

Mapping Dual-Degree Programs in Social Work and Public Health: Results From a National Survey

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Abstract: *Dramatic changes in the health system due to national health reform are raising important questions regarding the educational preparation of social workers for the new health arena. While dual-degree programs in public health and social work can be an important response to what is needed educationally, little is known about them. The National MSW/MPH Programs Study surveyed MSW/MPH program administrators to better understand the prevalence, models, structure, and challenges of these dual-degree programs. Forty-two programs were identified, and 97.6% of those contacted participated (n=41). Findings indicate that MSW/MPH programs are popular, increasing, geographically dispersed, and drawing talented students interested in trans-disciplinary public health social work practice. Challenges for these programs include the need for greater institutional support, particularly funding, and a general lack of best practices for MSW/MPH education. While findings from this study suggest graduates appear especially well-prepared for leadership and practice in the new health environment, additional research is needed to assess their particular contributions and career trajectories.*

Keywords: *MSW/MPH programs, public health social work, trans-disciplinary practice, health-related social work education*

As the Patient Protection and Affordable Care Act (ACA) implementation unfolds, it is clear that dramatic changes in the health system will continue to profoundly impact the social work profession (Andrews, Darnell, McBride, & Gehlert, 2013; Collins, 2013; Gorin, 2013). The ACA's broad aims of increasing access to care, bettering patient care outcomes, controlling costs, and improving population health are expanding social work opportunities in navigation and care coordination. This is seen especially in the integration of behavioral health and primary care and in patient-centered health homes (Allen, 2012; Bachman, 2011; Darnell, 2013; Golden, 2011; Spitzer & Davidson, 2013). The ACA's goal of improving population health outcomes and reducing health inequities is of particular importance to social work, resonating deeply with the profession's commitment to social justice (Ruth, Wachman, & Schultz, 2014). As has been broadly observed, these intended improvements in population health and in health justice are central to the ACA's success and will require systemic, public-health-oriented, wide-lens approaches that focus on

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impacting the social determinants of health (Beddoe, 2013; Braverman, Edgerter, & Williams, 2011; Moniz, 2010). As described by Beddoe (2013), wide-lens public health approaches are population-level efforts to create healthy communities and environments, including prevention, health promotion, health advocacy, and the integration of health into all policies and systems. There is general agreement within the public health field and beyond that wide-lens public health approaches have the greatest impact on human health and are especially important in understanding and responding to the social determinants of health, such as racial, socioeconomic, and gender inequities, which contribute to poor health outcomes (Beddoe, 2013; Frieden, 2010; Turnock, 2011). Social work practice in prevention, advocacy, community health empowerment, and public health social work exemplifies the profession's ongoing use of wide-lens approaches and provides an important base upon which to expand health social work in the ACA era (Reisch, 2012).

Logically, profound shifts in the practice environment should quickly and directly affect the education of social workers at the graduate level. Yet the interplay between education and practice is not always clear-cut. Tension between academics and leaders in the health practice environment regarding social work graduate readiness for health practice is not new (Spitzer & Davidson, 2013). Despite recent articles in social work journals calling upon the academy to teach specific health competencies—inter-professional teamwork, care coordination and integration, prevention and health promotion, advocacy, the ability to work within accountable care organizations, community-based practice, program evaluation, and cost-effectiveness—little is known about whether and how social work educates for contemporary health practice (McCave & Rishel, 2011; Pecukonis, Doyle, & Bliss, 2008; Reisch, 2012; Ruth et al., 2014; Zabora, 2011). One recent effort to assess current health content in MSW programs analyzed mission statements, courses, and concentrations listed on MSW program websites. The authors found that while most MSW programs offered health courses, the majority focused on clinical practice with individuals in health settings, not wide-lens approaches. In addition, most health concentrations framed health as a niche area of practice, not as a broad approach to promoting human well-being (Ruth et al., 2014). The authors observed that the failure to broadly educate students in multiple contemporary health approaches could hinder the impact and development of new social work roles in the current environment (Ruth et al., 2014). Given the stakes and the rapid pace of change, scholars have argued that preparing the next generation of social workers requires a critical assessment of social work education for health practice (Andrews et al., 2013; Reisch, 2012; Spitzer & Davidson, 2013).

Dual-Degree Programs in Public Health and Social Work

Amid the call for a changing approach to health in social work, MSW/MPH programs, which educate students in the integrated practice of public health and social work, deserve consideration. First established in the mid-late 20th century, dual-degree programs appear to have been developed in response to several phenomena: first, as an effort to formalize the sharing of knowledge and skills between schools of social work and other departments; second, as a way of increasing the marketability of both programs and graduates; and finally, as a method for preparing graduates for increasingly complex practice

environments (McClelland, 1985; Miller, Hopkins, & Greif, 2008). General interest in cross-disciplinary education appears strong at the graduate level; a recent review found that 35.3% (n=59) of accredited MSW programs offered a variety of dual-degree programs, with MSW/MPH programs the second most popular type (Miller et al., 2008).

Indeed, MSW/MPH programs appear to be proliferating (Ruth et al., 2014). In 2008, about twenty programs existed; recent estimates suggest that there are now more than three dozen (Council on Social Work Education [CSWE], 2012; McCave & Rishel, 2011; Ruth et al., 2008). MSW/MPH programs are, in part, a reflection of the ongoing collaboration between the two fields. Social work has deep roots in public health. It shares a history and natural overlap with public health on many issues of mutual concern, such as improving quality of life, achieving social justice, and engaging in interventions aimed at addressing the social determinants of national and global health (Ruth et al., 2008). The traditional term used to describe the integrated practice of social work and public health is *public health social work* (PHSW), which involves social work use of epidemiological approaches to prevent, address, and solve health problems (Ruth & Sisco, 2008). The total number of public health social workers in the US is unclear; it is estimated that less than 10% of the more than half million U.S. social workers describe themselves as “public health social workers” (Clark, 2006). However, it has also been noted that many social workers practice within public health without fully recognizing it or labeling it public health social work (Marshall, Ruth, Sisco, Cohen, & Bachman, 2011; Ruth & Sisco, 2008).

Over the years, social work scholars have raised general questions about the structure and outcomes of dual-degree programs, including MSW/MPH programs (McClelland, 1985; Ruth, Marshall, Velásquez, & Bachman, 2015). Concerns included the potential tensions of dual professionalism, the absence of proof for the added value of an additional degree, and the fear that dual-degree graduates do not develop or sustain strong identification with the social work profession (McClelland, 1985; Miller et al., 2008; Ruth et al., 2015).

Due to the minimal research literature on dual-degree programs, it is impossible to draw definitive conclusions about any of these concerns or to firmly determine whether social workers trained in dual programs experience a conflict of values or drift from the profession (Miller et al., 2008). In recent years, as additional programs have been developed, these topics have begun to garner more attention. A study conducted at the University of Maryland (Miller et al., 2008) suggests that satisfaction with dual-degree programs is high and remuneration appears higher than for MSW-only graduates; notably, this study did not include their then-new MSW/MPH program. Another study from Boston University compared 30 MSW-only and 30 MSW/MPH alumni and, consistent with Miller et al. (2008), found no significant differences in career or program satisfaction (Ruth, Wyatt, Chiasson, Geron, & Bachman, 2006). When asked about their identification with the profession--as measured by whether they called themselves a “social worker,” held membership in social work organizations, or had obtained social work licensure--the MSW/MPH and MSW alumni respondents were similar (Ruth et al., 2006). A third study (Ruth et al., 2015) attempted to better understand the self-reported outcomes associated with a large cohort of MSW/MPH alumni (n=294). Again, the findings did not support the assertion that dual-degree graduates were less identified with the profession of social work.

In fact, a large majority called themselves “social workers” or “public health social workers,” were licensed to practice social work, and belonged to the National Association for Social Workers (NASW)—signals of connection to the profession.

Generally, little is known about best practices in dual-degree education. There are multiple topics crucial to dual-degree program administration that remain largely unstudied, including the coordination and integration of knowledge and skills from both fields, the role of advising and faculty involvement, how best to organize coursework, and the need for dedicated financial aid (Miller et al., 2008; Ruth et al., 2015). One small qualitative study of MSW/MPH alumni from four established programs identified key areas for MSW/MPH program improvement, including: 1) the need for greater university investment, 2) coordination of dual degree programs, and 3) the strengthening of integration opportunities (Ruth et al., 2008).

Clearly, there is much more to know about the profession’s dual-degree programs, particularly MSW/MPH programs. Some have suggested that a return to the profession’s public health roots is a key response to the changing national health landscape (Reisch, 2012). A better understanding of MSW/MPH programs is an important step in determining their relevance to the profession’s changing educational needs and to the revitalization of public health approaches in the profession.

The Purpose of the National MSW/MPH Programs Study

The purpose of *The National MSW/MPH Programs Study* is to examine the prevalence, content, models, and challenges of current MSW/MPH programs by surveying current MSW/MPH program directors and associated faculty members. A team of four MSW/MPH professionals at Boston University undertook this study with the following goals. First, we wanted to identify the total number and location of all MSW/MPH programs. Second, we wanted to assess various program facets: mission and structure, faculty and university motivations, institutional support for programs, the number of students enrolled and number of alumni, and any program outcomes associated with each program. Third, we wanted to understand the strengths, successes, challenges, and trends in MSW/MPH programs, as identified by program directors, associated faculty members, or other key informants. Finally, the research team sought to understand whether individual programs identified their goals as related to the education of public health social workers.

Methods

Because there is no one source of information on MSW/MPH programs, multiple sources for identifying MSW/MPH programs were consulted, including the Council on Social Work Education’s (CSWE) list of dual-degree programs and the American Public Health Association’s Public Health Social Work section list of MSW/MPH programs. Additionally, all MSW programs on the CSWE membership list were compared with all MPH-granting schools and programs listed by the Association of Schools and Programs in Public Health (ASPPH). All schools with both a school of social work and a program in or school of public health were identified and their websites examined for evidence of an MSW/MPH program. Finally, key informants from several well-established MSW/MPH

programs were consulted and shared suggestions for identifying programs under development. A comprehensive list of MSW/MPH programs was developed by spring 2013.

All schools that hosted MSW/MPH programs were eligible to participate in the study; a total of 42 programs were identified. Schools' websites were reviewed, and the contact persons or offices listed were contacted by email for the names of each MSW/MPH program's key informants, including directors and faculty members involved with the MSW/MPH program. If there was no response to email, then phone calls to admissions offices were made and email addresses of each program's key informants obtained. Researchers reached out to all administrators and faculty members who were involved with MSW/MPH programs at each school. For some programs, there was more than one key informant; data from all key informant responders was included in the analysis.

The team created an electronic survey consisting of 27 questions; 24 were quantitative and 3 were open-ended. The scope of questions included logistics (location, number of students, number of graduates, when the program began, and number of credits); program details (support for students, career services available); student funding (scholarships, financial aid packages, loan information); students' motivation for enrollment; and specific questions about alumni. The open-ended questions focused on key informants' views of trends and directions. To enable all key informants from any one school to participate, we provided each MSW/MPH program with its own individual survey, and all key informants involved with each program were invited to participate. Surveys were distributed from fall 2013 through summer 2014. Three follow-up reminder emails were sent to all key informants. After data collection was complete, all schools' responses were aggregated in order to be able to report findings on all programs. The surveys were compiled and analyzed using Microsoft Excel 2010 to calculate frequencies. Narrative comments were analyzed using thematic content analysis (Neuendorf, 2002).

Findings

Sample

Respondents from a total of 41 out of 42 identified programs participated in the study, for a response rate of 97.6%. One school, unable to answer any survey questions because its newly launched program had no curriculum or enrolled students, was eliminated from the sample. We report below on a total sample of 41 schools. In some cases, respondents declined to answer items due to lack of information or skipped them altogether. We report on those who answered to give as clear a picture as possible of available information.

Respondents included directors of programs, faculty associated with the programs, and graduate assistants who helped with program administration. Of the 48 total respondents, 27 of 48 (56.2%) were based in schools of social work, 14 of 48 were based in public health (29.2%), 2 of the 48 respondents had dual appointments in social work and public health (4.2%), and 5 of 48 programs did not answer this question (10.4%).

Program Demographics

The majority of responding programs (n=29, 70.7%) were housed in public universities; 10 were in private universities (24.4%). Two programs were hybrids, or public-private university collaborations. Overall, programs were almost equally distributed around the regions of the United States with eight programs located in the West, 10 in the Midwest, 11 in the South, and 12 in the North. (See Table 1 below).

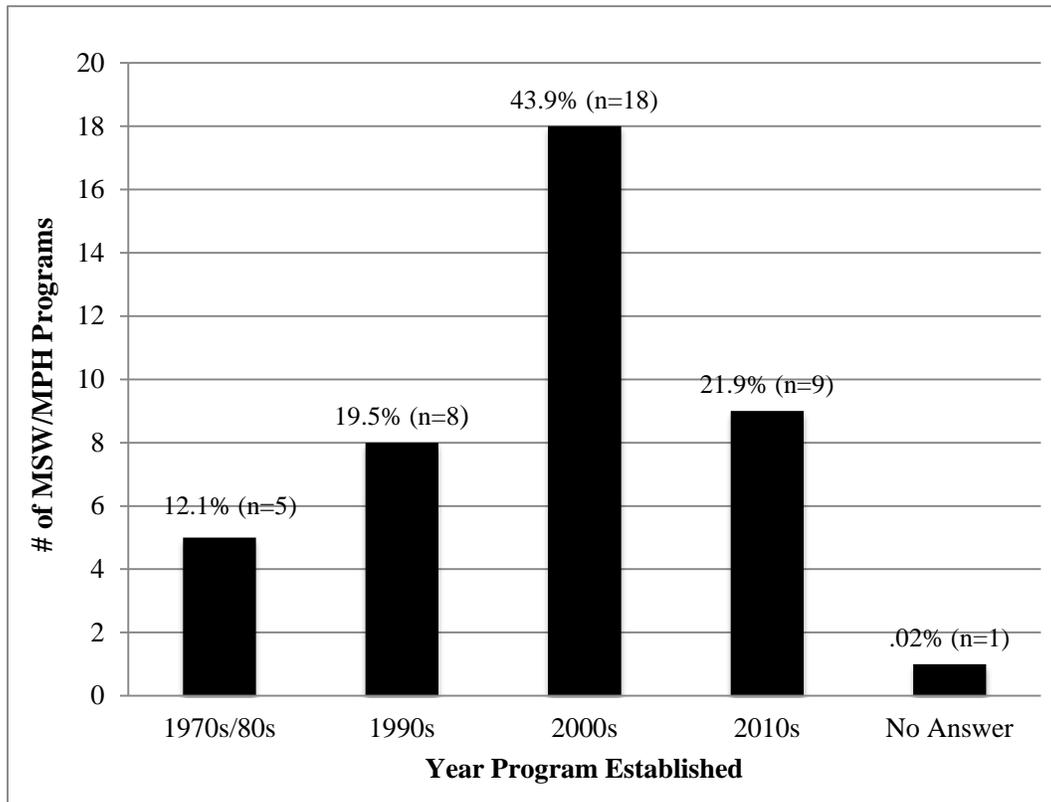
Table 1. *List of MSW/MPH Programs and Geographic Location*

West (8 Programs)	Midwest (10 Programs)
<ol style="list-style-type: none"> 1. New Mexico State University 2. Portland State University 3. San Diego State University 4. University of California – Berkeley 5. University of California – Los Angeles 6. University of Southern California 7. University of Utah 8. University of Washington 	<ol style="list-style-type: none"> 1. Indiana University 2. Michigan State University 3. Ohio State University 4. University of Illinois – Chicago 5. University of Missouri 6. University of Minnesota 7. University of Nebraska 8. Saint Louis University 9. University of Michigan 10. Washington University
South (11 Programs)	North (12 Programs)
<ol style="list-style-type: none"> 1. Tulane University 2. University of Alabama 3. University of Georgia 4. University of Houston 5. University of Maryland (Johns Hopkins University) 6. Virginia Commonwealth University 7. University of Oklahoma 8. University of North Carolina - Chapel Hill 9. University of Texas 10. University of South Carolina 11. University of South Florida 	<ol style="list-style-type: none"> 1. Boston University 2. Bryn Mawr College 3. Columbia University 4. Fordham University 5. New York University 6. Simmons College (Harvard University) 7. Temple University 8. University at Albany 9. University at Buffalo 10. University of Connecticut 11. University of Pennsylvania 12. University of Pittsburgh

Program Development and Enrollment

The oldest responding program began in 1979, and the newest responding program was added in 2014, creating a range of 35 years in the sample. The median year of program establishment was 2005 (See Figure 1 below).

Figure 1. *Year MSW/MPH Programs Established*



Most programs (75.6%, n=31) reported steady or increasing enrollment. MSW/MPH programs graduate an average of seven individuals per year, with a range of 0 to 25 graduates per year. Almost ten percent of all MSW/MPH programs estimated that there were no graduates from the program at all in the past year (9.7%; n=4); another 7.3% (n=3) did not know if anyone had graduated in the past year. Another 9.7% (n=4) had graduated only one MSW/MPH graduate in the past year. Together, this amounts to almost one-fifth of programs with one or fewer graduates per year (19.5%, n=8). When asked about the total number of graduates from the program, a little over 12% (n=5) programs reported never having anyone graduate from their MSW/MPH program. Another 19.5% did not know if anyone had ever graduated from the program (n=8), suggesting a lack of program history in a substantive minority of programs. Almost half of respondents agreed/strongly agreed that the MSW/MPH program was their most popular dual-degree program at their school (46.3%; n=19). Almost all agreed that the program brought in high quality students (90.2%; n=37).

Program Structure and Requirements

The average length of time to complete an MSW/MPH program was three years, although a few schools (14.6%; n=6) reported that students could complete all the

requirements for both degrees in less than three years and six schools reported that it took longer than three years (14.6%). Nearly half (48.8%; $n=20$) of MSW/MPH programs required their students to major or concentrate in a particular area of practice. Examples of required majors include macro practice within the school of social work and maternal and child health or health policy within public health. Most schools (73.2%; $n=30$) had specialized field internships that emphasized public health and social work, and about 15% ($n=6$) hosted a required integrative seminar in public health and social work.

Perceptions of Students' Motivation for MSW/MPH Programs

When asked why students enroll in the MSW/MPH program, 82.9% ($n=34$) of respondents strongly agreed/agreed with the statement that “students believe it will make them more marketable” as the primary reason for enrollment. Other motivations were also endorsed; 78.0% of respondents ($n=32$) agreed/strongly agreed that students were motivated by the desire to combine the skills and competencies of both fields, while the wish to “become a public health social worker” was considered a motivating factor for nearly half (48.8%, $n=20$) respondents. Similarly, 61% ($n=25$) agreed/strongly agreed that students drawn to this program were interested in “tackling big trans-disciplinary issues.”

Institutional Support for Programs

Institutional support for programs varied widely, and some schools lacked even the most basic support such as coordinators and advisors (See Table 2). About 81% of schools ($n=33$) stated that there were faculty coordinators for the MSW/MPH program, two schools (4.9%) did not know if there were faculty coordinators, and still others reported that there were no faculty coordinators or directors for the MSW/MPH program (14.6%; $n=6$). Roughly 61.0% of programs had faculty coordinators with specific interest or expertise in public health and social work ($n=25$). Only one school (2.4%) reported that the faculty coordinators received course release for coordinating the program. Only three schools had any budgets to support their MSW/MPH programs, and these budgets were modest ($n=7.3%$).

Table 2. *MSW/MPH Program Faculty Support (n=41)*

	Yes	No	Unsure/Did Not Respond
Faculty coordinator at both schools	33 (80.5%)	6 (14.6%)	2 (4.9%)
Faculty advisors at both schools	38 (92.7%)	2 (4.9%)	1 (2.4%)
Faculty course relief for MSW/MPH program leadership	1 (2.4%)	35 (87.5%)	5 (12.5%)

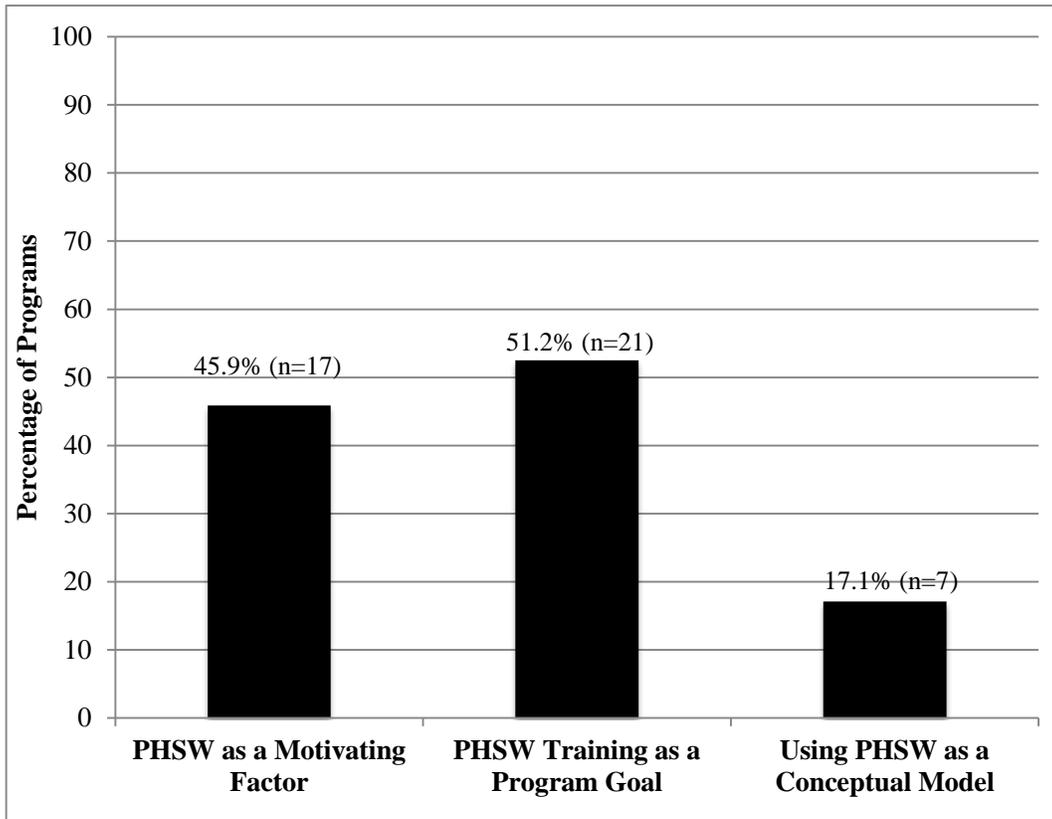
Despite these findings, most respondents agreed that MSW/MPH programs were important to both their schools. A little over 73% ($n=30$) agreed/strongly agreed that MSW/MPH programs were important to schools of social work, while 82.9% ($n=34$) agreed/strongly agreed that they were important to schools of public health. A total of 25 responding schools agreed/strongly agreed that there was “strong support” for the program

at their school of social work (61.0%), while 65.9% (n=27) agreed/strongly agreed that schools of public health were in strong support of the program. Still, nearly a third of respondents reported that, despite support, collaborative problem-solving between the two schools was difficult (29.3%; n=12).

Public Health Social Work

As noted above, “becoming a public health social worker” was not viewed as a particularly robust motive for student enrollment in most programs. This may relate to the finding that the “public health social work” model was not being widely used; less than a quarter (17.1%; n=7) reportedly used this as an organizing concept for their programs. Only half (51.2%; n=21) strongly endorsed the statement that the goal of their program was to “train public health social workers” (See Figure 2).

Figure 2. MSW/MPH Program Use of PHSW as an Organizing Concept (n=41)

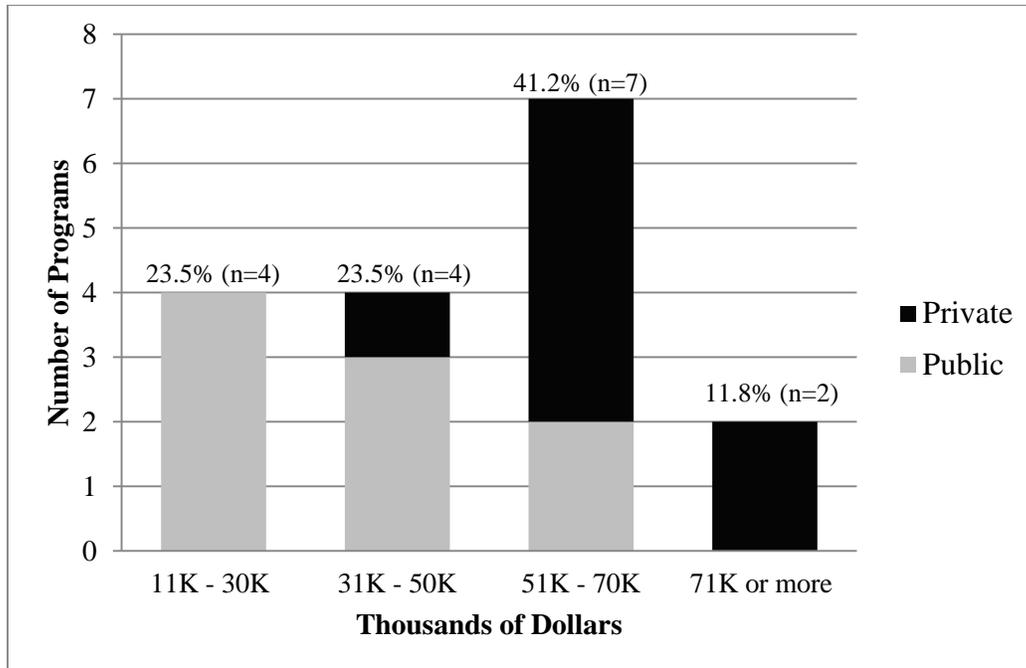


Student Support

Almost all schools (90.2%; n=37) had established program guidelines which specified the program requirements for students, and 92.7% (n=38) provided advisors for students at both schools. Though dual degree programs are likely to be significantly more expensive, only 12.2% of schools (n=5) provided targeted financial aid for MSW/MPH students. Most

respondents (58.5%; n=24) did not appear to know how much student loan debt MSW/MPH students acquired in the course of their programs. Of those who responded to these questions (n=17), the estimated student loan debt ranged broadly from 11,000 to more than 70,000. Of the 17 schools responding, more than half were private, the majority estimated student loan debt upon graduation to be greater than 51,000 (52.9%, n=9) (See Figure 3).

Figure 3. *Estimated MSW/MPH Student Debt (n=17)*



After Graduation

For alumni, only a handful of programs (12.2%; n=5) reported providing specific career services to MSW/MPH graduates, and only three programs (7.3%) reported offering continuing education tailored to MSW/MPH graduates. Less than a third of schools described systematic efforts to stay in contact with alumni (29.3%; n=12), and only 29.3% (n=12) reported engaging in any form of program evaluation. Almost half of respondents did not know whether graduates pursued social work licensure (51.2%, n=21). Similarly, more than half (58.5%, n=24) did not know whether graduates pursued public health certification.

Narrative Findings

The respondents were asked to describe program successes, challenges, and future trends, and many themes emerged. Several schools reported their greatest success was that successful MSW/MPH alumni tended to find leadership roles in the field after graduation. Similarly, another common response to the success question was the report of a continuous

stream of strong applicants applying to the program. One responder noted: "Graduation rate for completion of both degrees is high... Our alumni have gone on to great positions (in) which (they) combine the two fields well." Other responders noted that collaboration between the two schools was successful. Since the sample included some newer programs, multiple responders noted that thus far, their biggest success was simply the establishment of the program.

When asked to describe challenges, the most common theme reported was the inflexibility within programs, especially lack of electives. One responder reported "Neither program has very much flexibility nor elective credits ...so the combination does not save a student very much time or course work." Another frequently noted challenge was the need to build good working relationships across schools, particularly with admissions departments. Another responder stressed the need "To improve coordination between both schools, make faculty more responsive to needs of dual-degree students, and improve tracking systems for dual-degree students/logistics." Multiple responders reported a lack of program support, including lack of general funding and financial aid for students. Other concerns included the absence of an integrated seminar for MSW/MPH students, a shortage of MSW/MPH knowledgeable faculty, and insufficient support for students while they navigate complex programs.

Responders provided valuable insight into the future of their specific programs. Most observed that the future would include continued program maintenance and growth. Multiple participants reported they were hoping to refine their marketing and increase visibility as a program. Most wanted to increase enrollment in their MSW/MPH programs. Many reporters mentioned the ongoing need for mutual collaboration between schools of social work and public health, and finally, the perennial need for funding and financial support.

Discussion

Our data helps to answer questions related to one aspect of social work education in health: the growth and prevalence of MSW/MPH programs. The data indicate that MSW/MPH programs have increased steeply since 2000. Geographically well-dispersed throughout the country, the majority of MSW/MPH programs are housed in public universities. While programs vary in size, the total number of annual MSW/MPH graduates is modest.

There are some consistencies across programs: It was widely agreed that these programs are valuable to their institutions, and attract high-quality, mission-driven students interested in trans-disciplinary health practice. Respondents also agreed that these programs promote collaboration across schools of social work and public health at a time when inter-professional activities are ever more critical. Most MSW/MPH programs have established program guidelines, program coordinators, and faculty advising at both schools. In addition, the length of time to MSW/MPH program completion is generally three years.

Programs differ widely in a number of areas. Half of programs limit students' choice of majors at one or both schools. Only a quarter of schools use "public health social work"

as an organizing concept for their programs, even though most respondents agree that students are drawn to the public health social work model. Programs also differ in how much institutional support they receive. Some enjoy budgets (small though they may be), course release for faculty coordinators who are encouraged to provide leadership, and institutional cooperation regarding marketing and administrative infrastructure. The vast majority, however, do not.

Financial support for students is uniformly identified as a key challenge facing MSW/MPH programs and students, especially in light of the increased costs associated with two degrees. Despite this concern, most program coordinators knew little about student loan indebtedness of MSW/MPH students in their programs, perhaps because so few programs track alumni. The lack of systematic program evaluation also makes it difficult for program coordinators to speak to the employment, career trajectories, licensure, or continuing professional development needs of MSW/MPH alumni.

Limitations

The purpose of the *National MSW/MPH Programs Study* was to examine the prevalence, content, models, and challenges of current MSW/MPH programs by surveying current MSW/MPH program directors, coordinators, and associated faculty members. As with all research, there were limitations. The lack of an accurate compilation of MSW/MPH programs created sampling challenges, and while every effort was made to identify all MSW/MPH programs, it is possible that some were omitted. In addition, many programs lacked identifiable contacts in either school, and although efforts were made to identify and survey all involved faculty and administrators, in some cases the most knowledgeable people may not have been the ones who responded to the survey. Additionally, while all administrators or faculty associated with MSW/MPH programs were invited to participate, most surveys were completed by respondents from the social work side, which may have biased the findings toward a more social-work-centric view of MSW/MPH programs. Despite these limitations, the overall response rate was high (97.6%), and the findings provide a needed initial overview of existing MSW/MPH programs.

Implications

This study represents an initial effort to better understand one facet of social work education in health during the ACA era. Clearly, interest in MSW/MPH programs is high, and programs are being developed with increasing frequency, reflecting the continuing interest in health social work. The benefits of these programs can be substantial to all involved if opportunities are recognized and developed.

Many prospective students believe they will be more marketable in a competitive job environment with additional degrees and are prepared to make the investment in a dual-degree program (Miller et al., 2008). But this is likely not the only motivation for those drawn to MSW/MPH programs. Most current MSW/MPH students came of age at a time when global health, health equity, and health reform were subjects of popular heated debate and discussion. Many are frustrated by the medical model emphasis on diagnosis and

treatment and seek to integrate prevention and population health into their skill sets. Finally, perhaps more than at any other time, a large subset of students appear to recognize the limitations of any one profession in addressing major issues such as obesity and health inequities. To be more effective, these students seek new ways to combine the skills of trans-disciplinary practice in prevention, population health, and other wide-lens approaches with social work. For this group, programs that combine public health and social work have a particular appeal. To strengthen MSW/MPH graduates and to help maximize their contribution to the social work profession during this time of accelerated change, the intentional and focused integration of skills, values, concepts, and practices across the fields is needed. The use of the public health social work model is one method for organizing this integration and retaining the social work focus. Given its historic and contemporary relevance, MSW/MPH programs should consider anchoring their programs in this model.

The benefits to sponsoring schools and their faculty members can be substantial. The Affordable Care Act has put a high premium on trans-disciplinary and inter-professional collaborations. MSW/MPH programs offer a natural mechanism for building alliances and promoting the visibility of both fields and can provide faculty with initial opportunities to work across academic boundaries.

Finally, at a professional level, powerful forces are calling on social work to increase its impact in the wider arena of health justice. The growing cadre of MSW/MPH practitioners, skilled in both social work and public health, can play important leadership roles in our profession's response to the major health issues of our day. Because MSW/MPH practitioners emerge prepared to practice at the population health level, strengthening MSW/MPH programs is an already-existing mechanism for building the profession's capacity for action and impact in all aspects of population health.

Popular and plentiful, it is likely that MSW/MPH programs are here to stay. The attention and focus of social work educators is needed to better understand both potential and actual challenges and contributions. To that end, directions for additional research emerged from this project. First, schools would be wise to systematically track and evaluate their MSW/MPH programs to better understand the career trajectories, opportunities, workplace challenges, and benefits of MSW/MPH programs. Second, a national study of MSW/MPH alumni would yield important information on the challenges and obstacles of the integrated practice of public health and social work. Because a true understanding of the financial costs and benefits of MSW/MPH programs does not yet exist, an important goal of a national study would be to better understand the financial experiences of graduates who may be emerging from these programs with significant debt, along with their experiences of repayment on MSW/MPH salaries. This issue needs urgent attention. If we, as a profession, value the growing importance of the integrated practice of public health and social work, it is important to financially support students who commit to MSW/MPH education.

Finally, the conceptual model of public health social work, used by some MSW/MPH programs, can be studied for its particular relevance to social work goals such as inter-professional education, health equity, health reform, and addressing the social determinants

of health. The concepts, skills, and practices of public health social work, which integrate prevention and other wide-lens approaches into social work, may be a particularly powerful organizing framework for MSW/MPH programs. Centering MSW/MPH programs on the historic and current practice of public health social work can help to ensure that dual practitioners emerge committed to the social work profession. To reach these goals, MSW/MPH program directors and faculty may benefit from increased affiliation at conferences or other forms of cross-institutional support. With evaluation and enhancement, it is likely that MSW/MPH programs will be one of the profession's best efforts for developing leaders for a new era of social work in health.

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