Mental health expertise positioned in two ways: "As a specialty" and "Integrated in medical care"

From Patterson, Peek, Heinrich, Bischoff, & Scherger (2002)

Mental health is needed both as a specialty service and as an integrated aspect of medical care. It can be useful to highlight differences in between these two ways of deploying MH expertise in a care system. The following contrast is stereotypical. Actual practices employ many shadings between them.

Mental health as a specialty service	Mental health integrated in medical care
Professional model: Behavioral Health as a specialty service for referral and consultation	**Professional model:** Mental health services an integrated aspect of medical care. MH clinician as a member of the medical team
Clinical focus: mental health care • Often for distinct mental health problems • Use of a separate mental health care plan, team • Care of mental illnesses and conditions, e.g., -major mental illness and chemical dependency -diagnosable MH conditions -specialty treatment groups and programs -hospital, day treatment -emergency, triage -evaluation for any MH-related complaint • Coordination with medical care, nursing homes, other venues for care	**Clinical focus: medical and all healthcare** • Intertwined medical and MH problems • Seen as part of the medical care plan, team • Psychosocial aspects of care for any illness or complaint, e.g., -common depression and anxiety, comorbidity -somatic symptoms, psychophysiologic sx. -rehabilitation, back to work -complex cases, "thick charts", "difficult" patients -family distress that complicates medical care -chronic illnesses of all kinds -adjustment to illness, adherence to treatment -eval and referral for any MH-related complaint when not appropriate for FU care in medical • Coordination with specialty MH care, hospital, nursing homes, other care venues
Patient view • Seen by patients as "mental health care" • Patient may expect an exclusive relationship and little need for coordination or info sharing • Patient feels eligible to self-refer for MH care • The medical Dr. may ask patient to accept a MH referral to a MH clinician in a MH clinic	**Patient view** • Seen by patients as "health care" • Patient expects team-based medical coordination and automatic info sharing • Patient can just call in for medical care • The Dr. may introduce the integrated MH clinician to the pt. as part of the medical team
Operational systems and culture • Mental health clinic space and offices • MH scheduling, billing, chart, transcr. systems • Traditional MH clinic professional culture	**Operational systems and culture** • Medical clinic space and exam rooms • Medical scheduling, billing, chart, transcription • Traditional medical clinic professional culture
Covered benefits and financing • Care limited to diagnosable and covered MH conditions, as per patient's MH benefit • Considered part of mental health costs and revenue as another referral specialty	**Covered benefits and financing** • Might include behavioral aspect of care for any covered healthcare condition • Might be considered part of medical costs; a long-missing member of the in-house medical team

What stands out for mental health clinicians about integrated practice

Peggy Trezona, MS, RN, CS & CJ Peek, PhD (2001)

Therapists working as members of medical teams often notice common work themes associated with practice in medical clinics. Here is one such list:

1. Assess the *case* as well as the *patient*; organize the *system of care* while you treat the patient.

- Draw a complete picture of what is going on. What is the plan, the team, the roles and goals?
- Assess caregiving relationships: Where are they strong, weak, conflictual, or absent?
- Establish the larger care plan before jumping into psychotherapy; establish the meaning of psychotherapy within the overall medical / healthcare plan.
- Constantly take precautions against fragmentation of care.

Motto: "Preventing the classic and predictable case fractures and misunderstandings may be the most important part of your job"

2. Place multiple assessments and treatments in one interdisciplinary picture

- Bridge disciplines and professional practices; create one picture with a unified care plan rather than leave an uncoordinated slate of separate treatments in MH or medical realms.
- Work within patients' medical frame of reference for the complaints. Don't push MH language and explanations on patients. Respect "ripeness" for acceptance of MH factors.
- Translate the personal meaning of patient's medical problems for physicians and ask for translation of medical facts into meaningful expectations and self-mgmt goals for patients.
- Apply therapy progress to self-management of medical conditions (turn "therapy insight" into "self-care action")
- Accept when the doctor or nurse is the customer; not just the patient

Motto: "Watch the team score, not just your own score"

3. Accept the working style of medical clinic milieu

- Medical clinic culture, time sense, urgency, exam rooms, interruptions
- Information sharing- a wider circle of confidentiality
- Variable appointment lengths and flexible scheduling, sometimes same-day

4. Use the natural inclusion of family in a family medicine environment

Bring in couples, adult children, parents-- family is often key to change

5. Expand your "black bag"

- Have additions to talk therapy in your toolbox, e.g., hypnosis, guided imagery, biofeedback, breathing techniques, relaxation techniques.
- Learn how to talk in a practical way about "mind-body" interactions, e.g., common psychophysiological responses and symptoms
- Organize cases and keep people communicating and working well together-- “care manager”
- Educate yourself about complementary therapies your patients might be using on their own, e.g., qi gong, meditation, acupuncture.

6. Accept that the whole person may show up:

- Accept that meaning or spirituality may be bundled with patients' physical and MH concerns
- Listen and respond without pushing, getting beyond scope of practice, or injecting own beliefs
- Help patients ask what their own traditions might have to say about their suffering.

Therapist Identity:
"Who I am" and "What I pay attention to"

From Patterson, Peek, Heinrich, Bischoff, & Scherger (2002)

The work in medical settings invites a therapist to wear a somewhat different "hat" or broaden his or her identity-- "who I am" and "what I pay attention to"-- from that associated with stereotypically traditional MH settings. The contrast below highlights that expansion of identity.

Many therapists have already taken on this broader "hat" or identity whether working in medical settings or not. The contrast below is to highlight the concept, not to suggest that this is a brand new thing for therapists.

"Who I am"

In traditional specialty mental health	In MH integrated in medical care
• A psychotherapist	• A healthcare professional
• A member of a MH discipline or team of closely related disciplines	• A member of a very diverse multidisciplinary team
• A mental health specialist	• A healthcare generalist
• A "soloist" or partner with a MH person	• An "ensemble-ist" across many disciplines
• A provider of care for my patient	• A facilitator of improvement in teamwork and the system of care

"What I pay attention to"

In traditional specialty mental health	In MH integrated in medical care
• Specific "schools of therapy"	• Generic elements of "good clinicianship"
• Techniques belonging to your discipline	• Care plans that cross disciplines
• Mental illnesses and conditions	• Common clinical and self-mgmt. challenges that cross many diseases and conditions
• The mental health portion of the care	• The entire multidisciplinary process of care for the patient
• Improving the care for this patient	• Improving the total system of care for all patients