

CHECKLIST: MFTs in Small Practice Integrated Healthcare

MARTHA TEATER, MA

Integration between marriage and family therapists (MFTs) and primary care providers (PCPs) shows great promise for our shared clients. People treated in an integrated model attest to its positive impact on their lives.

I am an MFT and have worked in medical settings with PCPs for over 25 years. I currently work in a primary care medical clinic that also has an opiate addiction program and a free clinic for indigent people.

I've seen the power of medical and mental health providers working closely together, as our clients benefit tremendously from this integrated approach.

What is Integrated Care?

At its most basic, integrated healthcare includes behavioral and physical health specialists working together for the good of those we serve.

Alexander Blount (1998) notes, “It’s a service that combines medical and behavioral health services to more fully address the spectrum of problems that patients bring to their primary medical care providers. It allows patients to feel that, for almost any problem, they have come to the right place.”

MFTs in Primary Care

There are many compelling reasons for MFTs to work more closely with PCPs. The primary care setting is often the first and most trusted place people go with mental health issues. People like to get their mental health needs taken care of by their PCP. Seeking medical care for mental health needs helps people feel less of a stigma; they are not going to see a “shrink.” Having mental health needs treated by a PCP may be more cost effective, as health insurance may more readily cover medical needs than mental health needs. While MFTs are gaining ground in the fight for insurance parity, many current policies lag behind in covering mental healthcare by MFTs and other mental health professionals.

Also:

- Referral out of the primary care office reduces follow-up, so working in the same office increases the likelihood that the client will obtain mental health care
- The client isn’t the only one who benefits—the PCP’s awareness of mental health issues increases with the presence of an MFT onsite. Our proximity and involvement keeps psychological issues front and center in the mind of the PCP.
- It’s hard to think of any examples of medical problems that don’t have an effect on individual mental health and family functioning.

PCPs are Already Providing Mental Health Care. Research shows that 80 percent of patients want to get mental healthcare through their PCPs. Almost half of all substance abuse and mental health treatment is provided through a PCP only. Almost 70 percent of all psychotropic meds are prescribed by PCPs. Nearly 70 percent of all healthcare visits have a primarily psychosocial basis. Ninety percent of the most common complaints in PCP setting have no organic cause.

WHAT DO PCPS WANT FROM MFTS?

I'm often surprised to hear that MFTs haven't cracked the code on what PCPs want from us. PCPs really do want feedback, and they value our insight and expertise. Perhaps that knowledge will make us bolder in opening up dialogue with our professional peers across disciplines.

PCPs are often quite open in sharing what they would like from MFTs. Following are some of the requests for help that I hear most often when working in a medical setting.

- ❑ **Diagnosis:** Are there any mental health diagnoses that may complicate care? PCPs welcome our input about diagnoses and how those issues may impact medical care. Many have limited training in mental health diagnosis, and while they may have a DSM-IV on the bookshelf, it isn't their area of expertise. With a more obscure diagnosis, I have even copied information from the DSM-IV to send to the PCP so he or she can gain a more thorough understanding of the diagnosis and its ramifications.
- ❑ **Support systems:** Who does the patient depend on? Who does the patient respect? PCPs can use these relationships to improve compliance and increase patient motivation. PCPs will often get permission from a patient to include the family in the care of that patient.
- ❑ **Assessment of the patient's level of commitment to wellness:** Are there ways of enhancing motivation? Some PCPs are becoming more aware of motivational interviewing techniques, but we can certainly help in this area.
- ❑ **Educating patients about their conditions and treatment:** Could the MFT enhance and support the information that the PCP gives the patient? People are often anxious or intimidated when talking with the PCP in the exam room, and may not fully grasp the information the PCP is sharing about disease, treatment, and prognosis. MFTs can guide patients to appropriate sources of support and education.
- ❑ **Informing the PCP of patient changes:** Is there a change in the patient's life that could affect his or her care? When the patient is not doing well because of a change in mood or circumstances, the MFT may share this to help the PCP make informed treatment decisions.
- ❑ **Recommendations on medication management:** Does the MFT think the patient may benefit from a change in medications or an adjustment in the dose? Keeping an open line of communication between the patient, the MFT, and the PCP will help medication changes be made more effectively.
- ❑ **Help the patient develop a support system:** Could the MFT help the patient connect with sources of support? Improving the patient's level of social support and involvement in activities or support groups often make the patient more compliant with medical care.
- ❑ **Information:** What is happening in therapy? Most PCPs report that referrals to MFTs result in no feedback on the treatment plan or progress made. PCPs want to know the effectiveness of their referrals to MFTs. The PCP would like to know if the person is going to therapy, what the diagnosis is, and the expected course of treatment. I routinely obtain a signed release of information that allows me to coordinate care with the PCP. I don't call PCPs very often, and when I do, I keep it brief and to the point. With a signed release, I send the PCP copies of my progress notes. This is an easy way to improve coordination of care, but very few MFTs share any information with the PCP.

WHAT DO MFTS WANT FROM PCPS?

- ❑ **Diagnosis:** What does the PCP think could be going on with the client's mental health? The PCP can greatly assist the MFT in developing a diagnosis. The person may have seen the PCP for several visits over some time, giving the PCP more history with the client.
- ❑ **Medical conditions:** What medical issues are impacting the client? The PCP can shed light on the medical conditions the person has, and on how those physical challenges may impact mental health.
- ❑ **Medications:** What medications is the client taking, and how might they impact the client? The PCP is able to explain medications that the person is on, articulate what the medications are intended to do, and describe any potential side effects.
- ❑ **Specialty referral:** Does the PCP think referral to a medical specialist is indicated? PCPs are gatekeepers of the client's care. In some cases the PCP is the person to make a referral to another specialist and can best manage that referral.
- ❑ **Physical changes:** Is there a change in the client's medical condition that may impact the progress in therapy? It's helpful to know when a medical challenge is happening with a client so we can better assist the person in dealing with those changes.

Brief Screening Tools

As MFTs, we are well aware of the abundance of screening tools used in our profession. Consider working up a list of brief tools for the medical providers with whom you work. If you are working in an environment that has thus far not been very integrated, you can help everyone on staff become acclimated to look for mental health issues. The following checklist can be used as a starter to help everyone on the healthcare team discern a possible mental health diagnosis.



Martha Teater working in her clinic with doctor and patient.



PCP CHECKLIST

Panic Disorder *“Do you have anxiety or panic attacks?”* If the person isn’t sure, you can elaborate by describing this as “a sudden rush of fear and nervousness that makes your heart pound and makes you afraid you’re going to die or go crazy.”

Agoraphobia *“Have you had to limit where you can go because of your anxiety?”*

Substance Abuse *“Do you continue to use in spite of the consequences?”* The person may not initially be able to identify consequences, but with some questioning, providers can uncover consequences such as family discord, physical problems, legal issues, or financial costs related to using substances.

CAGE

Cut down: *“Have you ever felt the need to cut down on your use?”*

Annoyance: *“Have you ever been annoyed by someone’s concern about your use?”*

Guilt: *“Have you ever felt guilty about your drinking or drug use?”*

Eye-opener: *“Have you ever felt the need for a drink or a drug in the morning?”*

A positive response to two or more items implies a high likelihood of a substance use problem.

AUDIT (Alcohol Use Disorders Identification Test)
This is a well-validated instrument that is a highly effective tool to assess alcohol problems.

Depression *“Are you depressed?”* A study of terminally ill patients revealed that this simple question alone had incredible sensitivity and specificity in diagnosing major depression.

SIGECAPS
Sleep change
Interest deficit
Guilt (worthless, hopeless)
Energy deficit
Concentration deficit
Appetite change
Psychomotor retardation or agitation
Suicidality

PHQ-9 We routinely screen clients for depression using the PHQ-9. It is quick, easy to administer, and simple to score. We record the score in the chart so we can document changes over time. We also use the scores to help us assess treatment outcomes.

ZUNG SELF-RATING DEPRESSION SCALE The Zung self-rating depression scale is a 20-question scale that has well-documented validity and specificity in identifying depression.

BIPOLAR DISORDER *“Have you had periods of feeling so happy or energetic that your friends told you that you were talking too fast or that you were too hyper?”*

DIGFAST
Distractibility
Indiscretion (excessive involvement in pleasurable activities)
Grandiosity
Flight of ideas
Activity increase
Sleep deficit
Talkative, pressured speech

Bipolar Spectrum Diagnostic Scale Diagnosing bipolar disorder can be challenging; this tool is an objective way to get at the subtleties of making this diagnosis.

DYSTHYMIA *“When is the last time you felt good?”* Dysthymia is a chronic depression lasting at least two years. The average duration of dysthymia prior to diagnosis is 16 years.

Integrated healthcare is an effective, powerful way to manage the care of our clients. By working with our peers in primary medical care, we can dramatically enhance the wellbeing of our shared clients. MFTs have a unique systems orientation that fits well in an integrated care model.



Martha Teater, MA, LMFT, is director of mental health for Mountaintop Healthcare and Good Samaritan Clinic, nonprofit primary care

clinics in North Carolina. She is involved with the American Red Cross as a disaster mental health manager. A Clinical Member of the AAMFT, Martha wrote "Compassion Fatigue in Katrina's Wake" in the March/April 2007 edition of *Family Therapy Magazine*.

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