieving desired outcomes (Gant, et. al., 2009; Mann, Gaylord, & Norton, 2004). "An approach that focuses on subjective and interpretative dimensions of clients ensures that social workers will respect individual differences among people and avoid inappropriate interventions." (Richardson & Barusch, 2006, p. 52).

Teaching IHC interventions generally begins with knowledge of the environmental context (implicit curriculum) that both the program is situated and the students will be practicing. The goal is to support best practices for particular populations and/or individuals. Achieving a grasp of the practice wisdom that is gained from utilizing IHC interventions and listening to consumers are essential when approaching social work education from an implicit curriculum design. The hallmarks of the social work profession are noting the environment in which the student is learning and will be practicing, respecting cultural and religious diversity, viewing a client's presenting problem from a systems theory, and designing interventions from a client's strengths perspective (Hutchison, 2011). This implicit curriculum approach is aligned with IHC best practices and is supported in the IHC literature (NCCAM), 2012).

What is considered adequate knowledge, skills and values when teaching social work students best practices that may involve religious rituals, eastern meditation techniques, herbal remedies, and more? How will "adequate" be measured is a precursor question that each faculty will have to discuss, debate and decide (Lenaway, Sotnikov,

Corso, Millington, Halverson, Tilson, 2006). Much will depend upon the diverse cultural, religious and socio-economic environments in which the social work program is located. Taking into consideration the implicit curriculum, one of the social work educators' goals is to create a climate that promotes professional responsibility for students to be informed, educated and unbiased when making referrals and/or providing IHC approaches in the field. How much theoretical knowledge and practice skills are needed and/or desirable for social work students, in the bachelor and/or masters level, during their education and formation as professionals are important and necessary questions for each program to be asking. The implicit curriculum is just as important to consider as the explicit curriculum when creating models for integration (CSWE, EPAS, 2008)

The following models (Mann, Gaylord, & Norton, 2004) are useful when framing the core curriculum around the ten core competencies of social work education (CSWE, EPAS, 2008). These models are adopted and built upon schools of medicine approaches to provide utilitarian guidelines for other disciplines, which enable diverse programs to organize their pedagogical models around a series of assumptions about what might be most effective and efficient for their individual programs when integrating IHC into the curriculum. The appendix provides examples of defining, observing, and measuring practice behaviors attached to each of the ten core competencies (See appendix).

MODEL1. KNOWLEDGE

When using Model 1, faculty focuses upon instilling knowledge about the basic facts and assumptions about prevalent forms of IHC pertinent to the environment of the social work program. This includes the scope and limitations of practicing IHC and known benefits and potential negative interactions of IHC with traditional western

medicine and behavioral sciences. The benefits of this model are that students are introduced to basic terminology and achieve an understanding of various types of IHC being widely utilized, along with an ability to make informed decisions about IHC approaches to health care (Mann, Gaylord, & Norton, 2004).

This approach can be used in a stand-alone course, offered as an elective and team taught by faculty and IHC practitioners in the community. It could also be offered as an interdisciplinary course, with faculty from schools of medicine, nursing, allied health, and social work. Another approach would be to create course modules in Human Behavior & the Environment and/or individual/family practice courses. Research methods could use examples taken from IHC studies and policy courses could examine and critically analyze local, state, and national policies that impact IHC health/mental health care delivery and insurance reimbursement plans.

Limitations are that basic IHC knowledge does not mean that students are now competent to practice IHC, nor can they profess to be an expert in certain areas of IHC. Caution is always needed when using this model so that students are not given the impression that they are qualified to practice IHC. Although credentialing in many IHC practices are not available, students should obtain IHC knowledge from reliable sources supported in the literature and in the local professional community

MODEL2. NETWORKING & REFERING

This model builds upon the previous knowledge model and teaches students to be competent in making referrals to IHC providers and be able to assess outcomes related to IHC interventions (Mann, Gaylord, & Norton, 2004). This model implies that students are aware of IHC providers and their practices in the community. Students are able to

assess the credibility and efficacy of these practices, which entails interacting with IHC providers and maintaining responsible communication with all referrals. While observing IHC practitioners, students should be able to apply empirically based research methods regarding patient outcomes.

This model could also be introduced into Research Methods courses, with students using empirical methods to examine what works in IHC approaches and why. Qualitative studies can be set up with students interviewing social workers and clients regarding the use of IHC interventions. Teaching critical thinking skills is essential if IHC is to be introduced into the curriculum in order to establish competencies in the area of IHC practice (CSWE, EPAS, 2008).

The benefits of this networking approach to IHC education is that students will learn how to respect client autonomy and self-determination and be able to ethically and competently assess the value and limitations of utilizing IHC approaches to health/mental health care. Aspects of this model are increased responsibilities regarding client outcomes and the loss of control of the interventions being used with the consumer. It is important that students learn what are the scope and limitations of their professional responsibilities when making an IHC referral (Mann, Gaylord, & Norton, 2004).

III. APPLICATION

With this model, specific training is provided in IHC interventions. Students are trained to practice selected IHC interventions from skilled IHC practitioners in the community and/or faculty. This can take place in practice courses, where IHC techniques and skills are modeled and demonstrated; seeking to instill levels of competencies based upon course and program objectives. Also, students can be guided and mentored in field

practicum, selecting program approved sites where certain skill levels can be achieved by the student under the direction of the field supervisor and field coordinator.

Other options include an emphasis in the undergraduate social work program, with students taking electives in IHC, both in the social work and other campus degree programs. Graduate programs can establish concentrations and/or specializations in IHC practice, with faculty comprised of multiple disciplines from various allied health/mental health departments and recognized experts in the community practicing IHC.

The advantages of this model are that students are trained under the supervision of competent and qualified IHC practitioners and monitored by faculty. The limitations are that this model requires levels of accountability, and perhaps liability, for faculty and students that schools may be reluctant to assume. Since there is limited credentialing for many IHC interventions, making this determination that a student is competent to practice IHC interventions can be quite nebulous (Mann, Gaylord, & Norton, 2004).

IV. INTERDISCIPLINARY

The need for collaboration among multiple disciplines becomes apparent when social work programs begin to seriously address the issue of IHC education (Gant, et. al., 2009; MacKenzie & Rakel, 2006). There are anecdotal criteria being generated by physicians, social workers, chiropractors and other therapists that point to the benefits of professional networking and resource enhancement when maintaining health/mental health with adults (Barnes et. al., 2004; Frazer, Christensen & Griffiths, 2005; Hill et. al., 2007). For example, recent research supports this holistic approach in the treatment for depression in older adults. A meta-analysis of depression in older adults concluded that there is evidence that mixing various types of medical/pharmacological interventions,

with physical exercise, such as yoga, can improve mood and depression in older adults (Frazer et al., 2005; NCCAM, 2012). In an integrative review of the literature, Lindberg (2005) suggests that “meditation is beneficial for reducing acute anxiety and diminishing despair among the elderly” (p. 375).

An example of creative interdisciplinary collaboration is the research being funded by the Samueli Institute of Health (2008). Preliminary data are convincing and thus some physicians are utilizing the complementary use of yoga for the treatment of PTSD symptoms in enlisted military personnel at Veteran Administration sites. Other research studies integrating yoga with pharmacological approaches are being conducted with people experiencing chronic pain, depression and asthma and findings show a relief of symptoms (Shapiro, et al., 2007; Steffensen, 2007; Waede et. al., 2004). Meta-analytic studies indicate that the frequency and quality of physical activity lowers depression levels in older adults (William & Strean, 2006). The overlaps between the medical model with its emphases on medications/behavioral therapies and IHC approaches can inform and support each other when studied and researched in a multidisciplinary environment. “A holistic view is inclusive and considers healing needs unique to each individual’s presenting problem, history, other medical conditions, environment, preferences and lifestyle” (McBee, 2008, p. 9).

Establishing field sites where IHC approaches are being utilized by licensed social workers in collaboration with other health/mental health care providers is responsive to the needs of some students. Many social workers collaborate with other professionals, thus creating field opportunities for students to have this multi-disciplinary

knowledge and experience. This is a culmination of the process of integrating IHC education into the social work curriculum.

Social work researchers have an opportunity to be initiating these types of studies and be in the forefront of establishing empirical research that will inform best practices for health care in the 21st century. Social work's unique theoretical perspective can contribute immensely to empowering populations whose approaches to healing are marginalized by western medicine.

CONCLUSION

The curriculum challenge for social work faculty is to provide knowledge, skills, and values to support specific populations and their unique health/mental health care needs that students will serve. Some professional disciplines are both discussing and implementing into their curricula a systematic approach that incorporates best IHC practices (Elder, et. al., 2004; Mann, Gaylord, & Norton, 2004; Kligler, et. al., 2004; Wetzel, Kaptchuk, Haramati & Eisenberg, 2003) One example of this is the Society of Teachers of Family Medicine (STFM), (STFM, 2012). They are designing curricula that address the changing educational needs of family physicians, which entail IHC education.

Like family physicians, social workers are bombarded in their clinics, agencies, schools and hospitals with information and treatment requests from clients regarding IHC strategies, such as, healing their depression, lowering their stress, and managing their arthritis and blood pressure, through methods other than medication. Now is the time to approach this challenge through competency education. An IHS approach to educating students about health/mental health care has been successfully demonstrated with both

aging populations, substance abuse and trauma treatments (Emerson & Hopper, 2011; Lee, Ng, Leung & Chan, 2009; McBee, 2008; Shafer, 2007; Wang, 2009).

For several decades, the social work profession has been encouraging educators to include therapeutic approaches to healing that go beyond the medical model. (Derezotes, 2004). As western societies integrate more IHS approaches into health care, it is critical for social workers and other health/mental health care providers to examine the benefits and the risks involved in IHC interventions. Rising costs for acute health care and the burgeoning older population will increasingly tax current health/mental health care delivery systems. Shortages of resources and increasing populations without health insurance will stretch our paradigms to be creative and cost effective when providing services. Incorporating empirical research data about IHC and providing basic knowledge and skills in generalist social work training are the wave of the future. Students will be expecting this within their curricula and social work programs have the responsibility to include an integrated approach to health/mental health care education in the 21st century.

APPENDIX

Advanced IHC Social Work Practice (Educational Policy and Accreditation Standards (EPAS), CSWE, 2008)

EPAS 2.1.1. Identify as a professional social worker and conduct oneself accordingly.

Measuring practice behaviors would involve creating rubrics that assess student competencies in practicing across cultural, religious, gender and age orientations. Upon graduation students will be able to “explore, identify, and resolve their own biases, myths, and stereotypes” (CSWE, Advanced Gero Social Work Practice, 2010, p. 2) about IHC approaches to health care. “Through self-reflection, students continue to assess their

IHC knowledge and practice behaviors and address their biases against and for IHC, building knowledge to dispel myths regarding IHC.

Advanced practice would prepare Master in Social Work (MSW) students to play key roles in interdisciplinary teams to assess and plan for clients' care, respecting the contributions of each discipline. MSW graduates will be able to “understand the perspective and values of social work in relation to working effectively with other disciplines in interdisciplinary practice” (CSWE, *Advanced Gero Social Work Practice*, 2010, p.8), which may consist of physicians, chiropractors, herbalists, yoga instructors, to name just a few. The goal is to “understand the perspective and values of social work in relation to working effectively with other disciplines” (CSWE, *Advanced Gero Social Work Practice*, 2010, p. 9).

EPAS 2.1.2—Apply social work ethical principles to guide professional practice.

Under this standard, the curriculum would provide opportunities for students to “recognize and manage personal values in a way that allows professional values to guide practice and make ethical decisions by applying standards of the National Association of Social Workers (NASW) Code of Ethics and, as applicable, of the International Federation of Social Workers/International Association of Schools of Social Work Ethics in Social Work, Statement of Principles” (CSWE, *Advanced Gero Social Work Practice*, 2010, p. 9) . With IHC integrated into research, policy and practice courses, social work students will be able to recognize ethical conflicts, boundaries, and the issues related to IHC practice and resolve them according to the NASW Code of Ethics (CSWE, 2011).

Many ethical issues will surface for social workers as they engage clients' beliefs and practices about IHC and surface what types of IHC the client may already be

engaged in or is seeking to engage. Social workers need to be “knowledgeable about the value base of the profession, its ethical standards, and relevant law” (CSWE, Advanced Gero Social Work Practice, 2010, p. 9). Based upon the profession’s values, special attention is given to those who have limited resources and rely upon family, religious and community resources to meet their health needs. Sometimes IHC may be the most economical and simultaneously most efficacious for some clients. By educating students through an integrative curriculum, social workers will be able challenge stereotypes of persons who engage in IHC and advocate for their clients who choose to access IHC based upon sound empirical data and anecdotal wisdom of their clients.

EPAS2.1.3. Apply critical thinking to inform and communicate professional judgments

It will be critical for social work students to be able to distinguish, appraise, and integrate multiple sources of knowledge, including research-based knowledge and practice wisdom about IHC, and be able to analyze models of assessment, prevention, intervention, and evaluation of IHC (CSWE, Advanced Gero Social Work Practice, 2010). In designing a curriculum that respects the data associated with IHC and those who practice IHC, social work students upon graduation will be familiar with existing data to inform their role with clients and their families, and professionals who practice IHC. It is critical that social workers can communicate valid and reliable data about IHC to clients, their families, professional colleagues, and community stakeholders. (CSWE, Advanced Gero Social Work Practice, 2010; Runfola, Levine, & Sherman, 2006).

EPAS 2.1.4—Engage diversity and difference in practice

It will be important that social work students be able to recognize the extent to which a dominant culture's values may oppress, marginalize, and alienate populations who believe in and utilize IHC practices (CSWE, *Advanced Gero-Social Work Practice*, 2010). Recognizing only western medicine approaches to health care can create or enhance privilege and power or not allow people access to "best" care (NCCAM], 2008).

Social workers are able to understand and dispel personal biases and perspectives while supporting clients who choose IHC as a path to healing. "Social workers gain skill in identifying and respectfully addressing varying values, beliefs, and behavior" (CSWE, *Advanced Gero Social Work Practice*, 2010. p. 10). Research data indicate that social workers will frequently encounter consumers who are marginalized as a result of engaging in IHC approaches to their health (Graham et al., 2005; Kelly, Kaufman, Kelley, Rosenberg & Mitchell, 2006; Mackenzie, Taylor, Bloom, Hufford, & Johnson, 2003). Thus having valid knowledge about IHC is vital in meeting this competency.

A significant number of social workers report using IHC in their practices with marginalized populations (Henderson, L, 2000). By establishing standards for best practices, the social work profession can lower the risk of causing unintentional harm to marginalized populations and lower the stigma that can be associated with the use of some types of IHC. Relying upon empirical research can dispel some of these biases and oppressions even though some students and educators will have biases associated with various types of IHC approaches to health care. These are contingent upon the social worker's religion, age, gender, socio-economic status (SES) and other influences. It is critical that these biases are discussed in light of empirical research and reflected upon in their cultural contexts so that students have sufficient self- awareness to discern between

biases and facts associated with IHC. The value of self-awareness as an outcome of students' gaining knowledge about IHC is researched by Elder and colleagues (2004).

EPAS 2.1.5—Advance human rights and social and economic justice

Whether counseling the Christian Scientist woman who refuses chemotherapy for her cancer, supporting the Buddhist teenager who employs aroma therapy to address school anxieties, or teaching yoga to war refugees to manage their post trauma symptoms, it is critical that social workers are grounded in social justice standards established by CSWE and the NASW Code of Ethics (NASW, 2008). A mandate in the NASW Code of Ethics (2008) is for social workers to recognize and act upon covert and overt forms of oppression towards populations who choose IHC approaches without assistance from western medicine. This can be addressed throughout the curriculum if standards are established, knowledge is made available, and skills are taught. Identifying and surfacing the barriers that minority cultures and religions face when adopting IHC can strengthen students to practice responsibly with sensitivity and competence. Students will learn to respect and promote clients' right to dignity and self-determination when practicing IHC (CSWE, *Advanced Gero Social Work Practice*, 2010)

EPAS 2.1.6—Engage in research-informed practice and practice-informed research

Exploring the efficacy and safety of IHC interventions will be paramount in order to claim that social workers are providing adequate and responsible care for those entrusted to them (McBee, 2008). Reading the literature about IHC and creating research protocols that study the efficacy of IHC are avenues that need to be pursued by social work programs if the profession is to adequately address the future health care needs of

U.S. society (Gant, et. al., 2009; Barnes, Powell-Grinere, McFann, & Nahin, 2004; Coulter, 2006; Ezzo, Bausell, Moerman, Berman, & Hadhazy (2001).

Emphasis within the social work curriculum is upon “evidence-based practice,” which challenges practitioners to gather empirical data that indicate levels of effectiveness in meeting clients’ health goals (CSWE, 2011). Simply proclaiming that an intervention is effective because the social worker and the patient agree that it is will not be sufficient evidence to randomly teach a particular IHC intervention. Multiple confounding environmental, professional and personal factors should be taken into consideration when teaching IHC based upon empirical research.

It is reasonable to begin with the premise that populations are flooding IHC resources not only because it may be in vogue to practice yoga or receive acupuncture, but people are utilizing these interventions because they are receiving desirable outcomes (Institute of Medicine, 2005). Whether these outcomes are the result of the “placebo effect,” vast numbers of people indicate that they seek both complementary and alternative interventions that go beyond the scope of their physician’s and/or social worker’s expertise, knowledge and skills (Coulter & Willis, 2007). “Practice-based evidence” too convincing to be ignored or to be discredited as folklore or simply the “placebo effect?” These questions demand attention within research courses if we are to teach students evidence based best practices (Barkham & Mellor-Clark, 2003).

EPAS 2.1.7—Apply knowledge of human behavior and the social environment

Using systems theory to apply knowledge of IHC and using PIE as a model for interpreting the systems in which a client is functioning, students will make the connections between responsible use of IHC and social work practice. Identifying issues

of why, when, and how consumers choose to access IHC will enable the social worker to practice from an informed professional stance when designing interventions (CSWE, 2010). Establishing CAM competencies will increase the possibility that social workers who practice integrative health care and refer consumers to IHC will be doing so with professional knowledge of how the environment shapes IHC practice.

EPAS 2.1.8—Engage in policy practice to advance social and economic well-being and to deliver effective social work services

Will social work students have the knowledge, skills, and values to analyze, formulate and advocate for policies that advance IHC practices that science and clients value as credible? Assisting clients in obtaining insurance coverage for IHC interventions is one of many policy advocacy roles that social workers might be called upon to undertake. How do medical insurance policies inhibit IHC interventions that empirical research has indicated are valid and effective? Teaching students how health care policies impact consumers' rights to IHC resources is a vital role for the social worker who respects the autonomy and dignity of consumer choices (CSWE, *Advanced Gero Social Work Practice*, 2010).

EPAS 2.1.9—Respond to contexts that shape practice

The pulse of health care services indicates that IHC is a billion dollar industry annually. People are choosing IHC at higher rates than ever before (NCCAM, 2012). Integrative models of Western and IHC approaches for health care are gaining recognition and acceptance in the medical community (NIH, 2012). The social work profession has a stake in this surge of acceptance and trust in IHC approaches to health care. How will social work educators influence and direct CAM practice, research

and policy development into the future? With the recent passage of new health care legislation, The Patient Protection and Affordable Care Act (ACA) will trigger sweeping changes in how health care services are delivered and by whom (Healthcare.gov, 2012). Social work education is responding to these changes to meet the needs of individuals, families, groups, communities and organizations by addressing service systems of care (CSWE, 2012). The need for a concerted, organized and systemized approach to IHC education, research and practice needs to be a priority (Gant, et. al., 2009).

EPAS 2.1.10(a-d)—Engage, assess, intervene, and evaluate with individuals, families, groups, organizations, and communities

Each level of practice will require a set of competencies interwoven through the curriculum. Many resources are available for this to occur (NCCAM, 2012, CSWE, 2012, CDC, 2005, NIH, 2012). Assessing intervening, and evaluating each requires a skill set based upon reliable outcome measures. Integrating both theoretical and empirical knowledge about IHC, along with cultural and religious wisdom practices, schools of social work will determine which levels of practice are achievable and desirable for their students. What is critical, is creating dynamic centers of learning, which are preparing future and current social workers with the knowledge, skills and values needed to be competent practitioners when accessing, intervening, and evaluating IHC for the populations being served (CSWE, 2012; CSWE, 2010; CSWE, 2008). Tasks that remain are to organize and deliberate a cohesive and comprehensive plan of IHC education that can draw upon the best practices among social work programs , social work practitioners, that interface with other professional disciplines

currently engaged in integrating CAM into the curriculum (Gant, et. al., 2009; Elder, et.al., 2007; Klinger, et. al., 2004).

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