Emerging Areas of Systems Expertise for Family Psychologists in Federally Qualified Health Centers

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Federally Qualified Health Centers (FQHCs) provide comprehensive health care services to millions of low-income, uninsured, and underinsured Americans, including a high proportion of racially and ethnically diverse populations. Given their reliance on federal funding, FQHCs are at the forefront of recent health care reform initiatives, including integrated care and patient-centered health care. These initiatives call for a family-centered approach to care, which provides significant opportunities for psychologists trained in family systems theory. Four pediatric case illustrations demonstrate both the application and challenges of a systemic approach to assessment, intervention, and consultation in the unique setting of the FQHC. We end with a discussion of the competencies and adaptations necessary to provide family-centered services in pediatric primary care FQHC settings.

Keywords: family psychology, integrated care, patient-centered medical home, pediatrics, Federally Qualified Health Centers

This article provides an overview of the opportunities and challenges for family psychologists to provide family-centered integrated care (IC) in Federally Qualified Health Centers (FQHCs), which are the nation’s safety net medical providers for the uninsured and underinsured. FQHCs are encouraged to emphasize IC, family-centered care (FCC), and treatments that facilitate community linkages beyond the health care setting. As recipients of federal funding, FQHCs are at the forefront of the health care reform initiatives articulated in the Affordable Care Act (ACA), including the integration of mental health services with primary care, patient-centered medical care (PCMH), and it is considered essential to pediatric primary care (American Academy of Pediatrics [AAP], 2002). Therefore, in this article, we present pediatric case vignettes that illustrate the opportunities and challenges to family-centered practice in FQHC settings for family psychologists.

A shared language across disciplines is emergent in contemporary health care, and this article uses concepts and definitions according to the Lexicon for Behavioral Health and Primary Care Integration (Peek & National Integration Academy Council, 2013). The PCMH refers to an approach to providing comprehensive and continuous primary care that is based on a partnership between the patient and physician. FCC (Maternal and Child Health Bureau [MCHB], 2005), a related concept, focuses on the partnership between the family and the physician as the core relationship in health care. IC is an umbrella term

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1 Other terms used for the PCMH are the family-centered medical home, the person-centered healthcare home, and the healthcare home (Peek et al., 2013).
that refers to the integration of patient services from multiple disciplines via “on-site teamwork with a unified care plan as a standard approach to care for designated populations” (p. 51). Integrated primary care (IPC) refers specifically to the integration of behavioral and mental health services into the primary care setting. Traditionally, mental health services are considered treatments provided by licensed mental health professionals to persons with or at risk for mental illness. Currently, behavioral health services are considered treatments provided by licensed health care providers from various disciplines to reduce behavioral problems that impact overall health (including mental health conditions, substance use, and health behaviors). The distinction between these terms is blurring in the new health care landscape, and within this article, the term behavioral health services will be used.

FQHCs and Health Care Reform

The primary mission of FQHCs—a reimbursement designation of the U.S. Department of Health and Human Services (HHS)—is to counteract health disparities among racially, ethnically, and socioeconomically diverse populations by increasing access to high-quality health care for all. Community Health Centers (CHCs) are the most common health programs to receive this federal reimbursement designation. Capital investments under the ACA will provide more than $10 billion to expand services and support major construction and renovation projects at CHCs (HHS, 2012).

FQHCs differ from other health care settings in several key respects. First, they are required to provide affordable primary care to anyone in the community they serve, regardless of ability to pay. Second, FQHCs are required to provide comprehensive care, which in the majority of FQHCs includes mental health, dental, urgent care, pharmacy, and substance abuse services either on site or via a formal referral arrangement. Many FQHCs also provide support services such as case management, health education, and interpreter services. Third, FQHCs must be nonprofit organizations governed by a board of which at least 51% of the members are patients of the health center, ensuring that patient and community needs are represented in the FQHC’s service delivery. Finally, as recipients of federal funding, FQHCs adhere to federal reporting and performance requirements (Shin, Ku, Jones, Finnegan, & Rosenbaum, 2009).

The patient mix served by FQHCs is markedly different from that served by private physicians (National Association of Community Health Centers, 2013). The vast majority (92%) of FQHC patients are low-income (earning <200% of the federal poverty level), nearly three quarters are living in poverty (earning <100% of the federal poverty level), and the majority are either uninsured (36%) or publicly insured (40%). Nationally, >62% of patients served by FQHCs are members of racial and ethnic minority groups. As of 2011, nearly one quarter of patients reported a language other than English as their primary language (Uniform Data System [UDS], 2012).

Psychologists are significantly underrepresented among health care practitioners and often absent in FQHCs. Whereas psychologists represent only 16% of the behavioral health workforce in all health settings (Nordal, 2011), they represent 9% of the behavioral health workforce in FQHCs (UDS, 2012). The financial constraints and unique service demands of the FQHC, as well as the lack of relevant training in IC before licensure, have reduced the presence of psychologists. Behavioral health services are provided in FQHCs primarily by clinical social workers, licensed professional counselors, licensed marriage and family therapists, and nonlicensed mental health staff (UDS, 2012). Therefore, both the value and the distinctiveness of the role of psychologists can be less clear in FQHCs.

Given that FQHCs are recipients of federal funding and are accountable to federal reporting requirements, FQHCs are expected to continue to improve and streamline services through ACA-funded innovations, such as the PCMH, IC, and expansion of facilities to facilitate access, such as school-based health centers (SBHCs). Although the initiatives outlined in the ACA should benefit FQHCs by increasing revenue, they also create complex systemic challenges, as agencies adjust to new requirements (Bailey & Osberg, n.d.).

Patient-Centered Medical Home

The PCMH is a new practice model for primary care that shifts the focus from treatment of separate acute care episodes to management of the patient’s overall health and of chronic conditions (National Council for Community Be-
In the PCMH, the patient’s primary care provider (PCP) is responsible for coordinating all of the patient’s health care needs (Substance Abuse and Mental Health Services Administration [SAMHSA], 2011). The principles of the PCMH, established by four major medical associations (The American Academy of Family Physicians, the American Academy of Pediatrics, the American College of Physicians, and the American Osteopathic Association, 2007), follow: (1) Each patient has a relationship with a personal physician who in turn leads a team of clinicians. (2) The medical team takes a “whole person orientation” to the patient. (3) Care is coordinated and/or integrated across all elements of the health care system. (4) Quality, safety, and enhanced access to care are prioritized. (5) Financing is flexible to meet the needs of the PCMH in providing comprehensive care. The National Committee for Quality Assurance has developed a set of standards that are used to provide formal recognition of a primary care practice as a PCMH. By achieving PCMH recognition, primary care practices can pursue incentive payments for patient-centered care from public and/or private insurance (National Committee for Quality Assurance, 2011). In an effective medical home, services are integrated vertically (from direct service to administration), horizontally (across health, education, and community systems), and longitudinally (across the life span) (Bachrach, Isakson, Seith, & Brellochs, 2011).

Integrated Care

IC refers to on-site integration of health and behavioral health services provided by an interdisciplinary team using a unified care plan and a standard approach of care for defined populations (Peek et al., 2013). IC is congruent with the principles of the PCMH, as both depend on the collaboration of a team of professionals in providing comprehensive care for both physical and mental health concerns. Interdisciplinary treatment teams generally include physicians, social workers, psychologists, and occupational and physical therapists. The specific composition of these teams depends on the needs of the patient, as well as the human resources available in a given health care setting. Although Peek et al. (2013) focus on on-site integration in their consensus definition, a continuum of integration models exists that range from separate but co-located primary care and behavioral health services to models that involve systematic and collaborative development of treatment plans, provision of clinical services, and coordination of care among multiple health care providers (Hunter & Goodie, 2010). IC has been shown to be superior to traditional primary care in utilization of referred treatment (85%–90% vs. 10%), compliance with medical recommendations, and sustained patient lifestyle changes. Integrating behavioral and medical care has also been shown to more effectively reduce medical costs when compared with providing separate behavioral and medical care (Cummings, O’Donahue, & Cummings, 2009).

School-Based Health Centers

SBHCs are health centers based in schools that provide a full range of services to children. Services may include primary medical care, mental/behavioral health care, dental/oral care, health education/promotion, substance abuse counseling, case management, and nutrition education. SBHCs are a major component of the nation’s health care safety net and enable children with acute or chronic illnesses to attend school. SBHCs emphasize prevention, early intervention, and risk reduction. SBHCs often are operated as a partnership between the school and a community health organization, such as a CHC. Thus the specific services provided vary based on community needs and resources (Health Resources and Services Administration [HRSA], n.d.). The ACA appropriated $200 million in capital grants over 3 years (2010–2013) to improve and expand services at SBHCs (HHS, 2011).

Family-Centered Care

FCC2 is an approach to health care delivery in which the medical team collaborates with the family, not only the patient, to address medical decisions, concerns, and priorities (Kuo, Frick, & Minkovitz, 2011) via a “respectful family professional partnership” that “honors the strengths, cultures, traditions, and expertise” of all collaborators (MCHB, 2005). The principles

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2 Multiple terms have been used for a family-focused approach to health care, including family-centered care (FCC; MCHB, 2005), family-oriented primary care (McDaniel et al., 2005), and family pediatrics (Schor & AAP, 2003).
of FCC include collaboration, respect, trust, communication, joint decision making, and willingness to negotiate (MCHB, 2005). FCC encourages relationships between family members and health care providers, recognizes that family is a central and primary source of strength for patients, and allows for more personalized care and sustainable treatment plans for patients (MacKean, Thurston, & Scott, 2005). In practice, FCC can range from engaging an entire family in the examination room for each visit, to an awareness of the impact of other family members on the development of the individual patient (Fox, Hodgson, & Lamson, 2012).

Pediatric primary care is an example of a setting in which families are readily accessible and the benefits of FCC are particularly apparent. The AAP recognizes that “families are the most central and enduring influence in children’s lives,” and advocates for pediatric care that not only involves the family in the care of the child but also addresses family problems that can impact the well-being of children (Schor & AAP, 2003, p. 1541). FCC is considered so critical to the delivery of health care services to children that the AAP uses the term Family-Centered Medical Home in its initiative to implement medical homes in pediatric primary care settings (National Center for Medical Home Implementation, n.d.). Research has demonstrated that FCC is more effective than traditional pediatric care in engaging families in developmentally appropriate prevention discussions (also known as age-appropriate anticipatory guidance), which result in reduction of childhood injuries, enhanced developmental and parenting skill acquisition, a stronger family–provider alliance, and increased family satisfaction with care (Kuo et al., 2011, 2012).

In summary, FCC broadens the focus of treatment from the physical symptoms of the individual patient to the interrelated physical and mental health of not only the patient but also the overall family system. FCC involves family members in all levels of care and ensures that this paradigm shift occurs across all levels of the system (administrators, policy, and providers) (Fox et al., 2012; Johnson, 2000). Within the specialty of family psychology, primary care family psychology provides guidance for the application of FCC to primary care (McDaniel & LeRoux, 2007). Family psychologists with training rooted in systemic epistemology are uniquely equipped to provide FCC and facilitate the necessary systemic paradigm shift within health care settings; however, system- and population-level barriers exist.

**Challenges to Family-Centered IC in FQHCs**

Despite legislative and evidence-based support, significant challenges to FCC remain at both the systemic and patient population levels in FQHCs. System-level challenges include logistical issues such as space, electronic health records (EHRs), and billing requirements, as well as cultural differences between medical and mental health providers. Patient-level challenges reflect population characteristics typical of FQHCs that serve as barriers to health care access.

**System-Level**

Family psychologists integrating into FQHCs can expect to face a number of practical barriers. As clinics whose primary mission is to provide medical services, FQHCs tend to lack space designed for the delivery of health care services. Behavioral health providers in these settings often provide services in examination rooms or in small shared office spaces (Seaburn, Lorenz, Gunn, Gawinski, & Mauksch, 1996; Fox et al., 2012). This lack of space is particularly problematic when attempting to provide family-focused services, as these commonly require more people to be in the treatment room than individual-focused services.

Billing requirements and restrictions are a challenge to all forms of IC services but particularly challenging to the provision of family-centered services. Whereas IC calls for flexible models in which medical and behavioral health providers see patients or patient families together or sequentially, same-day billing of mental health and medical visits is typically not permitted (Cummings et al., 2009; Monson, Sheldon, Ivey, Kinman, & Beachem, 2012). Furthermore, family therapy services may not be allowable by Medicaid. Although federal Medicaid rules allow for the use of family therapists as behavioral health providers, the rules
do not mandate coverage for their services, a decision that is determined at the state level; currently, 38 states allow for some reimbursement of family therapy through Medicaid (American Association for Marriage and Family Therapy, 2012). Even when covered by Medicaid or other reimbursements, the traditional model of 50-min therapy sessions is unlikely to be reimbursed at rates that fully compensate the salaries of providers or permit billing for related essential services such as consultation with relevant systems (Monson et al., 2012; Sanchez, Thompson, & Alexander, 2010). The pressure to increase billable hours by shortening sessions and/or seeing groups of clients at the same time may be a particular disincentive to providing family-centered services when only one family member is the identified patient.

The use of EHRs poses another challenge to the delivery of family-centered services. One of the primary purposes of EHR is to facilitate the exchange of information among providers and clinic staff. However, this openness of records to all staff conflicts with the ethical obligations of psychologists to maintain the confidentiality of psychosocial information (American Psychological Association [APA], 2013; Smolyansky, Stark, Pendley, Robins, & Price, 2013). The use of EHR poses particular challenges to the delivery of family-focused behavioral health interventions, as these records are currently maintained for individuals, making it difficult to link together family members’ shared history or to document family-level interventions, and reinforcing an individual-level approach to problem identification and treatment rather than a family systems approach (Fox et al., 2012). The confidentiality of family members other than the identified patient is particularly concerning with the use of EHRs that are accessible to all clinic staff (Drogin, Connell, Foote, & Sturm, 2010).

Interprofessional differences between behavioral health providers and medical providers are often cited as a challenge to IC, including FCC. Despite widespread acceptance of the biopsychosocial model, the vast majority of medical education programs provide training from a predominantly biomedical model, which emphasizes the biological aspects of health over psychological and social factors (Astin, Soeken, Sierpina & Clarridge, 2006; Association of American Medical Colleges, 2011). Lack of training in psychosocial issues can result in discomfort treating mental health symptoms and conditions (Davis et al., 2012) and may limit physicians’ willingness to actively collaborate with psychologists in diagnosis and treatment (Fox et al., 2012). Despite significant evidence that psychological interventions improve a wide array of common health complaints, surveys of physicians have shown that a sizable majority do not believe behavioral health interventions would add value to their treatment of most conditions (Astin et al., 2006). Finally, guidelines for IC emphasize the importance of individuals’ social and community context but typically do not explicitly mention the family context (Fox et al., 2012; Association of American Medical Colleges, 2011). Thus, psychologists seeking to use family systems approaches in FQHCs may face resistance from medical providers more comfortable with individual-level interventions.

**Patient-Level**

There is a scarcity of research documenting the implementation of family-centered behavioral health services in primary care settings, and thus, little is known about the barriers families face in accessing these services within FQHCs. However, research identifies that low-income ethnic minority parents experience significant socioeconomic and linguistic barriers to accessing children’s specialty care services. Nearly 60% of working, low-income, Hispanic parents reported “leaving work” as the major barrier to completing specialty care referrals (Zuckerman, Perrin, Hobrecker, & Donelan, 2013) because access to paid sick leave is uncommon in low-wage service sector jobs (Williams, Drago, & Miller, 2011). Non-standard work schedules, although common throughout the U.S. population, are especially common among low-wage jobs (Presser, 2003), and can present a barrier to the attendance of multiple family members or to attending appointments outside children’s school hours. Lack of reliable transportation was a commonly cited reason among low-income parents for missing visits for primary pediatric care (Yang, Zarr, Kass-Hout, Kourosh, & Kelly, 2006), dental care (Mofidi, Rozier, & King, 2002), immunizations (Thomas, Kohli, & King, 2004), and chronic illness management (Garwick,
Kohrman, Wolman, & Blum, 1998). Low-income parents are more likely than middle- or high-income families to be without a vehicle, to have an unreliable vehicle, and to experience transportation-related financial hardships (Garsky, Fletcher, & Jensen, 2006). Needing to rely on public transportation or rides from others also increases the time low-income parents must dedicate to transportation (Roy, Tubbs, & Burton, 2004). Nearly 40% of parents reported childcare for siblings was a barrier to pediatric specialty care referral completion (Zuckerman et al., 2013). Because of the cost of formal childcare and the nonstandard work schedules of many low-income parents, these parents often rely on informal care arrangements that are more likely than formal care to be inconsistent, unreliable, and dependent on parents’ social networks (Henly & Lyons, 2000).

The large immigrant population served by FQHCs presents an additional challenge to family-centered behavioral health care. Nationwide, there is a shortage of ethnically and linguistically diverse behavioral health providers (Chapa & Acosta, 2010; HHS, 2001). Immigration status presents a further barrier. As of 2005, it was estimated that more than 3 million U.S.-born children were living in families with at least one undocumented adult member (Passel, 2006). Particularly in light of recent laws aimed at identifying and deporting unauthorized immigrants (e.g., Arizona’s SB 1070), undocumented parents may fear accessing services or collaborating in their children’s care (Capps, Castañeda, Chaudry, & Santos, 2007; Hacker, Chu, ArsenaULT, & Marlin, 2012).

A final patient-level challenge is the stigma often associated with mental health problems and their treatment among diverse populations. Studies of mental health stigma among adults have indicated that adults of lower socioeconomic status and those who belong to ethnic minority groups may be more likely to endorse stigma of mental illness and less likely to seek mental health treatment for themselves (Alvidrez, 1999; Corrigan & Watson, 2007). Although research on stigma associated with children’s mental health problems is limited, fear of being blamed for their children’s symptoms may prevent some parents from discussing emotional or behavioral concerns, and may particularly limit their openness to family-centered approaches to psychological treatment (Hinshaw, 2005; Dempster, Wildman, & Keating, 2013).

Opportunities and Training Needs for Family Psychology in FQHCs

The systems orientation of the family psychologist is well-suited to the multiple levels of behavioral health intervention necessary in the FQHC, including direct clinical services to patients and their families, consultation services to medical professionals, and organizational interventions to improve system functioning. FQHCs are in a stage of transformation as new practice models are implemented that are designed to improve health care quality and effectiveness, such as the PCMH, IC, and FCC. The common theoretical basis of these approaches is the biopsychosocial model, in which illness is conceptualized as resulting from a combination of biological, psychological, and social factors (Engel, 1977). The biopsychosocial model and the family systems theory both developed from general systems theory, and the combination of the two, that is, “the biopsychosocial systems approach,” is the conceptual model that links family psychology and health care in practice models such as primary care family psychology, family-oriented primary care, and medical family therapy (McDaniel & LeRoux, 2007, p. 24).

The biopsychosocial systems approach emphasizes an understanding of the patient in the context of the family, the health care setting, and other systems. Rather than viewing an artificial separation between medical and behavioral health concerns, or individual and family concerns, the patient’s concerns are conceptualized at multiple levels from the beginning. The patient, family, and clinician(s) collaborate in the process of resolving health problems, and the clinician(s) are conceptualized as part of the system affecting the patient. Although the patients may not always be seen with family members, the patients can always be seen in the context of their family system. This includes understanding of the following influences: health beliefs and behaviors originate in the family, family developmental transitions cause stress that can result in physical symptoms, symptoms can have an adaptive function in the family, family patterns can maintain symptoms, and families can be a resource and provide...
support when managing illness (McDaniel, Campbell, Hepworth, & Lorenz, 2005).

Services provided by the family psychologist in primary care may involve therapy, assessment, and consultation to individuals and families, as well as consultation to medical professionals on behavioral health and family systems (McDaniel, Hargrove, Belar, Schroeder, & Freeman, 2004). An example of therapy that is designed for health care settings is medical family therapy, which always includes a collaborative approach that empowers the family as care providers, focuses on health and coping, and makes families part of the health care team (McDaniel & Hepworth, 2004). Assessment in primary care may include administration of screening and self-report measures, diagnostic interviewing, observation of interactions, and more extensive formal assessment. Family assessment techniques, such as genograms, observation of family interactions, and family interviewing, are compatible with primary care, as they can be incorporated into medical visits or one-session meetings. Whereas family psychologists may incorporate these techniques in working with therapy patients, in the primary care setting, a family assessment may be requested to assist another provider in planning treatment; thus, there is often a natural link between assessment and consultation. Consultation services may be provided by the psychologist directly to families, or may be provided to team members to increase their understanding of the influence of family systems on a particular case.

Family psychologists can further contribute an understanding of the impact of the social context on the health, functioning, and engagement of clients with the medical system (McDaniel & Fogarty, 2009). This is particularly relevant in the FQHC setting, in which clients face multiple stressors due to low socioeconomic status and lack of access to needed services. Families from disadvantaged backgrounds often have different experiences than middle-class families with social institutions: “Many institutions, although very respectful of the family boundaries of the middle class, feel free to intervene on behalf of poor families. On behalf of the children, they enter the familial space, creating not only dislocation of family organization but affiliations between children and the institutions” (Minuchin, Lee, & Simon, 2006, p. 21). A systemic perspective that takes into account the impact of larger systems on family functioning can result in interventions that are respectful of family boundaries, emphasize collaboration, and build on family strengths (Kazak, Simms, & Rourke, 2002).

FQHCs are primary health care settings. Recommendations for specialized training of psychologists who seek careers in primary care have been clearly articulated (McDaniel et al., 2004). Using the biopsychosocial model as a starting point, these authors delineate a comprehensive self-study curriculum that includes objectives, resources, and exercises to develop knowledge and skills in components essential to primary care practice by psychologists. The unique population and service demands of the FQHC setting suggest particular emphasis may need to be placed on the section of the curriculum that addresses knowledge of the sociocultural components of health and illness. The FQHC setting also demands considerable linguistic competence for service delivery in regions of the nation where populations served do not speak English fluently. An equivalently detailed training curriculum in primary care family psychology was not located by the authors, although an established training program in this area has been described in the literature (McDaniel & Leroux, 2007) and a volume on medical family therapy in IC is forthcoming (McDaniel, Doherty, & Hepworth, 2013).

Case Illustrations

The following case illustrations highlight both the opportunities and challenges involved in integrating family-centered behavioral health care into primary care within FQHCs. Cases from two FQHCs in Texas have been selected. One FQHC is a large organization of CHCs that extends across a broad geographic region, serves a diverse rural and suburban population, and incorporates several IC models including co-located behavioral health services, embedded behavioral health consultants (BHCs) in family practice, and SBHCs. The second FQHC is a single urban clinic serving a mix of urban, suburban, and rural populations. The patients served are primarily Latino, and many are monolingual Spanish-speaking or Spanish/English bilingual.
The FCC providers in the selected cases were doctoral students in their third to fifth year of training in an APA-accredited psychology program who were completing a year-long clinical experience as part of a program in IC funded by the Graduate Psychology Education Program of the HRSA. All had built on foundational academic training in child assessment, intervention, and school consultation with advanced courses and practicum in family psychology and family systems therapy, health psychology and pediatric psychology, and integrated behavioral health. The trainees had received exposure to the biopsychosocial model, FCC, family assessment, and a broad range of family therapy models; they had received live supervision in conducting family assessment, structural family therapy, and solution-focused brief therapy. The cases demonstrate the unique linkages that can occur in pediatric primary care when taking an integrated family-centered systems approach to behavioral health treatment. Consistent with the principles of the PCMH and IC, the trainees functioned in the role of BHC providing services to the client on referral by another member of the IC team. Names and identifying details have been changed to protect patient privacy.

From Individual to Family Therapy

This case illustrates how the BHC shifted from individual to family therapy within a family practice clinic with embedded behavioral health.

Jay, a 13-year-old Caucasian male, was referred to the BHC by his pediatrician after his mother discovered that he was cutting himself. Jay was in the eighth grade and doing well academically; however, he was increasingly socially isolated, had little interest in enjoyable activities, and was irritable and angry toward his younger siblings on a daily basis. Jay’s parents divorced when he was 7 years old, and he had limited contact with his father. Jay’s father had a history of schizophrenia and his mother was concerned about Jay’s current symptoms in light of this psychiatric history.

Jay attended 10 therapy sessions over 9 months that began as individual cognitive-behavioral therapy and evolved into family therapy. Jay’s mother attended part of each individual session to check in on Jay’s progress and learn about the coping skills Jay was practicing. When Jay’s mother joined the therapy session, it became clear that Jay’s progress was being impacted by the family dynamics both at home and during phone calls with his biological father. The family was highly stressed as a whole, there were intense pressures on Jay as a family member, and his mother had difficulty positively reinforcing Jay’s improved behavior.

Therefore, in the sixth visit, therapy shifted to family therapy with Jay and his mother with the goals of improving communication, problem-solving, and positive interactions between Jay and other family members. Soon after, Jay’s depressive symptoms were reduced and family communication and problem-solving had improved. However, Jay continued to have diminished interest in activities and social interactions. The BHC referred Jay back to his pediatrician for evaluation for antidepressant medication, who in turn referred to the psychiatrist, with an antidepressant eventually prescribed. At the end of treatment, Jay had a successful weekend visit for his middle school graduation with his entire extended family, including his father.

This case illustrates the importance of a family therapy orientation in an IC setting. The patient was initially referred for individual therapy, which was the clinic’s standard of care. However, the BHC’s training allowed her to assess the impact of stress in the family context on the child’s depressive symptoms and transition the treatment to brief family therapy. Interprofessional collaboration in this case was aided by the use of one EHR by multiple specialties. For example, the child psychiatrists used the intake, notes, and assessment forms from the family practice clinic in addition to their own interview to diagnose and initiate medication.

The BHC’s role as individual therapist in this setting was similar to the role of other BHCs who were licensed clinical social workers or professional counselors, and was appropriate for her role as a supervised psychology trainee. A family psychologist in this role might also take a leadership role by training the behavioral health team in family systems interventions, supervising other clinicians and trainees, and providing consultation to colleagues on medical and behavioral health issues that are exacerbated by family dynamics. The psychologist in this role can impact the system by improv-
ing its capacity to implement FCC across system levels.

**Single-Session Family Intervention**

The following case illustrates how a single-session family intervention was used with the parents of an adolescent receiving individual therapy when work schedules precluded their participation in ongoing family therapy. The patient’s PCP initially referred the case to the BHC for the purpose of consulting with both the family and the health care team about the client’s educational needs and services.

Melissa Garcia was a 17-year-old bilingual Hispanic female who was in individual therapy for depression and anxiety. Melissa’s parents were both immigrants from Central America who worked in low-wage service jobs and spoke only Spanish. The PCP (a nurse practitioner) and individual therapist (social worker) referred Melissa to the BHC to liaison between the clinic and the school. With parental consent, the BHC obtained and reviewed Melissa’s special education records, and, at her father’s request, attended Melissa’s annual required Admission, Review, and Dismissal meeting at school. Following the Admission, Review, and Dismissal, the BHC met with Mr. Garcia to answer his numerous questions about what was discussed and decided. She then met with Melissa and the therapist to explain to them her special education classification (multiple specific learning disabilities) and its implications. At this meeting, Melissa reported feeling that she was a disappointment to her parents, particularly her mother, because of her learning difficulties and anxiety. The therapist and BHC concurred that family therapy would be ideal for Melissa and her parents. Because the therapist did not speak Spanish, she had not previously been able to involve Melissa’s parents in treatment.

When the BHC, who was Spanish-speaking, called Melissa’s father to discuss the possibility of seeing the family for therapy, Mr. Garcia explained that he and his wife worked opposite schedules during the week and thus could not regularly attend sessions together. Given this constraint, the family was invited to participate in a one-session brief family intervention. The session, which had to be rescheduled several times because of Melissa’s mother’s difficulties in obtaining time off from work, was held with Melissa, both her parents, the therapist, and the BHC, who cofacilitated and interpreted. The session focused on summarizing Melissa’s engagement and progress in treatment, eliciting her parents’ understanding of her emotional conditions and her educational disabilities, and eliciting Melissa’s concerns and questions. Melissa’s parents expressed a good understanding of her emotional and educational difficulties, and evidenced consistent empathy and support. Both the BHC and therapist highlighted and reinforced the parents’ support of their daughter throughout the session. Melissa’s parents asked how they could help her more, and the therapist and BHC gave them printed information for parents (in Spanish) about learning disabilities and anxiety. In subsequent individual counseling with Melissa, the therapist leveraged the family intervention to challenge Melissa’s negative cognitions about her parents’ view of her.

This case illustrates the effectiveness of a family-centered approach in a case originally referred for a consultation on educational issues. The BHC’s family systems training allowed her to identify salient family issues contributing to the patient’s distress and use a brief family intervention with a family that was unable to participate in weekly therapy. It also illustrates the importance of cultural and linguistic competence when working in an FQHC setting with a diverse population, particularly when using a family systems approach. Although Melissa, a fluent English speaker, was able to engage in individual therapy with a non-Spanish-speaking social worker, her Spanish-speaking parents were unable to participate fully in her treatment.

In this case, the BHC consulted with the school to clarify their understanding of the patient’s mental health needs, with the PCP and therapist to increase their understanding of the patient’s learning disabilities and educational plan, with the patient’s parents to explain her progress in counseling and answer their questions about her educational plan, and, finally, with the patient herself to address her concerns both about school and her parents’ view of her. The BHC’s training in family and school psychology led to an understanding of the broader systemic issues impacting the patient, and positioned her as the IC team’s expert on psychoeducational assessment and special education procedures. A family psychologist in this role...
could also implement clinic procedures for interpreting school records for patients with learning and developmental issues and for collaborating with schools and families to establish care plans for patients with complex medical, learning, and mental health needs.

**Family Assessment in IC**

This case illustrates the use of family assessment to identify and address barriers to medical adherence within a multistressed family system. It also illustrates the challenge of moving from a patient-centered approach, in which individual interventions are prioritized, to a family systems approach, in which systemic interventions are identified and implemented.

This case began as an individual referral by the pediatrician to the BHC for a psychological evaluation of a 10-year-old boy, Ivan, due to symptoms of inattention and hyperactivity. Ivan’s mother, Gloria, a Spanish-speaking single mother, lived with her three children in a single bedroom in a house shared with her own parents and extended family. She was dependent on them for childcare due to having two jobs that did not allow paid time off. The children’s father had been in jail for several years. Gloria had a history of reporting multiple problems during clinic visits, but then not following treatment recommendations. Gloria agreed, however, to an evening appointment with the BHC for an initial intake interview for the evaluation.

At the intake appointment, Gloria stated that Ivan was doing well and that she instead wanted to talk about her 5-year-old son, Eduardo. She reported that Eduardo had enuresis and encopresis, as well as a history of dangerous impulsive behaviors such as running into the street, being aggressive, and playing with a lighter he found in the house. When asked why she had not reported these concerns to her pediatrician, Gloria stated that she feared she would be misunderstood if she spoke in English or via a translator. The BHC completed an immediate safety assessment. Gloria appreciated the severity of the situation, had taken steps to increase her child’s safety, and was desperate for help from the BHC. However, she also reported feeling overwhelmed and undermined by her parents, who often contradicted her parenting decisions.

The BHC then initiated a two-session family assessment followed by a three-session family systems intervention in which Gloria’s role as a family leader was emphasized. She opted not to include her older relatives, to highlight her parental authority, and the sessions were conducted in Spanish, to empower her in relation to her bilingual children. Gloria attended the family assessment with her two sons and 13-year-old daughter, Nina. A recurring theme across the family interview and interactions, self-report measures, and Kinetic Family Drawings was disorganization in their family life, as well as conflicting behavioral expectations from the adults in the home. The BHC observed that Gloria seemed to have little control over the children—Ivan frequently interrupted her and Eduardo ignored her efforts to discipline. Nina either withdrew or allied with her mother in directing her brothers’ behavior. Ivan reported via his Kinetic Family Drawings that family members constantly scolded each other. All family members complained about Eduardo’s behavior, and he in turn engaged in distracting impulsive behaviors. Family strengths included expression of warmth toward each other and interest in improving their home situation.

In the assessment feedback session, family strengths and the consistency of family members’ perspectives were highlighted. Eduardo’s behavior was reframed as a reflection of the chaos in the house. The family came to see Eduardo as the family’s best communicator, because his behavior was an indicator of the high stress level in the home. A contract for family therapy was established, and subsequent sessions focused on empowering Gloria as head of her family. Gloria worked on establishing routines and clear behavioral expectations for her sons, and took steps to secure her own housing near her family.

Gloria began attending appointments regularly, assisted by the BHC coordinating behavioral health appointments with medical visits. The health care team established a treatment plan that included family therapy, consultation with the school, and ongoing primary care for the children. For Eduardo, attention deficit hyperactivity disorder medication was prescribed via a psychiatric consultation, and a specialty medical referral was provided to address enuresis and encopresis. For Ivan, a psychological evaluation was scheduled. The BHC provided consultation to the health care team about patient engagement strategies using a family systems perspective. Despite these strategies, how-
ever, Gloria faced concrete barriers to pursuing treatment recommendations, such as transportation difficulties and financial stressors. The BHC referred Gloria to a Medicaid-funded bilingual case manager who met with her in the home to address these barriers to medical care. The BHC and case manager consulted via phone and focused on increasing Gloria’s capacity as the head of her family. Gradually, Gloria was able to follow through on treatment recommendations, although the process was lengthier and more complex than was initially expected by the treatment team.

This case illustrates how a family assessment and brief family intervention can help in identifying and altering systemic issues that are interfering with medical and behavioral health treatment. Family assessment and consultation by the BHC to the health care team allowed for a broader systemic conceptualization of the case, which then informed the team’s approach to treatment. This case also illustrates that barriers such as transportation and adequate housing have a strong impact on health behaviors. Continuity of care is improved when health care teams establish linkages with community resources, such as in-home case management services, that can assist in addressing these barriers.

In the setting described earlier, individual psychological assessments for diagnostic clarification were an important component of interdisciplinary treatment planning. The BHC’s training in family assessment allowed her to broaden the conceptualization of this case. Psychologists in IC settings can play a unique role by conducting assessments to guide treatment of complex cases, and family psychologists in particular can contribute their knowledge of family assessment and conceptualization. They may also train other professionals in family-centered interviewing and screening measures. As psychologists strive to define their unique contributions to primary care settings, the adaptation of assessment practices to these settings is an area of future growth.

Systemic Therapy in a School-Based Clinic

This case demonstrates how a multisystemic approach, including linkages with the family, school, psychiatry, and social work, was necessary to meet the care needs of an adolescent client in a school-based health clinic.

Gloria was a 17-year-old Caucasian, English-speaking, uninsured female from a disadvantaged socioeconomic background in a school special education program for students meeting eligibility criteria for emotional disturbance. She was referred by her school nurse to the school-based health clinic for behavioral health services. Sarah had a history of childhood sexual abuse, and she presented with auditory and visual hallucinations, delusions, and self-injurious behaviors. At the time of treatment, Sarah was living at home with her father, stepmother, and siblings; however, in the previous year, she had also spent time in a residential treatment center due to psychotic episodes and in a transitional home to increase her readiness for independence after high school. Although Sarah’s symptoms were minor at school, they tended to be exacerbated by family conflict and lack of structure at home. Treatment focused on increasing her emotional stability, helping her develop adaptive coping skills, and enhancing her understanding of safe and appropriate boundaries in relationships. Strong emphasis was placed on working with Sarah’s parents and siblings to increase emotional warmth and communication, and minimize conflict across familial relationships.

Sarah’s parents were frequently unable to attend sessions in person due to health issues and work constraints. Because of the barriers to her parents’ involvement in care, the BHC at this site consulted with them during weekly phone calls. She also spent a substantial amount of nonbillable hours per week to consult with health care professionals, community organizations, and insurance companies to help Sarah and her family to obtain medications and therapy services. A priority in involving Sarah’s parents in treatment was to update them on information gathered from various health care professionals who were part of Sarah’s care team. The setting of a school-based clinic facilitated Sarah’s involvement in therapy and allowed for linkages between the school and other systems, but presented barriers to family-centered treatment.

This vignette illustrates a family-centered approach to an individual patient with major mental illness in a school-based clinic. It demonstrates the necessary adaptations required to actively involve family members from low socioeconomic backgrounds in treatment. For
Sarah to be able to control and cope with her psychotic symptoms, it was imperative to educate and consult with her family members about strategies to minimize conflict across all relationships in the home, not solely those involving Sarah. The use of structural family therapy strategies, such as increasing empathy for Sarah and highlighting her strengths, helped to change her parents’ view of her as the main cause of problems in the home.

In this case, the BHC’s official role was as a therapist; however, given the various socioeconomic barriers to treatment, substantial case management was needed to support the family. In this particular clinic, no administrative or case management support was available and thus, the BHC fulfilled multiple roles. In this way, this case illustrates the flexibility required of psychologists in emerging IC systems, particularly FQHC settings serving disadvantaged populations. Ideally, an IC team would include case managers, thus allowing psychologists to dedicate their time to those activities for which they are uniquely trained and qualified. Psychologists in leadership roles are in a position to advocate for appropriately staffed systems that meet the needs of patients and employ different professionals effectively.

**Discussion**

This article describes the process of family-centered IC in four separate cases within FQHC settings. Given the presently evolving health care landscape, FQHCs provide a unique opportunity to implement behavioral health programs that are integrated with primary care services and informed by family systems perspectives. However, there is little published literature available on the role of the family psychologist in these particular settings. In this article, we used four case illustrations to demonstrate the present state of family-centered intervention in FQHCs, as well as the possibilities for the future of family psychology in these settings. The case illustrations demonstrate multiple approaches to the delivery of family-centered behavioral health services, including family therapy, single-session family intervention, family assessment, and ecosystemic therapy, in a range of FQHC settings including family practice, pediatric practice, and an SBHC.

FQHC settings are in the process of implementing innovative integrated health care models; however, health care services have historically been fragmented across multiple systems. This fragmentation can be addressed in the family-centered medical home model, with family psychologists contributing their knowledge of systemic change and intervention to both system-level program implementation and patient/family-level care.

The cases focus on the family psychologist’s role at the patient/family level, and demonstrate multiple ways in which the biopsychosocial systems perspective (McDaniel & LeRoux, 2007) can positively impact the delivery of family-centered services in primary care settings. The BHCs in these cases generally did not practice family therapy in the traditional sense (i.e., 50-min weekly sessions), but rather applied a systemic perspective to cases ensuring that the patients were viewed in the context of their family, school, and community. This is a necessary adaptation in primary care settings, in which brief problem-focused interventions are favored over longer-term outpatient therapy approaches.

The cases highlight unique competencies needed by psychologists in IC settings, as well as adaptations of these competencies for family psychologists in particular. A major competency required of psychologists in IC is interprofessional collaboration. The future of health care involves the delivery of services by multidisciplinary teams of professionals who provide comprehensive health care. Team-based care takes advantage of the unique contributions of professionals from different disciplines, but also creates challenges in collaboration, given differences in levels of training, background, professional skills, and goals for patients. Family psychologists in primary care are particularly well-suited to providing leadership in improving team communication and addressing systemic barriers to collaboration.

Flexibility is another major competency for psychologists in IC, and is particularly relevant in FQHC settings that treat patients with complex needs and few resources. Not surprisingly, the low-income families receiving behavioral health services at these FQHCs experienced all the same barriers to engagement previously documented in studies of barriers to medical care access—transportation, childcare, and...
schedule difficulties. Addressing these barriers required considerable flexibility on the part of the providers, as well as an emphasis on adapting treatment approaches to meet the needs of the patient.

Beyond flexibility, an appreciation of the significant societal and economic challenges encountered by families in FQHC settings is critical to FCC. Family psychologists should work to ensure that the health care team maintains a systemic perspective in which they view barriers experienced by patients in the social context, rather than placing blame on individual patients. Indeed, one of the recommendations for training in primary care psychology is learning about sociocultural components of health and illness as a core competency equivalent to understanding biological, cognitive, and affective components of health and illness (McDaniel et al., 2004). Given the linguistic diversity of patients served by FQHCs, competence in providing services in multiple languages and/or collaborating with interpreters will also need to be emphasized in training and professional development.

Another major competency for psychologists in IC is becoming familiar with the infrastructure of primary care while also being careful to assess how professional practice in psychology fits into this infrastructure. System-level challenges were encountered throughout the cases, including challenges related to clinic space, billing, and EHRs. EHR systems facilitated interprofessional collaboration in these cases, but also created challenges for the documentation of family-focused services. EHR systems raise multiple ethical dilemmas for the behavioral health provider, such as whether patients’ behavioral health history should be kept separate from their medical record, how much detail to provide about family history while maintaining confidentiality for other family members, and whether patients in a medical practice have given informed consent for the sharing of their behavioral health history with other practitioners on the interdisciplinary team (APA, 2013; Smolyansky et al., 2013; Drogin et al., 2010). Thus, it is important that psychologists develop competence in using EHR systems effectively and ethically, and that family psychologists ensure that their use of EHR is reflective of ethical family therapy practice. The sustainability of family psychologists in IC settings will also be partially dependent on advocacy within the field for billing and reimbursement systems that recognize the full range of both direct and indirect services provided to individuals and families by family psychologists.

These challenges underscore an important tension confronting psychologists working in the emerging setting of IC. On the one hand, it is critical that psychologists remain flexible to practicing in innovative ways and integrate themselves into primary care with a willingness to “act like a guest” in a new environment (Behavioral Health Optimization Program, 2011, p. 75). On the other hand, psychologists must be proactive in defining appropriate roles and responsibilities for the profession in these settings, demonstrating their unique value and striving to obtain privileges and compensation commensurate to their level of training and expertise (APA, 2013).

There are several factors that limit the generalizability of the case illustrations described in this article. First, the cases were limited to three clinics operated by two agencies located in the same geographic region, both of which have well-established IC programs and chose to participate in a training program for psychologists. It is reasonable to assume that family psychologists integrating into FQHCs with less well-established IC programs might encounter more systemic barriers than described here. Another limitation is that the BHCs profiled were all doctoral students in the same graduate program, and thus have similar exposure to family systems theory and IC in their training. Experienced family psychologists would likely have brought greater breadth and depth of knowledge and skill to the cases. Finally, the case illustrations were not designed as evidence-based case studies, and thus quantitative data that ascertain the effectiveness of family-centered treatment were not available. Despite these limitations, given the dearth of published literature on family-centered IC services in the FQHC setting, the case illustrations do provide a window into the challenges and opportunities for family psychologists in this practice setting.

The rapidly evolving health care landscape, clearly evidenced within FQHCs, provides an exciting opportunity for family psychologists to be at the forefront of improving the health and behavioral health safety net for families, and influencing practice models and standards in the future of IC. Key initiatives such as the PCMH,
integrated health care, and school-based health clinics, all provide opportunities for the systemic practice of family psychologists. Medical family therapy provides an established and applicable model for practice and training of family psychologists in health care. However, the unique demands of health care delivery within federally funded health care settings such as FQHCs also compel adaptations to the existing training, research, and evidence-based clinical practice of family psychologists. Greater attention is warranted in training, research, and practice to cultural and linguistic competence, brief screening measures of family functioning, family consultation skills, family health promotion and wellness, and even briefer evidence-based interventions that demonstrate an impact on health and well-being. We also urge family psychology to increase the emphasis in training, research, and practice on pediatric primary care, given the strong support for family-centered diagnosis and intervention by the AAP. In summary, health care reform is demanding a more systemic approach to health care delivery. Family psychology has a strong foundation in systemic epistemology and medical family therapy on which to build in responding to the demands of health care reform; however, the future of family psychology in integrated health care will be defined by the contributions of family psychologists not only in direct clinical practice but also in administration, advocacy, training, and research.

References


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