



Intégration de psychologues au sein
d'équipes de médecine familiale

Integration of Psychologists into Family
Medicine Teams

FHT Tool kit

The information contained in this document was taken, in part, from the grant application of the IPEM Study (Integration of Psychologists in Family Medicine Teams) funded by the Ontario Primary Health Care Transition Fund. It aims at providing general information concerning the rationale for including a psychologist in a Family Health Team.

For further details or information, please do not hesitate to contact the principle investigators of the IPEM Study:

Dr. Jean Grenier

Psychologist – Montfort Hospital
Clinical professor - School of Psychology, University of Ottawa
CNFS / Montfort Hospital
713 Montreal Road
Pavilion B
Ottawa, ON
K1K 0T2
Tel. 613-746-4621 (6005)

Dr. Marie-Hélène Chomienne

Family physician
Assistant professor – Department of Family Medicine, University of Ottawa
CNFS / Montfort Hospital
713 Montreal Road
Pavilion B
Ottawa, ON
K1K 0T2
Tel. 613-746-4621 (6015)

Project team

Dr. Marie-Hélène Chomienne: is a lead proponent of the project. She has been a family physician for 20 years and has many years of experience in private practice. She is also an assistant professor at the University of Ottawa's Department of Family Medicine and a researcher affiliated with the University of Ottawa's Population Health Institute and is associated with the Consortium national de formation en santé (CNFS) and the Montfort Hospital as an active member, with clinical, teaching and research responsibilities. She brings to the project her knowledge of the working conditions of family physicians, including the substantial challenge that psychosocial problems present in their practices. She is currently completing her masters in epidemiology and thus brings the necessary rigour to this demonstration project, which requires an epidemiological methodology.

Dr. Jean Grenier: is also a lead proponent of the project. He is a professor at the University of Ottawa's School of Psychology and has a posting as a psychologist at the Montfort Hospital and the CNFS. His responsibilities at the University of Ottawa include supervising doctoral students in clinical psychology as well as teaching doctoral level courses in psychology. At the Montfort Hospital he is director of clinical health psychology and director of training and psychology internships. He also provides psychological services in the hospital setting and is actively involved in interdisciplinary research projects. Dr. Grenier also offers psychological services in private practice on a part-time basis.

Dr. William Hogg: is participating in the demonstration project as a co-proponent. He is a professor and research director at the University of Ottawa. He is a researcher at the University of Ottawa's Population Health Institute and a researcher affiliated with the Ottawa Health Research Institute. He has previously worked in association with a mental health team while in private practice and found the experience highly positive. Dr. Hogg is currently working in a family health network and will assist with the inclusion of a psychologist in this model of practice. He has received over \$8.5 million in grants, most of which have been used to develop demonstration projects relating to primary care in community practice. He will be able to contribute to contribute to the research team with his experience in methodology and data collection and will also coordinate this study with the other projects coming out of the University of Ottawa.

Dr. Pierre Ritchie: is participating in the project as a co-proponent. He is a full professor at the University of Ottawa's School of Psychology. As well, he is Secretary-General of the International Union of Psychology and Executive Director of the Canadian Register for Health Service Providers in Psychology. He has also played various leadership roles in psychology in Canada, the United States and internationally for the past 20 years. He continues to maintain an

active career as a clinician and clinical professor and contributes regularly to publications in the fields of professional ethics, health care and public health care policy.

Rationale for including psychologists in primary care

Introduction

The current situation in primary health care services is disturbing. Canada's population is aging, and patients typically seen in primary care present with multiple medical pathologies intertwined with a complex of psychosocial difficulties. The burden on family physicians has become overwhelming, and despite a number of government incentives, fewer and fewer physicians are going into family medicine (Carms, 2003). We have to be innovative and develop new initiatives, notably models of collaboration among health professionals, to give family physicians an opportunity to collaborate fully with specialists and other health care workers. Such initiatives would lighten the load for family physicians and improve their practice by offering high-quality, effective, equitable medicine.

Given the extent of consultations of a psychosocial nature in family medicine (Shiber, 1990) and the proven effectiveness of psychological intervention for various medical and psychosocial conditions, it makes sense to add the services of a clinician psychologist to a family medicine practice. We hope thereby to promote the development of true interdisciplinary collaboration, in which the principles of proximity, direct access, integration, continuity, coordination and collaboration are recognized as being fundamental and essential. The success of such collaboration will make it possible to maintain a continuum in primary health care services and strengthen the relationship of confidence between patient and family physician.

Such interdisciplinary collaboration, based on these principles, will foster improvement in the areas of: access to services offered by the professional deemed most appropriate; coordination and continuity of care through teamwork; greater patient satisfaction through quicker access to appropriate services, and a shared commitment to the patient's well-being by physician and psychologist; satisfaction for providers through collaboration and shared responsibility for care; and, potentially, cost-effectiveness for the current health care system.

1. Psychosocial problems: central to the practices of family physicians

Psychosocial problems account for a substantial portion of family medicine consultations. Studies show that the proportion may vary between 30% and 50% (Barrett, 1988; Creed, 1990; Shiber, 1990), with some reporting rates as high as 50% to 70% (VandenBos & Deleon, 1988). Moreover, 35% to 50% of patients presenting with psychosocial problems are treated by their family physician (Lesage, 1997; Kates, 2002; Lin, 1996). The family physician is still the first-line health care professional the patient sees for this type of problem (Boerma, 1999) and thus plays a key role in the recognition and treatment of psychosocial problems.

The relevance of the problem appears even more apparent with the results of certain studies, including one showing that nearly 50% of psychosocial problems in patients are never disclosed by the patient or addressed as such by the physician (Bridges, 1985; Gulbrandsen, 1997). Many of these problems manifest themselves in ways such as somatization or repeated and prolonged visits to the patient's family physician. Hence, these visits considerably weigh down the physician's workload. Physicians are quite aware of this situation and feel frustrated at not being able to relieve the patient's condition more effectively and with greater frequency, for various reasons: sometimes because of lack of skills (if they need to perform psychological interventions) or simply lack of time, but as well because of the lack of appropriate, accessible resources to support them (Craven, 1997).

According to Craven's analysis (1997), the impact on a day's practice is not negligible. Consultations fall behind and schedules are upset by unexpected consultations of a psychosocial nature. Psychosocial problems, even if they are sensed by the family physician, are often not broached or documented because of time constraints. In this study, physicians report that they may have up to three therapy sessions not included in their schedule for every day at the office.

When questioned on the subject, the majority of patients indicate that they prefer to be treated by their family physician, even for emotional problems (Hansen, 1987). On the other hand, after a brief twelve weeks of psychotherapy with a psychologist for mild to moderate depression, patients so treated said they were more satisfied than a patient group treated by a family physician (Friedli, 1997).

According to Craven et al. (1997), the majority of family physicians are of the opinion that it is hard to practice medicine that is truly patient centred by trying to isolate the psychological from the physical. They are also reluctant to state that they are offering "psychotherapy" as such, preferring instead to describe their interventions in terms of "counselling" or support therapy.

The economic repercussions of psychosocial difficulties are significant. Stress associated with working conditions leads the list of psychosocial problems that

affect individuals' health (Gulbrandsen, 1997) with the consequences being absenteeism, sick leave, and lower productivity. From a societal and economic point of view, depression is just as incapacitating as cardiovascular disease or rheumatoid arthritis in terms of the cost it represents for the individual and society (Hays, 1995).

In Great Britain, a gradual introduction of mental health professionals into family practice has been taking place over nearly the last twenty years. At present, almost two thirds of family medicine practices have a mental health worker associated with their clinic (Friedli et al., 2000). Physicians respond favourably to this collaboration (Craven, 1997; Murray, 2000), seeing advantages in terms of both their own satisfaction and that of their patients.

In the United States, randomized clinical trials have been conducted to measure the effectiveness of multidimensional treatment (including intervention by a physician and a psychologist) intended to improve the management of depression (Katon, 1996) and attention-deficit hyperactivity disorder in children (Wells, 2000). Katon (1996) shows that patients who have received combined treatment (medical follow-up and cognitive-behavioural psychological treatment given by psychologists) have shown improvement in their compliance with pharmacological treatment and their overall satisfaction with the care received. The results also showed significant improvements in depression. Wells (2000) describes the strategies adopted in the implementation of four different types of psychological treatment (parent training component; school intervention; intensive summer treatment program; community care), some of which was conducted by psychologists, in the context of pharmacological and psychosocial management of attention-deficit hyperactivity disorder in children. Although these studies substantiate the validity and the effectiveness of combining interventions by family physicians with psychosocial interventions conducted by psychologists, they differ from the project proposed here. Our project reflects a medical and clinical reality that is very different from that of the United States, namely the context of two family medical clinics in Ontario. Rather than verify the effectiveness of interdisciplinary treatment modalities for specific problems, our project will endeavour to test a model of interdisciplinary collaboration in the daily operations of family medical clinics.

1.1 Including a psychologist in a Family Health Team

There are seven major reasons in favour of including a psychologist in the primary health care offered in a Family Health Team.

a) ***Psychology and health:*** Psychology puts its expertise to use in the field of mental health as well as in health in the broad sense of the term. In North America, a significant portion of contemporary problems can be attributed to individual behaviour and lifestyle (e.g. anxiety, depression, stress, diabetes, chronic pain, cardiovascular disease, functional problems and somatization).

These major problems cannot be adequately treated without incorporating changes in the individual's psychological, social and behavioural dimensions. The inclusion of psychological and behavioural interventions, judiciously applied, can alter behaviour, improve quality of life, promote illness prevention, and develop patient independence. The health system will then be able to achieve its long-term objectives: enhancing people's well-being and ensuring access to appropriate treatment suited to the patient's needs. This sort of high-quality care will allow long-term costs to be contained.

b) **Convergence between medicine and psychology:** Family medicine and psychology converge on the philosophical level in terms of their conceptualization of the individual and illness in that both adhere to the biopsychosocial model. This philosophical convergence makes the disciplines natural allies and facilitates collaboration between them.

c) **Effectiveness of psychological treatments:** There is an abundance of conclusive empirical evidence that psychological interventions are effective in treating a range of non-psychiatric mental health problems, along with physical health problems (Hunsley, 2002): depression, anxiety, panic disorder, stress, post-traumatic stress, obsessive-compulsive disorder, social anxiety, eating disorders and chronic pain (Chambless & Ollendick, 2001; Nathan & Gorman, 1998, Roth & Fonagy, 1996), along with other chronic conditions that pose a challenge for medicine, such as type 1 diabetes (Hampton et al, 2000), chronic fatigue syndrome (Whiting et al, 2001) and other more nebulous physical symptoms or symptoms unexplained by conventional medicine (Nezu, Nezu & Lombardo, 2001).

d) **Reduction of health care costs:** As discussed by Hunsley (2001), not only are psychological interventions effective in themselves, they also have the potential to reduce costs in the health care system. Some provincial and national associations have recently submitted reports to various government authorities and commissions indicating that psychological services are underused in the health care system and pointing out that the impact of increased access to appropriate psychological services had an effect of reducing health care costs (Canadian Psychological Association, 2001; l'Ordre des psychologues du Québec, 2000; Manitoba Psychological Society, 2001; Saskatchewan Psychological Association, 2001). Other studies show that appropriate psychological intervention for depression (especially cognitive-behavioural psychotherapy) had effects comparable to or better than antidepressants but at significantly lower cost (Antonucci et al, 1997; DeReubis et al, 1999).

Moreover, when given a choice, patients preferred psychological to pharmacological methods in treating anxiety (Walker et al., 2000), hypochondria (Walker et al., 1999), chronic insomnia (Vincent & Lionberg, 2000) and panic disorder (Walker et al., 1993). Unfortunately, in the current operation of the

health care system, access to pharmacological treatment is easier than to psychotherapeutic intervention.

e) ***Psychology and primary health care services:*** As presented by the Ontario Psychological Association as part of a Ministry of Health project on interdisciplinary primary care models (OPA, 1997; Working Group on Interdisciplinary Care Models, 1997), the majority of services offered by psychologists are consistent with the contemporary definition of primary health care services. Increasingly, the scientific literature highlights the importance of prompt care for patients' psychological histories, the correlates and sequelae of a range of problems and illnesses. Psychologists can bring a number of skills to primary care, including their expertise as diagnosticians, psychotherapists, consultants and scientists.

f) ***Fees for psychological services:*** In Ontario, as in the rest of Canada, psychologists' services are not paid for by provincial health insurance plans, with the exception of those services provided in hospital. Access to such services is thus restricted to the private sector; in this sense, they serve a privileged clientele. The inaccessibility of appropriate treatments for health problems whose prevalence is significant is thus disturbing and calls into question the principle of universality upheld by our health care system. It is in part this economic dimension of the problem that this study attempts to short-circuit.

g) ***Rationale for including psychologists:*** While it is acknowledged that many actions have been taken to find solutions in matters of mental health, most of the collaborations referred to involved an association between psychiatrist and family physician (Craven, 1997; Nickels, 1996; Kates, 2002). In the model proposed by Craven, the psychiatrist lends support to the family physician without seeing patients. The work remains unchanged and family physicians thus continue to devote a considerable portion of their schedule to psychosocial problems. In the Nickels model, therapists, in liaison with a psychiatrist, are included in a family medicine clinic. This model requires the mobilization of two new kinds of workers: therapists and psychiatrists, which has the effect of weighing down the model. Although this sort of intervention is definitely necessary in serious, severe and chronic mental health patients who have been reintegrated into the community, it does not meet day-to-day needs in psychosocial health, clinical psychology and health psychology.

The majority of psychosocial problems that fill up family physicians' schedules do not require the specific intervention of a psychiatrist and can definitely be treated by psychologists, the reason we are proposing this demonstration project. The inclusion of psychologists is highly desirable in that they can improve patients' psychosocial problems in a concrete way, an aspect too often prevalent but overlooked.

2. Objectives of demonstration project

The proposed study is a descriptive study with essentially qualitative measures aside from the economic evaluation section. It will be submitted to the ethics and research committee for approval. Four major variables will be studied and analyzed on the basis of the project's outcomes: access to service, quality of patients' lives, quality of physician's practice and quality of collaboration process. Our project assumes that the presence and support of psychologists in family medicine clinics will assist in earlier identification of psychological disorders and in diagnosis, support the therapeutic approach, improve the quality of the care provided to the patient and free up time for family physicians, who could then offer more efficient primary health care. We explain here each of these objectives, which are directly related to the criteria of the Primary Health Care Transition Fund.

- a) ***Improving access to primary health care:*** Studies show there are different reasons limiting referrals to a psychologist (Craven 1995). These may be factors originating with the physician, such as lack of resources in the region of his or her practice, lack of knowledge of the skills relating to the psychologist's practice, or factors specific to the patient: prejudice against the intervention of a psychologist or inability to pay the costs of a private consultation with a psychologist. As Nickels (1996) demonstrated in Rochester, the inclusion of a mental health therapist in the same physical location as patients' regular physicians demystified people's prejudices regarding "mental health" problems. Offering a psychological consulting service opens up access to that portion of the population otherwise deprived of such service for economic reasons.
- b) ***Quantification of psychosocial problems in primary health care:*** In allowing patients to self-refer, we could better serve this part of the disadvantaged population through the health system currently in place. The burden of psychosocial problems is largely underestimated when it is considered that close to 50% of patients do not disclose their problems to their family physician for various reasons. In allowing patients to consult with a psychologist of their own accord, we hope to be able to better understand the true burden posed by the problem.
- c) ***Improving the quality of medical procedures:*** Physicians will have at their disposal, in their clinics, the services of psychologists using empirically proven treatments. We feel that this will noticeably improve the quality of medical procedures.
- d) ***Reducing costs to society:*** Properly conducted evidence-based psychological treatments will give patients the tools they need to make the appropriate behavioural changes that will result in a long-term reduction in relapses, the taking of psychotropic medication, repeated visits to the doctor, and absenteeism at work. Aside from psychosocial problems, physicians will be

able to refer their patients for adjustment difficulties related to chronic illnesses from which their patients suffer – pulmonary disease, coronary disease, diabetes, hypertension – and bring about the appropriate behavioural changes in order to better control these illnesses.

e) ***Importance of an integrating process and interdisciplinary collaboration in primary health care services:*** When psychologists are included in family medicine practices, a better reciprocal understanding of the work done by the two types of professionals will be established, paving the way for an effective dialogue and the creation of new connections. Those working in both professional areas will see their knowledge and skills grow.

f) ***Improvement in satisfaction of patients and health care providers:*** All of these factors taken together will result in an improvement in the well-being of individuals and communities, along with increased satisfaction of both health professionals in question. Prompt availability and accessibility of psychologists in family medicine clinics will enhance the quality of life of family physicians.

Psychology and Psychologists

PSYCHOLOGY AS A PROFESSION

Psychology has been a statutory, self-governing health care profession in Ontario, since 1960.

Ontario psychologists are governed by the Regulated Health Professions Act, 1991 (RHPA) and the Psychology Act, 1991.

A *Psychologist* is a person who is fully licensed for the independent practice of psychology as a member of a provincial or territorial body authorized in legislation to regulate the profession of psychology and who has been granted use of the title “psychologist” by that body.

Psychologist: is a one of six of the 24 professions regulated under the RHPA authorized to communicate a diagnosis.

Psychologist: is one of five RHPA regulated professions authorized to use the title “doctor.”

In Ontario, to be registered to practice autonomously as a *psychologist*, a candidate must hold a doctoral degree in psychology acceptable by the College of Psychologists of Ontario. This typically entails having completed a 4 year Honors Degree and an additional 5 to 6 years of doctoral studies (Ph.D). This totals to approximately 9 to 10 years of university studies and approximately 4000 hours (equivalent to 2 years of full-time practice) of supervised clinical practice. Once a candidate has obtained a doctoral degree, he or she must apply to become a member of the College of psychologists of Ontario and must: 1) complete an additional 2000 hours of post-doctoral supervised practice; 2) pass the Examination for Professional Practice in Psychology (EPPP); 3) pass the College's Jurisprudence and Ethics Examination; and 3) pass the College's final oral examination. In essence, the entire process to autonomous practice takes approximately 10 to 11 years to complete.

Psychologists are trained in various practice areas. Pertinent examples for Family Health Teams include Clinical Psychology and Health Psychology. The College of Psychologists offers the following definitions:

Clinical Psychology

All members of the College of Psychologists require the following minimum working knowledge base:

- knowledge in the foundational content areas of psychology, i.e., the biological bases of behaviour, the cognitive affective bases of behaviour, the social bases of behaviour, and the psychology of the individual;
- knowledge of learning;
- knowledge of all relevant ethical, legal and professional issues;
- knowledge of research design and methodology;
- knowledge of statistics; and,
- knowledge of psychological measurement.

Clinical Psychology is the application of knowledge about human behaviour to the assessment, diagnosis and/or treatment of individuals with disorders of behaviour, emotions and thought.

In addition to the above minimum knowledge base, members practising Clinical Psychology require the following:

- knowledge of psychopathology/abnormal psychology;
- knowledge of personality/individual differences;
- knowledge of psychological assessment;
- knowledge of psychodiagnostics;
- knowledge of intervention procedures/psychotherapy; and,
- knowledge of evaluation of change.

In addition, practitioners who provide services in Clinical Psychology to children and adolescents must have a background in developmental psychology and knowledge of appropriate assessment and therapeutic techniques.

For members practising Clinical Psychology, the following minimum skills are required:

- the ability to perform an appropriate clinical assessment;
- the ability to formulate and communicate a differential diagnosis; and,
- the ability to plan, execute and evaluate an appropriate treatment program.

Health Psychology

All members of the College of Psychologists require the following minimum working knowledge base:

- knowledge in the foundational content areas of psychology, i.e., the biological bases of behaviour, the cognitive affective bases of behaviour, the social bases of behaviour, and the psychology of the individual;
- knowledge of learning;
- knowledge of all relevant ethical, legal and professional issues;
- knowledge of research design and methodology;
- knowledge of statistics; and,
- knowledge of psychological measurement.

Health Psychology is the application of psychological knowledge and skills to the promotion and maintenance of health, the prevention and treatment of illness, and the identification of determinants of health and illness.

In addition to the above minimum knowledge base, members practising in Health Psychology require the following:

- knowledge of normal lifespan development;
- knowledge of psychopathology/abnormal psychology;
- knowledge of personality/individual differences;
- knowledge of psychological assessment;
- knowledge of psychodiagnostics;
- knowledge of intervention procedures/psychotherapy;
- knowledge of evaluation of change; and,
- knowledge of behavioural medicine and psychological issues related to health.

In addition, practitioners providing services in Health Psychology to children and adolescents must have a background in developmental psychology and knowledge of appropriate assessment and therapeutic techniques.

For members practising Health Psychology, the following minimum skills are required:

- the ability to perform an appropriate assessment;
- the ability to formulate and communicate a differential diagnosis; and
- the ability to plan, execute and evaluate an appropriate prevention and/or treatment program.

EVIDENCE-BASED PSYCHOLOGICAL TREATMENTS

Examples of disorders for which there exists ***evidence-based psychological treatments***:

- Agoraphobia
- Panic disorder
- Specific phobias
- Generalized anxiety
- Obsessive Compulsive Disorder
- PTSD
- Social anxiety/phobia
- Major depression
- Geriatric depression
- Personality disorders (Borderline)
- Post-partum depression
- Alcoholism
- ADHD
- Hypochondria
- Chronic pain
- Chronic fatigue
- Irritable Bowel Syndrome
- Sexual Dysfunction
- Sleep disorders
- Chronic Insomnia
- Eating Disorders
- Smoking cessation

PSYCHOLOGISTS' ROLES IN PRIMARY CARE

The following information is an excerpt from a document entitled "Psychological Services in Primary Care" prepared by the Ontario Psychological Association's Working Group on Interdisciplinary Care Models for the Ontario Ministry of Health and Long Term Care, Toronto, Ontario, 1997.

1. Professional role

1.1 Principles

Ontario psychologists are committed to working with patients and all primary care partners as well as the Minister and Ministry of Health to establish the most appropriate roles for psychological services in PCAs based on the principles of patient choice, rational utilization and evidence-based decision making. These elements are closely associated with the tenets and values which have always characterized approaches to care offered by psychologists.

All health professionals have a responsibility to promote the most effective use of the expertise found among the various regulated health professions. Psychologists expect themselves and others to be proactive in providing information and education on the expertise and services which can best meet patients' acute and preventive health needs. This can be accomplished, and the resultant fiscal benefits achieved, only when patients and all primary care provider partners have direct access to each other.

1.2 Scope of practice

The Psychology Act (1991) defines the profession's scope of practice broadly, including the authorized act of diagnosis. (See Appendix II for the pertinent extract from the Act). It would be clearly inaccurate to characterize all the clinical services provided by psychologists as properly falling within the aegis of primary care. Indeed, it will be vital to the success of primary care reform to ensure that primary care roles are well defined for health professions like medicine, nursing, physiotherapy, and psychology with scopes of practice that span primary and tertiary care.

Most clinical services provided by, or under the direction of, most health service psychologists fall within contemporary definitions of primary care. The empirical literature increasingly underscores the importance of promptly addressing the psychological antecedents, correlates and sequelae of a wide range of disease, injury and illness (e.g., Lipsey & Wilson, 1993 review more than 300 published meta-analyses with effectiveness of psychological treatment established for entities ranging as broadly as depression, Raynaud's disease and cardiovascular disorders). Equally compelling in the current fiscal climate is the cost-

effectiveness of psychological interventions. (See Linden, 1995 for a summary of current evidence and cost-benefit ratios.)

1.3 A further confound for some professions, of which psychology is one, is that some of the services properly construed as primary care have been historically provided in tertiary care settings (e.g., hospitals). Notwithstanding the current downsizing of tertiary care facilities, psychologists and others will continue to deliver services which clearly are part of tertiary care; they do not belong in the realm of primary care (e.g., sophisticated neuropsychological diagnosis and initial psychological rehabilitation of closed head injury patients). A different example is pre-operative psychological intervention for defined surgical procedures. The efficacy of brief psychological intervention (based on defined health and fiscal outcomes; e.g., rate of return to healthy functioning, post-op hospital days) is now well established (e.g., see Linden, Stossel, & Maurice, in press, for a meta-analysis of patients with coronary artery disease). Depending on local/regional tertiary resources, this type of intervention could be provided by psychologists in a PCA in advance of scheduled surgery.

2. Competencies

Psychologists bring several specific competencies to primary care. Rather than catalogue specific disorders which would ultimately be a lengthy list of DSM-IV Axis I & II entities plus others from ICD, the generic roles which contribute directly to the provision of primary care services will be emphasized in this brief document.

2.1 Diagnosis

Expertise as **diagnosticians** is a major clinical service that psychologists will provide to PCAs. This will occur in two ways.

2.1.1 Given the high prevalence of psychological factors associated with accessing community based health care settings, it will be crucial to do very good job in **determining the real nature of the problem** and to **put the proper course of care or treatment in place expeditiously**.

In traditional settings, diagnostic utilization patterns often consider the psychological factor only after other, usually considerably more expensive diagnostic procedures are pursued. This is neither cost-effective nor good patient care. Major reasons are that psychologists have not been easily accessible to physicians and nurses (let alone to other health care professionals who themselves are frequently not readily accessible), their community based services have not been publicly funded, precluding assistance to many non-privately insured persons. In addition, psychologists, like other health

professionals have not been reimbursed/reinforced/encouraged to informally consult each other providers of care.

While it will be unquestionably appropriate from the perspective of good patient care that psychologists actually see patients for diagnostic consultation, it is equally likely that as many or more patients will benefit from another primary care professional's consultation with a psychologist around a diagnostic question. This will be one of the key benefits of working within or being rostered with a CPC-oriented PCA.

2.1.2 In most instances where the psychological dimension is the principle diagnostic question, the psychologist also will be the most effective **coordinator of the diagnostic process**. For both quality of care and cost-effectiveness, this will be particularly important **when the psychological dimension is both the most probable feature to be investigated and where the level of diagnostic complexity is moderate to high**.

Instances where the diagnostic complexity is low may sometimes be better coordinated by another provider. In this respect, further clarity of role definitions in PCAs will be required for all professions which have been authorized under the Regulated Health Professions Acts to perform the controlled act of diagnosis. This should not preclude full participation in the diagnostic process of other health professions who provide considerable assessment expertise within their scopes of practice and areas of competence.

2.2 Treatment

Competencies in treatment are a second major area of direct and indirect service. Treatment needs will vary depending on case-mix, as well as other demographic and local factors. For example, where an established children's mental health centre exists, there should be no duplication of service. Community linkages are the PCA's preferred treatment option for most elements of sustained mental health treatment of children and related family components.

Some elements of psychological treatment will be constant across PCAs. For all direct patient intervention, the emphasis will be on short-term, empirically validated approaches. Where efficacy has so established, group therapy will be the preferred treatment modality. However, timely utilization of individual, couple or family psychotherapies will also be core primary care treatment services.

2.2.1 The advanced skills in psychotherapy of psychologists will be required for persons presenting diagnostically with multiple psychological factors who are amenable to treatment within a primary care setting, for those with concurrent serious medical and psychological problems, and for those for whom the treatment issues are complex and multi-faceted.

2.2.2 Depending on the qualifications of other psychological personnel, psychologists may or may not have to provide treatment supervision. It would be preferable to utilize psychological associates since they are also regulated by the College of Psychologists of Ontario and may practice autonomously within their scope of practice. However, there may be instances when non-regulated personnel with appropriate training and experience will be employed by a PCA for the provision of mental health services. Supervisory arrangements will then need to be put in place.

2.3 Treatment Planning

A substantial part of psychologists' treatment services will be in the form of consultation to other providers. This will be particularly the case for well-established, structured treatments which can be appropriately and effectively be provided by sub-doctoral personnel, especially when the diagnosis is uncomplicated and the prognosis is generally favourable. In these instances, the higher cost of using psychologists is not justified. However, consultation on treatment planning, will be a particularly important service to them and to all health professionals in the PCA who provide some element of mental health intervention in their plan of care.

2.4 Health promotion and disease prevention

Critical to the success (clinical outcomes, cost-effectiveness, health status, patient satisfaction) of a CPC-driven PCA will be activities centred on health promotion and prevention. Historically, this has been the missing element in all health care. Psychologists have been leaders in developing large-scale community based prevention and health promotion programs.

Beyond including prevention and promoting healthy behaviours at a molecular level in their clinical activities (expected of all practitioners in a PCA), psychologists can be especially useful in the design, adaptation and refinement of broader PCA sponsored prevention and health promotion programs (e.g., for persons presenting with higher risks for cardiovascular disease).

2.5 Applied Research

The capacity to conduct good quality in-house applied research will increasingly be a standard feature of most health care settings. PCAs will be confronted with a considerable challenge in this area since few primary care providers receive any substantial research training. For most health disciplines, virtually all their research expertise is based not only in tertiary settings, but is even more concentrated in those facilities with a university affiliation. A value-added feature which psychologists bring to primary care is their advanced education as applied scientists. It is the applied dimension, particularly in needs assessment, outcome evaluation and clinical research, that will be especially useful in PCAs. This can

benefit both clinical as well as broader prevention and health promotion programs.

References

Reference list is broader than the authors listed in this document.

1. Antonuccio DO, Thomas M, WG. D. A cost-effectiveness analysis of cognitive behavior therapy and fluoxetine. *Behavior Therapy* 1997;28:187-210.
2. Barrett JE, Barrett JA, Oxman TE, Rogers W, Spritzer K. The prevalence of psychiatric disorders in primary care practice. *Archives of General Psychiatry* 1988;45:1100-6.
3. Boerma WG, PF. V. The general practitioner as the first contacted health professional by patients with psychological problems: a European study. *Psychological Medicine* 1999;29(3):689-96.
4. Bridges KW, D G. Somatic presentation of DSM-III psychiatric disorders in primary care. *journal* 1985.
5. Canadian, Psychological, Association. Putting human behaviour at the heart of health care in Canada. Ottawa, Ontario, 2001.
6. CaRMS. Canadian Resident Matching Service Cumulative Data. 2003.
7. Craven MA, Allen CJ, N. K. Community resources for psychiatric and psychosocial problems.family physicians' referral patterns in urban Ontario. *Canadian Family Physician* 1995;41:1325-35.
8. Craven MA, Cohen M, Campbell D, Williams J, N. K. Mental health practices of Ontario physicians: a study using qualitative methodology. *Canadian Journal of Psychiatry* 1997;42(9):943-949.
9. Creed F, Gowrisunkur J, Russell E, Kincey J. general practitioner referral rates to district psychiatry and psychological services. *British Journal of Psychiatry* 1990;40:450-4.
10. EuroQol, Copyright, Group. EuroQol-a new facility for the measurement of health related quality of life. *Health Policy* 1990;16:199-208.
11. Friedli K, King M, Llyod M, J H. Randomised controlled assessment of non-directive psychotherapy versus routine general-practitioner care. *The Lancet* 1997;350:1662-65.
12. Friedli K, King M, M. L. The economics of employing a counsellor in general practice: analysis of data from a randomised controlled trial. *British General Practice* 2000;50(453):276-83.
13. Fyke, Report, Care: SttscoH, medicare. rtfrotSCo, Regina S. Saskatchewan Psychological Association. 2001.
14. Gulbrandsen P, Fugelli P, P. H. Psychosocial problems presented by patients with somatic reasons for encounter: tip of the iceberg? *Family Practice* 1997;15:1-8.

15. Hansen JP, Bobula J, Meyer D, Kushner K, K. P. Treat or refer: Patients' interest in family physician involvement in their psychosocial problems. *The Journal of Family Practice*. 1987;24(5):499-503.
16. Holroyd KA, O'Donnell FJ, Stensland M, Lipchik GL, Cordingley GE, BW. C. Management of chronic- type headache with tricyclic antidepressant medication, stress management therapy, and their combination: a randomized controlled trial. *Journal of the American Medical Association* 2001;285:2208-15.
17. Hays R, Wells K, Sherbourne C, Spritzer K. Functioning and well-being outcomes of patients with depression compared with chronic general medical illness. *Archives of General Psychiatry* 1995;52(11-9).
18. Lambert M, Okiishi J, Finch A, L. J. Outcome assessment: from conceptualisation to implementation. *Professional Psychology: Research and Practice* 1998;29(1):63-70.
19. Lesage AD, Goering P, E. L. Family physicians and the mental health system. Report from the Mental Health Supplement To the Ontario Health Survey. *Canadian Family Physician* 1997;43:251-6.
20. Lin E, Goering P, Offord D, Campbell D, MH. B. The use of mental health services in Ontario: epidemiologic findings. *Canadian Journal of Psychiatry* 1996;41:572-7.
21. Kates N. Shared Mental Health. *Canadian Family Physician* 2002.
22. L'ordre, des, psychologues, du, Québec. Pour une transformation optimale des pratiques de santé: la contribution des psychologues. Montréal, QC. 2000.
23. Manitoba, Psychological, Society. Position on access to psychological services in Manitoba. Winnipeg MN. 2001.
24. Chambless DL, Ollendick TH. Empirically supported psychological interventions: controversies and evidence. *Annual Review of Psychology* 2001;52:685-716.
25. de Reubis RJ, Gelfand LA, Tang TZ, Simons AD. Medication versus cognitive-behavioral therapy for severely depressed outpatients: Meta-analysis of four randomized comparisons. *American Journal of Psychiatry* 1999;156(1007-13).
26. Murray GC, Sharp KM, Quigley A, K. M. An evaluation of primary care psychotherapies clinic. *Scottish Medical Journal*. 2000;45(6):174-6.
27. Nickels MW, JS. M. A model for psychiatric services in primary care settings. *Psychiatric Services* 1996;47(5):522-26.
28. Nezu AM, Nezu CM, ER. L. Cognitive-behaviour therapy for medically unexplained symptoms: A critical review of the treatment literature. *Behavior Therapy* 2001;32:537-83.
29. Ontario, Psychological, Association. Psychological Services in Primary Care, présenté dans le cadre du projet du ministère de la Santé sur les modèles interdisciplinaires de soins primaires, Toronto. 1997.
30. Roth AD, P F. What works for whom? A critical review of psychotherapy research. New York : Guilford.s, 1996.
31. Shiber A, Maoz B, Atonovsky A, Atonovsky H. Detection of emotional problems in the primary care clinic. *Family Practice* 1990;7:195-200.

32. Vincent N, C L. Treatment preference and patient satisfaction in chronic insomnia. *Sleep* 2001;24(4):411-7.
33. Walker J. Relative costs of pharmacological and psychological treatments for anxiety and depression. *Canadian Clinical Psychologist* 1999;10(1):6-7, 9-11.
34. Walker J, Eldridge GD, Hazen AL, GR. N. Self reported preference for type of treatment for panic disorder. Presented at the Anxiety Disorders' Association of America. Santa Monica,CA. 1993.
35. Walker J, Joyce B, Furer P, Vincent N, Kjernsted K. Facilitating informed decision-making:A survey of patients referred to a speciality anxiety program. Presented at the Annual Conference of Anxiety Disorders of America. Washington DC. 2000.
36. Walker J, Vincent N, Furer P, Cox B, K. K. Treatment preference in hypochondriasis. *Journal of Behavior Therapy and Experimental Psychiatry* 1999;30:251-8.
37. Whiting P, Bagnall AM, Sowden AJ, Cornell JE, Mulrow CD, G. R. Intervention for the treatment and management of chronic fatigue syndrome: A systematic review. *Journal of the American Medical Association* 2001;286:1360-68.
38. Working group on interdisciplinary care models. *Interdisciplinary Primary Care Models -final version;préparé pour le ministère de la Santé, Toronto.* 1997.
39. Nathan PE, Gorman JM. *A guide to treatments that work.* New York: Oxford University Press, 1998.
40. Hampton SE, Skinner TC, J H. Behavioral interventions for adolescents with type 1 diabetes: How effective are they? *Diabetes Care* 2000;23:416-22.
41. Gulbrandsen P, Hjortdahl P, P. F. General practitioners' knowledge of their patients' psychosocial problems: multipractice questionnaire survey. *British Medical Journal* 1997;314:1014.
42. Van den Bos GR, PH. D. The use of psychotherapy to improve physical health. *Psychotherapy* 1988;25:335-343.
43. Hunsley J. The cost-effectiveness of psychological interventions. Reprt commisioned by the Canadian Psychological Association. 2002.
44. Katon W, Robinson P, Von Korff M, Lin E, Bush T, Ludman E, Simon G, Walker E. A Multifaceted Intervention to Improve Treatment of Depression in Primary Care. *Arch Gen Psychiatry* 1996; 53: 924-932.
45. Wells KC, Pelham We, Kotkin RA, et al. Psychosocial Treatment Strategies in the MTA Study : Rationale, Methods and Critical Issues in Design and Implementation. *Journal of Abnormal Child Psychology* 2000; 28(6): 483-505.