Divided No More: Psychology’s Role in Integrated Health Care

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Abstract
Health-care providers increasingly recognize the need to address behavioural and emotional influences on physical health in order to provide quality and cost-effective services. As behaviour change experts, psychologists can be critically important in new models of integrated care that focus on both physical and psychological health. However, to be effective, psychologists must be prepared to address the major issues facing health-care systems today and be willing to re-examine and modify current modes of education and practice. This article describes important trends affecting health care and the ways in which psychologists could contribute. Lastly, two psychologists involved in new models of integrated care describe their training and the challenges and rewards of their current activities.

An Historical Public Health Perspective

Good health is the bedrock on which social progress is built. A nation of healthy people can do those things that make life worthwhile, and as the level of health increases so does the potential for happiness. The Governments of the Provinces and of Canada have long recognized that good physical and mental health are necessary for the quality of life to which everyone aspires. Accordingly they have developed a health care system which, though short of perfection, is the equal of any in the world.... At the same time as improvements have been made in health care, in the general standard of living, in public health protection and in medical science, ominous counter forces have been at work to undo progress in raising the health status of Canadians.... For these environmental and behavioural threats to health, the organized health care system can do little more than serve as a catchment net for the victims. Physicians, surgeons, nurses and hospitals together spend much of their time in treating ills caused by adverse environmental factors and behavioural risks. It is evident now that further improvements in the environment, reductions in self-imposed risks, and a greater knowledge of human biology are necessary if more Canadians are to live a full, happy, long and illness-free life.... The Government of Canada now intends to give to human biology, the environment and lifestyle as much attention as it has to the financing of the health care organization so that all four avenues to improved health are pursued with equal vigour. Its goal will continue to be not only to add years to our life but life to our years, so that all can enjoy the opportunities offered by increased economic and social justice. (Lalonde, 1974, pp. 5-6)

This policy document contained a number of highly relevant observations regarding the fundamental questions before us today. Its relative silence, however, on the explicit potential role and contributions of Canada’s health professions’ educational institutions must not be overlooked.

In most minds the health field and the personal medical care system are synonymous. This has been due in large part to the powerful image projected by medicine of its role in the control of infective and parasitic diseases, the advances in surgery, the lowered infant mortality rate and the development of new drugs. This image is reinforced by drug advertising, by television series with the physician as hero, and by the faith bordering on awe by which many Canadians relate to their physicians. (Lalonde, 1974, p. 11)

And yet, there is also the clear recognition of the potential role that psychology can play.
Past improvement has been due mainly to modification of behaviour and changes in the environment and it is to these same influences that we must look particularly for further advance (p. 13)…When the full impact of environment and lifestyle has been assessed, and the foregoing is necessarily but a partial statement of their effect, there can be no doubt that the traditional view of equating the level of health in Canada with the availability of physicians and hospitals is inadequate. (Lalonde, 1974, p. 18)

Extraordinarily strong words from the highest government public health official of Canada.

The Lalonde report (1974) continued: “It is estimated that about half the burden of illness is psychological in origin and this proportion is growing…. And yet mental health, as opposed to physical health, has been a neglected area for years; unfortunately there is still a social stigma attached to mental illness” (p. 25). Interestingly, the first of five proposed national strategies was: “A Health Promotion Strategy aimed at informing, influencing and assisting both individuals and organizations so that they will accept more responsibility and be more active in matters affecting mental and physical health [which included an]…. (I)nterest in the awareness of health professionals of factors affecting physical fitness” (pp. 66-68). The Research Strategy discussion recommended: “An ongoing dialogue between health planners and the research community on the priorities for mission-oriented health research while preserving for the research community the setting of priorities in basic research” (p. 69). The Health Care Efficiency Strategy proposed: “Support for programs for increasing the number and skills of professions dealing with mental health and mental illness including particularly nurses, social workers, health educators and teachers” (pp. 70-71). This section further recommended making continued federal health professional training support conditional upon ensuring better geographical and patient economic-level distributions, as well as encouraging efforts to diminish the time between the latest medical knowledge discoveries and the application of that knowledge in the practice of medicine. However, in our judgment, it is also highly significant that there was essentially no express recommendation for taking a careful and systematic look at reshaping the fundamental structure of health professional training programs or their historical priorities.

Approximately five years later, the Surgeon General of the United States issued a very similar health policy document: Healthy People: the Surgeon General’s Report on Health Promotion and Disease Prevention (U.S. Department of Health, Education, and Welfare, 1979). Once again, the critical importance of prevention, lifestyle, and the behavioural sciences, as well as the psychological aspects of health care were emphasized.

Let us make no mistake about the purpose of this, the first Surgeon General’s Report on Health Promotion and Disease Prevention. Its purpose is to encourage a second public health revolution in the history of the United States. And let us make no mistake about the significance of this document. It represents an emerging consensus among scientists and the health community that the Nation’s health strategy must be dramatically recast to emphasize the prevention of disease…. Clearly, the next public health revolution must be aimed at these new killers and cripplers. And clearly it makes sense in that revolution to emphasize strategies for preventing these afflictions, rather than relying entirely on treating them after they have already struck. Not to find and employ those strategies would be irresponsible…. But we are a long, long way from the kind of national commitment to good personal health habits that will be necessary to change drastically the statistics about chronic disease in America. (U.S. Department of Health, Education, and Welfare, 1979, p. vii-ix)

Some of the highlights of the U.S. Surgeon General’s report (U.S. Department of Health, Education, and Welfare, 1979) include:

Prevention is an idea whose time has come. We have the scientific knowledge to begin to formulate recommendations for improved health. And, although the degenerative diseases differ from their infectious disease predecessors in having more – and more complex – causes, it is now clear that many are preventable. (p. 7)

In fact, of the 10 leading causes of death in the United States, at least seven could be substantially reduced if persons at risk improved just five habits. (p. 14)

Psychological expertise is conceptualized as possessing a major role.

To imply, therefore, that personal behavior choices are entirely within the power of the individual is misleading. Yet, even awareness of risk factors difficult or impossible to change may prompt people to make an extra effort to reduce risks more directly under their control and thus lessen overall risk of disease and injury. Healthy behavior, including judicious use of preventive health care services, is a significant area of individual responsibility for both personal and family health. (p. 18)

Healthy People (U.S. Department of Health, Education, and Welfare, 1979, p. 141) concluded that:
Americans are becoming healthier people – but more can be achieved.... To reach these goals will require a national effort and the commitment of people extending far beyond what we traditionally consider the health sector. No single segment of society can accomplish them alone. Unnecessary death and disability can be prevented – and better health can be maintained – only through a partnership that involves the serious commitment of individual citizens, the communities in which they live, the employers for whom they work, voluntary agencies, and health professionals. Government agencies at all levels must encourage and bolster their efforts. How to move expeditiously toward the goals of prevention is the challenge for the years to come.

Once again, however, as was the case with the Lalonde report, there were very few, if any, concrete suggestions as to ways in which the American health professions’ educational system could become involved.

Health professionals. Physicians, nurses, and other health professionals have a particular opportunity and obligation to provide information and services necessary to promote better health and prevent disease.... These professionals need to be trained to view themselves as educators and models, as well as practitioners of a particular discipline.... Responsibility for implementing the newer approaches to health promotion and disease prevention has for the most part rested everywhere, and thus nowhere. (U.S. Department of Health, Education, and Welfare, 1979, pp. 143-145)

Health Policy Reflections

During the 25 years that have transpired since the issuance of these two thought-provoking and highly futuristic health-policy documents, there has been considerable progress in the manner in which health care is being delivered in both Canada and the United States, as well as evidence of the beginning of a fundamental appreciation and re-conceptualization as to the relevance of emotional and behavioural elements in the definition of “quality” health care, and, equally importantly, the potential leadership role of health professions training institutions. We feel that it is very important for health professions educators to reflect, from time to time, upon the “bigger picture” (Kenkel, DeLeon, Albino, & Porter, 2003). To collectively wonder: How will their graduates practice and meaningfully contribute in the health-care systems of the future? This is an educator’s societal responsibility.

Within the United States, the Congress and health policy experts have historically given considerable credence to the deliberations and recommendations of the Institute of Medicine (IOM). The IOM was established in 1970 by the National Academy of Sciences in order to secure the services of eminent members of appropriate professions in the examination of policy matters pertaining to the health of the public. The IOM acts under the responsibility given to the National Academy of Sciences by its congressional charter to be an adviser to the federal government and, upon its own initiative, to identify issues of medical care, research, and education.

In 2001 the IOM released its report Crossing The Quality Chasm: A New Health System For The 21st Century. The IOM highlighted the importance and inevitability of educated consumers ultimately taking control over their own health destinies. And, noted that: (H)ealth care delivery has been relatively untouched by the revolution in information technology that has been transforming nearly every other aspect of society.... Although growth in clinical knowledge and technology has been profound, many health care settings lack basic computer systems to provide clinical information or support clinical decision making. The development and application of more sophisticated information systems is essential to enhance quality and improve efficiency.... The Committee believes information technology must play a central role in the redesign of the health care system if a substantial improvement in quality is to be achieved over the coming decade. (Institute of Medicine, 2001, pp. 15-16)

The IOM (2001, p. 155) further noted that: “(T)he lag between the discovery of more efficacious forms of treatment and their incorporation into routine patient care is unnecessarily long, in the range of about 15 to 20 years. Even then, adherence of clinical practice to the evidence is highly uneven.” It has been our experience that the same can unfortunately be said for the health-care system’s (and society’s) appreciation of the critical importance of the psychosocial-cultural-economic gradient to quality health care, an observation that should be of paramount importance to psychology’s educators.

It is within this broader context that American President George W. Bush and APA President Ron Levant have each recently commented upon, from their own unique perspectives, changes in the status quo that they feel must soon evolve. The President:

Yesterday I talked about ways for us to make sure America stays... a leader in the world, particularly when it comes to technology and innovation. That’s what we want. We want to lead. We’re not interested in following. America is a nation where the entrepreneurial spirit is strong, where the focus of the Government, in my judgment, is right. We’re
willing to spend research money…. The way I like to kind of try to describe health care is, on the research side, we’re the best. We’re coming up with more innovative ways to save lives and to treat patients. Except when you think about the provider’s side, we’re kind of still in the buggy era…. And the health care industry is missing an opportunity…. It’s like IT, information technology, hasn’t shown up in health care yet. (Bush, April, 2004, pp. 698-699)

APA President Ron Levant remarked that:

The historical separation of physical from mental throughout our health care system is precisely the problem that my ‘Health Care for the Whole Person’ Presidential initiative was designed to solve. By collaborating with a broad range of health care organizations on a public statement on the role of psychology in health care, I hope to promote the integration of physical and psychological health care in a reformed health care system in which health care professionals team up to treat the whole person. I have been working with Dr. Margy Heldring, the chairperson of my Health Care for the Whole Person Presidential initiative, for many months, talking with leaders of key health care groups, including physicians groups, other provider groups, consumer groups, and health policy groups. We have found a tremendous degree of enthusiasm for, and consensus on, the importance of integrating behavioral science into the very heart of health care, and of delivering health care through multi-disciplinary teams using the biopsychosocial model. So far, the following groups have become partners with the APA in the Health Care for the Whole Person Presidential initiative: the American College of Nurse Practitioners, American Nurses Association, American Public Health Association, Association of Academic Health Centers, Center for the Advancement of Health, Consumers Union, Families USA, National Association of County and City Health Officials, and the Society for Behavioral Medicine. (Ronald Levant, personal communication, April 2005)

There have been multiple calls for psychology to redefine itself as a “health profession.” To be effective in this new role, psychology must be active in, and responsive to, the major health-care trends and issues. This article outlines our collective view as to some of the major opportunities and challenges in health care and describes their impact on behavioral health care and the activities of psychologists. We also will discuss how psychological knowledge, research, and interventions can be used to address these critical issues in health care. Under APA President Norine Johnson’s leadership, the APA membership voted in 2001 to expressly include “health” in the association’s underlying mission statement. This was a major step forward into the changing health-care environment of the 21st century. Nevertheless, we can appreciate that this will not be an easy transition for many of our colleagues, especially for those employed within traditional academic institutions. And, it is important for all of us to realize that psychology is not alone in facing the challenges (or opportunities) of the new century.

In 2003 in the Health Professions Education: A Bridge To Quality, the IOM expressed its view that:

the reform of health professions education is critical in enhancing the quality of health care in the United States… that any such reform effort must encompass all health professionals, recognize each profession’s contribution, and include those outside education who, to more and lesser degrees, shape what health professionals are taught (p. ix) ...Education for the health professions is in need of a major overhaul. Clinical education simply has not kept pace with or been responsive enough to shifting patient demographics and desires, changing health system expectations, evolving practice requirements and staffing arrangements, new information, a focus on improving quality, or new technologies… All health professionals should be educated to deliver patient-centered care as members of an interdisciplinary team, emphasizing evidence-based practice, quality improvement approaches, and informatics. (Institute of Medicine, 2003, pp. 1-3)

Health professionals of all disciplines must be committed to lifelong learning experiences, appreciate the importance of moving towards competency-based approaches to education, and embrace truly interdisciplinary educational and service delivery experiences. The development of a common language across disciplines with the ultimate aim of achieving consensus on a core set of competencies is an absolute necessity. This will not be easy.

Significant reform in health professions education is a challenge to say the least. The oversight framework is a morass of different organizations with differing requirements and philosophies, now under considerable pressure to demonstrate greater accountability…. In academia, deans, department chairs, residency directors, and other leaders face a stream of requests for adding new elements to a curriculum that is already overcrowded. (Institute of Medicine, 2003, p. 12)

And yet, the IOM emphasizes that:

(M)ost important, professionals will need to break down the silos that exist within the system, and seek to understand what others offer in order to do what is best for the patient. (p. 37)
The absence of a common language, differing philosophies, politics, and turf battles across the professions remain the norm. This situation is exacerbated by the fact that in the vast majority of educational settings, health professionals are socialized in isolation, hierarchy is fostered, and individual responsibility and decision making are relied upon almost exclusively. Health professions education occurs largely in an environment of separately housed professional schools and separate clinical arenas governed by powerful separate deans, directors, and department chairs. (p. 79)

Although perhaps unsettling to many, dramatic change in the status quo is necessary. In another report, the IOM (Institute of Medicine, 2002, pp. 1-2) expressed the view:

The American health care system is confronting a crisis…. The health care delivery system is incapable of meeting the present, let alone the future needs of the American public…. Yet despite some laudable examples of integrated care, the delivery system consists of silos, often lacking even rudimentary information capabilities to exchange patient information, coordinate care across settings and multiple providers, and ensure continuity of care over time.

Current Health Care Issues

What are the major health-care issues facing us today? Concerns over rising health-care costs continue to spur many of the trends and initiatives in health care. Efforts to contain costs and reduce expensive health-care treatments have prompted new directions, including: 1) a growing recognition of the importance of lifestyle factors on health and a shift to preventive care; 2) the development of innovative treatment for chronic conditions; 3) an increase in technology utilization; and 4) a shift to primary care and a greater use of nonphysician providers, particularly nurse-practitioners, physician assistants, and clinical pharmacists.

Another major trend in health care is increasing consumer activism (Porter Research and Solutions, 2003). Consumers have become more knowledgeable about and involved in their health care. As a result of consumer activism, a heightened emphasis on quality care and accountability has emerged. When quality care concerns are combined with cost containment efforts, the result has been such initiatives as: 1) integrated or collaborative care models; 2) the use of evidence-based clinical guidelines; 3) attempts to resolve disparities in health-care treatment; and 4) attempts to increase patient safety and reduce medical errors. This paper will address the impact of these issues on the role of psychologists as health professionals.

Preventive Care

As health-care costs continue their upward trend, there is a growing recognition that the best way to control costs is through good preventive care and routine screenings for early detection of problems. The U.S. and Canadian populations are growing older due to the aging of the Baby Boom generation. As people age, they experience more chronic illnesses and use more health services. To counteract these trends, health services funders, rather than continuing the dominant model of treating conditions once they appear, increasingly are paying for a number of regularly scheduled health screenings and diagnostic tests (e.g., mammograms, pap smears, colonoscopies, stress tests, and diabetes screenings), as well as providing websites and newsletters with health promotion information and discounts on health club memberships, weight control programs, and smoking cessations groups.

Research has consistently identified certain lifestyle factors – lack of exercise, weight, diet, smoking, and stress – as being associated with multiple medical illnesses. Positive changes in these lifestyle behaviours can prevent the occurrence of various conditions as well as ameliorate the negative impacts of chronic diseases. Additionally, the presence of mental health conditions is associated with increased morbidity and mortality in a number of medical conditions (cf. Druss, Rohrbaugh, & Rosenheck, 1999; Frasure-Smith, Lesperance, & Talajic, 1993). Diagnosing and intervening with these mental health problems can lead to better physical health outcomes.

Health-care payers are not the only ones interested in preventing illness. Consumers themselves are more involved and knowledgeable about their health care and their health-care options. Easily accessible and comprehensive information on health conditions and treatments via the Internet and other media, direct marketing of pharmaceuticals to consumers, and competition among health providers have all contributed to making health consumers more knowledgeable, empowered, and demanding.

What do psychologists have to offer in this arena? Clinical-community psychologists historically have advocated for mental health prevention methods. They have instituted programs in the schools and the community that seek to prevent mental health problems before they begin, as well as other programs focused on early identification and treatment of mental health problems. Additionally, psychologists have long advocated for mental health prevention and promotion efforts in public health policies (Lorion, Myers, & Bartels, 1994). In Canada, The Mental Health Promotion Unit (MHPU) was created in 1995...
as the focal point of Health Canada’s efforts to maintain and improve positive mental health and well-being for the Canadian population. The unit uses a population health perspective and seeks to develop and disseminate knowledge and programs that promote mental health.

As health professionals, psychologists have many opportunities to use mental health promotion and early detection skills in the health arena. Members of the APA Workgroup on Expanding the Role of Psychology in the Health Care Delivery System (Brown et al., 2002) describe a framework that outlines the services (assessment, intervention, consultation, and liaison) that psychologists can provide in primary, secondary, and tertiary prevention. One promising development is the design and implementation of brief screening instruments that can be used in primary care and other medical settings to detect mental health problems. Since it has been found that a large number of visits to primary care physicians are primarily due to mental health or emotional concerns (Strosahl, 1996), identifying and dealing with these mental health issues reduces the repeated visits and health-care costs.

Another initiative is the training of other healthcare professionals in mental health detection and early treatment measures. Successful programs have been developed that train Primary Care Providers (PCPs) to better detect and treat depression. This requires some new thinking on the part of psychologists. Rather than all mental health care being referred out to psychologists, psychologists increasingly are partnering with physicians and other health professionals in a collaborative care model. This will be discussed in more depth below.

Psychologists also have been the leaders in developing programs to promote healthy lifestyle behaviours, such as smoking cessation and stress reduction, as well as developing theoretical models and methods, for example, the Transtheoretical model of change (Prochaska & Velicer, 1997), self-regulation (Bandura, 2004, 2005), Motivational Interviewing (Miller & Rollnick, 2002), for explaining and encouraging reluctant individuals to make behavioural changes. Despite overwhelming evidence and education about the importance for good health of a nutritious diet, regular exercise, and no smoking, many citizens have been reluctant to make these lifestyle changes. It is clear that education alone does not motivate all to engage in these healthy behaviours. As health professionals and behaviour change experts, psychologists can tackle these perplexing and intransigent problems and produce positive results in the health of the population.

**Technology Utilization**

Both medical and information technology is on the increase among physicians, hospitals, and outpatient centres. In 2002, of the physician executives surveyed by PricewaterhouseCooper, more than 46% worked for organizations that have invested in electronic medical record systems or were planning to do so in the next year (Porter Research and Solutions, 2003). Computer-based systems are more and more in use for clinical protocols, diagnostic imaging, prescription writing, drug alerts, and lab orders. Telemedicine, first used as a way to reach isolated rural populations, is being used in new venues, for example, in correctional facilities, military operations, and in-home health care. While regulatory and funding issues still hamper wider use of telemedicine, patient satisfaction with telemedicine interventions, has generally been very high.

Physicians and nursing are finding more ways to use technology to improve patient care and to increase efficiency. Psychologists, on the other hand, have been slow to warm to the use of technology in their clinical practice. While psychologists have integrated computer technology into their practices for clerical and billing activity, e-mail correspondence, and computer-based assessments and scoring, technology has not been a major part of most psychology services. However, some progress is being made. Increasingly, psychologists are adopting computerized office systems, including electronic patient records. In doing so, they have recognized both the benefits and potential hazards (e.g., confidentiality of records) of this technology. Perhaps in acknowledging psychologists’ roles as health professionals, psychologists have been invited to join the national discussions concerning the protection of patients’ confidential information in electronic records.

A growing number of psychologists are developing and using webpages (Palmiter & Renjilian, 2003) to inform the public about mental health issues and about their services. Increasingly, technology-savvy consumers seek out information about issues and services on the Internet (Harris Interactive, 2002). Mental health issues are one of the leading topics for Internet searches. Mental health education, including prevention strategies, mental health screenings, and treatment options, are available on the web. These sites inform the public about self-help strategies for mental health issues, alert individuals about their need for treatment, and reduce the stigma and mystery surrounding mental health treatment.

Computer programs, interactive video-conferencing, online support groups, and other forms of technology are being used to treat psychological condi-
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al., 1994; Brody, 2003). Even when the physician
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mental health professional and makes an appropriate
referred patients make

tions (e.g., the use of virtual reality displays to treat
those with phobias), and to provide support and interven-
tions for those suffering with chronic illness, for
rehabilitation populations (e.g., stroke and brain
injuries) and for their caregivers (Glueckauf & Ketterson, 2004; Glueckauf et al., 1999). Online
counseling and psychological treatment via videocon-
erencing are still a small fraction of mental health
care. However tele-behavioural health interventions
are increasing, especially with those client groups
experiencing access barriers (e.g., correctional
inmates, rural populations, hearing-impaired clients,
etc.) (Jerome et al., 2000). As health-care profes-
sionals, psychologists increasingly will be interacting
with multidisciplinary team members who readily rely on
technology to improve the quality and efficiency of
care. Psychologists have the opportunity to discover
and refine new uses of technology in behavioural
health care.

Accountability and Evidence-Based Treatment

Health-care costs continue to rise, and with the
increase come renewed measures to try and contain
costs. At the same time, health consumers are
demanding high-quality care – although the Institute
of Medicine (2004, p. 1) concludes that “(N)early half
of all American adults – 90 million Americans – have
difficulty understanding and acting upon health infor-
mation.” These two forces have resulted in a major
focus in the medical establishment on evidence-based
medicine. According to Guyatt, Cook, and Haynes
(2004), the term “evidence-based medicine” appeared
little more than a decade ago to promote practice
based on the examination of evidence from clinical
research and to reduce the emphasis on unsystematic
clinical experience and pathophysiological rationale.
For physicians, evidence based medicine required new
skills, including efficient literature searching and the
application of formal rules of evidence in evaluating
the clinical literature. This has been a challenge for
physicians, since “Too often clinicians are unaware of
the available evidence or fail to apply it” (Guyatt et al.,

As in medicine, the emphasis on evidence-based
treatments has generated major debates in psychology
(Norcross, Beutler, & Levant, 2005). While all can
agree on the goal of treating patients with “proven”
methods, many question whether tightly controlled
clinical laboratory research is applicable to the real
world of practice. Others question whether the out-
comes of certain types of psychotherapy can be fully
examined in laboratory research. However, psycholo-
gists being trained in scientific and clinical methods
have much to contribute to this major trend within
health care. While psychology still struggles to close
the “gap” between researchers and clinicians, there is
clear recognition of the need and desire to do so.
Some psychological journals (e.g., Professional
Psychology: Research and Practice) explicitly state that
their mission is to translate research findings into
information that practitioners can use in their prac-
tices. A task force of APA’s Division 12 has provided a
compendium of evidence-based treatments, and APA
has published several sets of evidence-based guide-
lines for interventions with different clinical popula-
ations. As the calls for evidence-based treatment
become stronger in health-care policy discussions, psy-
chologists will have a sound footing to discuss the
issue regarding evidence-based behavioural health
care. At the same time, psychologists need to be aware
of the barriers to incorporating the most efficacious
treatments into health-care settings. A recent report
from the Milbank Memorial Fund (2000) indicates that
the foremost barrier is health-care funders’
emphasis on cost over quality. Behavioural health
interventions are often viewed as more costly, labour
intensive, and variously effective than pharmaceutical
interventions. Therefore, to gain acceptance of behav-
ious interventions, even those that have demonstra-
table clinical effectiveness, economic outcomes, includ-
ing cost-offset effects, need to be built into effective-
ness studies. Models for conducting effectiveness stud-
ies in medical settings (Schwartz, Trask, Shanmugham, & Townsend, 2004) and for incorporat-
ing economic outcomes (Bickel & Vuchinich, 2000)
show promise.

Shift to Integrative Care

Integrated Primary Care combines medical and
behavioural health services to more fully address the
spectrum of problems that patients bring to primary
medical care. Because so many patients in primary
have physical ailments affected by stress,
unhealthy lifestyles, or a psychological disorder, it is
clinically effective and cost effective to make behav-
ious health providers part of primary medical care
(Blount, 1998).

Integrated primary care emphasizes and requires the
collaboration between mental health professionals
and primary care providers (DeLeon, Giesting, &
Kenkel, 2003; DeLeon, Rossomando, & Smedley,
2004). Typically, in nonintegrated care models, the
primary care physicians may miss 50% or more of
mental health problems in their patients (Badger et
al., 1994; Brody, 2003). Even when the physician
accurately determines that the patient needs to see a men-
tal health professional and makes an appropriate
referral, only about half of the referred patients make
even one visit to the mental health provider (Schulberg, 1990; Schulberg, Coulehan, & Black, 1993).

In integrated primary care models, the psychologist is a member of the primary care health team. He or she works in the same offices with the medical providers, consults with them on behavioural health issues, and sees clients referred by them. The mode and methods of behavioural health treatment are different from those delivered in mental health treatment centres. Sessions are generally shorter and the duration of treatment is briefer. The advantages are that more patients follow through with referrals for treatment, less stigma is associated with treatment in the primary care office, and there is a closer relationship with the patient’s medical providers with a better coordination of care. In our judgment, this type of clinical practice environment represents an outstanding “living laboratory” for those colleagues who are interested in pursuing prescriptive authority (DeLeon, Crimmings, & Wolf, 2003; Dunivin & Orbana, 1999). Presently, the legislatures of New Mexico, Louisiana, and the Territory of Guam have granted this clinical responsibility to appropriately trained psychologists. Those who are prescribing are extraordinarily enthusiastic about the quality of care that they can now provide.

Patients report great satisfaction with integrated care and improved mental health outcomes have been found (Katon et al., 1996). Physicians likewise are highly satisfied with the model (Kates, Craven, Crustolo, Nikolau, & Allen, 1997) since it assists them with patients they often find problematic, such as somatizing patients whose complaints have no discernible physical cause. Studies (Cummings, 1994, 1997; Mumford, Schlesinger, Glass, Patrick, & Cuerdon, 1998) on the integration of mental health and health services showed positive effects on worker absenteeism and productivity, and cost offsets in the form of fewer and less costly health-care visits. Therefore, preliminary reports suggest that integrated care positively addresses all of the major issues in health care today. It promotes quality care, consumer satisfaction, as well as significant health-care offsets (i.e., reduction in health-care visits). A variety of models both at the pre- and postdoctoral levels (Anderson & Lovejoy, 2000; Garcia-Shelton & Vogel, 2002; Zilberg & Carmondy, 1995) are being used to train psychologists in this model. Clearly, this is one of the very promising trends for psychologists as health-care professionals.

Living Case Examples

Two of the authors have been personally involved in the type of training experiences that we feel represent the future of professional psychology. Angie Steep’s exposure to integrated care models during her predoctoral and postdoctoral training prepared her for her current employment in a community health centre. Elaine Orabona Mantell received extensive postdoctoral training in psychopharmacology. They both have lived the transition from considering themselves as being exclusively “mental health providers” to becoming more comprehensive “health-care providers” – which is what professional psychology must be in the 21st century (DeLeon, Paige, Smedley, & Sammons, 2004).

Blending and Bridging Talents

Angie Steep obtained her clinical PsyD from the Florida Institute of Technology. Her predoctoral internship was at the Medical College of Virginia (MCV/VCU), and for her postdoctoral training she specialized in primary care psychology at The University of Oklahoma Health Sciences Center (at the time the only APA-approved primary care fellowship). She currently works as a behavioural health consultant with Cherokee Health Systems, a comprehensive health service organization that annually serves over tens of thousands of people from Eastern Tennessee. Her story:

What I want to convey in the following section are my clinical experiences and reflections of working in primary care as a behavioral health consultant, my passion for integrated care, and my dedicated support for training recommendations that broaden the scope of practice for psychologists as future health care providers.

Change is on the horizon and ever present. As behavioral change experts, we are certainly experiencing a paradigm shift in how we view health, provide care, and even how we actively lobby to get reimbursed for our health care services (96150 CPT series). I have been working in integrated care as a health care provider for approximately three years (inclusive of pre-doc, post-doc, and current employment). My training experiences have included doctoral psychology training in behavioral medicine and neuropsychology at Florida Institute of Technology, pre-doctoral internship rotations in primary care at The Medical College of Virginia/Virginia Commonwealth University (MCV/VCU), and formal APA post-doctoral training in primary care at The University of Oklahoma Health Sciences Center (VA Medical Center and Family Medicine). All that being said, the single most important realization and change that I have made for myself upon graduating is changing the way that I view the services that I deliver to patient and providers alike. I consciously made an identity
shift from clinical psychologist to “health care provider/consultant in primary care.” This identity shift in attitude, practice, and skill set is critical and not to be underestimated. With this identity shift, I have been able to successfully partner with a variety of PCP’s (family doctors, internists, ob-gyn’s, nurse practitioners, etc.) in the role of consultant, educator, and have experienced parity as a primary care team member. Without it, one has the potential to function as a mental health specialist housed in primary care. It has been described earlier in this article and elsewhere that integrated care has resulted in an effort to improve access, provide comprehensive care, and enhance the lives of our patients that we serve (similar to the strong arguments for prescription privileges). Many of the skill sets that we are taught in our formal graduate psychology training are helpful, but there are also numerous gaps in our curriculum that need to be addressed so that we may successfully meet the demands of health care in the future and continue to educate providers and the public as to what we do and how integrated services benefits providers and patients alike.

Some of the more obvious gaps that could potentially marginalize us from practice in primary care if we do not deconstruct and re-position our training curriculum are the need to modify current clinical skills taught in graduate training, embrace and develop new service delivery models, introduce tele-health initiatives to decrease access barriers, increase preventive health promotion and psychopharmacology knowledge, enhance familiarity with motivational interviewing skills, augment knowledge regarding change agents and how we can positively impact different systems, increase program evaluation skills, consciously increase critical thinking skills and the ability of providers to “think on their feet,” and strategically implement advocacy and public policy skill sets. The cost and consequences of not proactively addressing these gaps in our education could cost us a front seat in health care where we belong, so as to insure that the WHOLE (mind and body) person is addressed.

As a behavioral health consultant, I see patients walk in everyday with multiple somatic complaints, sleep disturbances, anxiety, and irritability concerns that often mask their feelings of depression. It is the rare primary care patient who comes in and states that he is feeling depressed and anhedonic. Depression is the most common psychiatric symptom encountered in primary care and often overlooked, which is not always a function of incompetence, but rather, indicative of time pressures for PCP’s. At Cherokee Health Systems we are in the process of implementing a depression management protocol in primary care to help identify, monitor, and treat depression. We actively participate in joint collaborations with the Bureau of Primary Health care (intensive diabetes management program) and the Maternal and Child Health Bureau funds many of our integrated care services. Another exciting aspect of integrated care, involves our internship program at Cherokee, the Tennessee Internship Consortium in Psychology (TIC), which provides students with real world opportunities to work with various populations, be that pediatric, family medicine, and even the seriously and persistently mentally ill (SPMI). It is at this juncture where we can really make an impact in training and skill sets, thereby increasing an individual’s knowledge of medicine and how the mind and body interact and affect health outcomes, both at an individual and population levels.

I feel privileged to work in a primary care environment, where the physical concerns of a patient are just as important as the emotional concerns, and there is mutual respect for providers, as each is seen as extenders of each other in patient care. I look forward to augmenting the ideology of population based health care, with actively promoting and advocating legislatively for integrated care and prescription privileges for psychologists. In sum, my varied experiences in primary care as a health care provider has taught me a great respect for the impact that behavioral lifestyle changes (medication compliance, sleep, diet, exercise, smoking) can make in a patient’s life, the limited time frame with which skilled family practice doctors CAN successfully listen to patients and treat their concerns. It is my mission to continue to reduce health disparities, improve health outcomes, decrease unnecessary medical utilization, and improve collaboration between various health care providers. This is accomplished through mutual respect, daily nurturance of relationships, an open mind, and gratitude to be able to help such a broad spectrum of people (many disenfranchised) that would otherwise go unserved.

*The Future of Prescribing Psychologists*

Elaine Orabona Mantell is one of ten Department of Defense Prescribing Psychologists (Newman, 2000; Newman, Phelps, Sammons, Dunivin, & Cullen, 2000; Sammons, Paige, & Levant, 2003). Her story:

I was fortunate to be serving in the United States Air Force at a time when the Department of Defense had established a Psychopharmacology Demonstration Project (PDP). At that time, psychologists could volunteer for post-doctoral fellowship training to learn to independently prescribe psychotropic medications. My class was the third iteration of a total of four cohorts that completed this training through the Walter Reed Army Medical Center and the Uniformed Services University of the Health Sciences (USUHS). While the different iterations of the PDP under-
I joined the PDP after adjustments had been made to the curriculum to allow for the fact that most of us had at least five years of pre-doctoral education and several more of post-doctoral experience which we brought to this post-doctoral fellowship. Psychopharmacology was a good example of a relevant course that was specifically tailored to our existing levels of expertise. This course was exclusive to the PDP and utilized interactive, advanced case studies with liberal class participation as contrasted with our medical school courses which were essentially the first two years of medical school collapsed over the course of one year, and taken alongside the traditional medical school students.

A course in health assessment and physical examination was an example of a class that required enhancements based on our lack of experiential base and educational background. In fact, the first phase of the course was spent helping us adjust to the idea of touching our patients – an activity which was heretofore taboo throughout our entire psychological careers. Suddenly we were being asked, no, required to physically manipulate our “patients,” to explore orifices, to palpate organs. At a minimum, this required some cognitive reframing especially since we started out by utilizing one another as subjects. But, in seemingly no time, we were poking and prodding and marveling at our great “discoveries;” the pearly iridescence of a healthy tympanic membrane, the rhythmic lub-dub of live heart sounds, the bulky feel of a fatty liver, and all the other previously unexplored systems that make up our biological existence. These experiences, taken together with the classes we took in human anatomy, pathology, physiology, pathophysiology, clinical medicine, and clinical concepts gave us great insight into a complementary approach to understanding and evaluating our patients’ concerns. Now when we heard, “I’m feeling tired,” “I can’t concentrate,” and “I don’t seem motivated to do anything,” we did still consider various psychological disorders, but we also thought about medical diseases that similarly manifested such as hypothyroid, anemia, diabetes, etc. We further considered drugs and drug interactions that could result in these types of complaints. We asked about diets, nutritional supplements, and herbal remedies. Even the questions we had formally asked as psychologists, before our post-doctoral training now carried new meaning. For instance, when we asked about smoking the idea was not just to determine whether the person needed help with smoking cessation, or might be prone to cancer, but to consider whether their smoking might be influencing the serum levels of their medications since smoking and smoking cessation can alter the way a drug is biotransformed and therefore, influence drug effects. For reasons such as these, I often found myself asking over the course of my fellowship: How would my interviews, assessments, and interventions have differed with my former patients if I knew then what I know now?

Our one-year supervised clinical practicum provided us with ample opportunity to explore methods for integrating the new skills and medical training we possessed with our more practiced skills as behavioral change experts. Fortunately, we rapidly discovered that our former training and the comfort level we had developed communicating with others as psychologists served as powerful currency in the world of clinical medicine and psychiatry. On the six-month inpatient psychiatry practicum rotation, psychological principles helped avoid seclusion and chemical restraints for several patients who required reflective listening, relaxation training, schedule modifications, and environmental manipulations to feel safe/calm. Primary care doctors were more willing to listen when “no psychotropic medications” or changes in current medication regimens were recommended based on our bio-psycho-social assessments. I remember one case referred to me by a primary care physician who questioned why the patient had not benefited from Effexor, but was instead feeling worse than he had before starting this medication. After my clinical assessment, I discovered that the patient had been on 37.5 mg of Effexor for two weeks – a dose just high enough for side effects but no antidepressant effect. I later discovered that primary care doctors very commonly prescribe subtherapeutic doses of antidepressant medications, and tend to abandon those treatments before a full trial is completed. Moreover, this particular case involved an individual who was divorcing and the idea that we could structure his treatment to assist with stages of bereavement so common to this life event was cause for relief for both the patient and the physician! This simple intervention garnered several more referrals from this primary care physician, who quickly realized the value of interdisciplinary teamwork.

Immediately after graduating from the PDP fellowship, I was sent to Keesler Medical Center, a USAF regional hospital in Biloxi, Mississippi where I remained for five years. While there, I served as chief of outpatient for two years, worked as a provider on the inpatient psychiatry unit for three years; and in the last year, served as chief of that inpatient unit. Despite the heightened responsibilities of that position, it was a great honor to be asked to serve in that capacity because it established a vote of confidence in
my integrated clinical skills – especially since there were four psychiatrists that could have served in that capacity. This experience also taught me that while psychiatrists may disagree with the prescriptive authority movement on the whole, it is possible to convince them on a more personal level, that properly trained psychologists can be competent, and bring to the field a fusion of skills that are different even from psychiatry, because we are first trained as psychologists and later trained in medicine.

The integration of prescriptive authority with my psychological practice has augmented my service delivery in varied ways. I found that many times my patients were eager to implement behavioral, lifestyle changes, but neurovegetative symptoms such as lack of sleep, low energy, poor appetite, and easy fatigue prevented them from going to the gym, reading, or going out to make new friends. Others worried so much that they constantly felt tense, irritable, and avoidant. I found that those who could not comply with behavioral homework assignments for those reasons would often benefit from medication first to assist with initial symptom relief which later had the added benefit of improving adherence to the treatment plan. With renewed focus on lifestyle and attitudinal changes, we could then provide the tools that sustain recovery long after medications have been discontinued.

Other benefits. I no longer have to suffer along with my patient while we wait for an available psychiatrist to conduct a medication evaluation. As a bilingual, Hispanic psychologist, I no longer have to search far and wide for a Spanish-speaking psychiatrist or even primary care doctor to treat my Hispanic patients. Along these lines, it is clear that psychologists are in a unique position to contribute to the emerging field of transcultural pharmacology through our expertise in research design, and pragmatically, through the value we place on learning the meaning our patients assign to their symptoms, to their help-seeking behaviors and to their treatments/medications.

Integrating treatments means that if my patient and I want to make changes based on new or unremitting symptoms I can modify the treatment immediately, utilizing my own knowledge of the patient’s history rather than spending hours on the telephone trying to reach the psychiatrist to discuss, beg or cajole him or her to assist. The consultations I now offer to women’s health, family practice, internal medicine and primary care providers allows me to impact the care of many more patients than I have time for on my schedule. Finally, it is personally satisfying to watch my patients react with surprise to a psychological approach to pharmacotherapy versus the medical approach they have grown accustomed to over the years. Typical physician approach: “Take this medicine, it will make you feel better.” Typical prescribing psychologist approach: “Well, here are your options…” Prescriptive authority has provided me with a greater respect for the long-term benefits of cognitive, emotional and lifestyle changes afforded by psychological therapies. Most patients look to the day they can definitively discontinue medications, and, fundamentally, it is the tools we teach them about coping, problem solving, stress management, and relationship building that will sustain them long after the medications have exhausted their influence. It is ironic that the greatest truth I learned in medical school came from a neuroscience professor, who argued, that change is only possible through genuine learning. In his words: “that which you learn, is yours forever.”

Concluding Reflections
Numerous opportunities exist for psychologists to participate in the building of quality health-care systems and services. However, to do so, the education and training of psychologists will have to be broadened and modified to reflect the knowledge and skills needed in these new venues. While this will require some changes in the curriculum (cf. McDaniel, Belar, Schroeder, Hargrove, & Freeman, 2002), even more important is exposing students to the new models of practices, such as those described by Drs. Steep and Orabana in this article. Nothing can substitute for, or be more educational than, real-time experiences with multidisciplinary health teams dealing with multiple patients’ demands/problems and with the constant time, policy, and funding constraints of current health-care systems. Since psychologists receive most all of their training from other psychologists, with little to no exposure to other health professionals, this experience may be the only chance for learning to work in a collaborative mode in a health-care team. If such training opportunities are not readily available, academic programs may need to take steps to create them in their areas. Faculty in a few psychology programs already are experimenting with developing integrated health-care opportunities for their students (Dobmeyer, Rowan, Etherage, & Wilson, 2003; Masters, Stillman, Browning & Davis, 2005; Pisani, Berry, & Goldfarb, 2005; Talen, Fraser, & Cauley, 2005) and finding that they are learning as much as the students. Such is the case as psychologists venture out into new territory and it therefore takes some courage and sense of experimentation to make these ventures work. However it should be remembered that the nonpsychologist health-care professionals also are learning much from these encounters, as they work with their new psychologist partner on the health-care team. But the main beneficiary clearly is the patient who can access comprehensive and coordi-
nated health care: health care that addresses the biological, social, and psychological factors that promote a full and healthy life. The benefits to be derived by patients and society create the imperative for psychologists to move swiftly and deliberately into this new world of integrated care.

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Résumé
De plus en plus, les pourvoyeurs de soins de santé reconnaissent la nécessité d’examiner les influences comportementales et émotives sur la santé physique afin de pouvoir offrir des services de qualité et peu coûteux. À titre d’experts du changement de comportement, les psychologues peuvent jouer un rôle de premier plan dans les nouveaux modèles de soins intégrés qui englobent la santé physique et psychologique. Cependant, pour être efficaces, les psychologues doivent être prêts à faire face aux problèmes majeurs auxquels font face les systèmes de soins de santé d’aujourd’hui et accepter de réexaminer et de modifier les modes actuels d’éducation et de pratique. Cet article décrit les tendances importantes qui touchent les soins de santé et les façons qui pourraient permettre aux psychologues de contribuer. En dernier lieu, deux psychologues travaillant dans de nouveaux modèles de soins intégrés décrivent leur formation ainsi que les défis et les récompenses de leurs activités actuelles.

References


