

IAAP E-News (June, 2019)
(Division 17)
Division of Professional Practice



NEW IAAP WEBINAR SERIES

The Division 17 highlight for this month was our role in hosting the first of the New IAAP Webinar Series entitled: “[*The Critical Role of Psychology in an Integrated Primary Care Model*](#)”.

The rationale for our emphasis on Integrated Care was provided in detail in our May Newsletter ([see link at the end](#)).

Professor James Bray (Division 17 Immediate Past President) and **Dr Robyn Vines** (current Division President) provided an overview of the field of primary care psychology and answered questions from the Convenor, Professor Lyn Littlefield, about the details of this work.

Speaker Bios:

- **James H. Bray, Ph.D.** is the Chairman of the Psychology Department at University of Texas San Antonio. He was the 2009 President of the American Psychological Association. His presidential themes were the Future of Psychology Practice and Science and Psychology’s Contribution to Ending Homelessness. He is also a member at large the International Association of Applied Psychology. Dr. Bray’s NIH funded research focuses on adolescent substance use, divorce, remarriage and stepfamilies. He is a pioneer in collaborative healthcare and primary care psychology. He has presented his work in 20 countries.
- **Robyn Vines, MSc, PhD** is a Clinical & Health Psychologist currently practicing in primary care psychology in regional New South Wales, Australia. She is the mental health academic at the Bathurst Rural Clinical School, Western Sydney University School of Medicine and teaches medical students alternative paradigms & ways of thinking about mental health issues, as an alternative/complement to the still-predominant medical model. Robyn has served for three terms (7yrs) on the Board of Directors of the Australian Psychological Society, two terms (6yrs) on the NSW Psychology Council, is a Fellow of the IAAP and current President of the IAAP Division of Professional Practice. Robyn’s PhD Thesis trialed a collaborative model of mental health care between GPs and clinical psychologists - one of the research studies which led to the advent of Medicare rebates for psychologists in Australia in 2006 (see: <https://ses.library.usyd.edu.au/handle/2123/6640>).

Key topics covered and Summary Content of the Webinar:

- **What do we mean by “integrated” primary mental health care?**
 - 1) **Theoretically:** We mean provision of the **true Bio-Psycho-Social model** so often talked about in medicine, psychology and other allied health professions

- but still rarely “truly” delivered in primary care settings (where patients first seek help)

- 2) **Practically: Collaborative multi-disciplinary care:**
 - in which **professions work together ‘in situ’** (i.e. preferably co-located) to provide optimal multi-faceted treatment for patients’ often complex, frequently comorbid problems
 - **Breaking down the current counter-productive ‘silos of care’** which exist in many Western service delivery models.
- 3) **Different paradigms/ways of thinking about the patient** and their “comorbid disorders” – starting with the “PERSON” and their complex and interrelated personal, psychological and health narratives. It provides an alternative and/or complement to the still-predominant medical model – what is often referred to as the “*medicalisation of unhappiness*” in Western society.
- 4) **Integrated thinking about comorbid conditions and provision of “wholistic treatment”** of mental health and physiological comorbidities as they inter-relate with each other
 - e.g. 50% of those suffering with diabetes have comorbid depression - consequential upon their condition (two-way impact). Optimal intervention requires CBT strategies for treatment compliance as well as expert help with diabetes-specific emotional symptoms (APA Monitor, May 2017)
- 5) **It also means an integrated approach to treatment, involving the Inclusion of Lifestyle Factors** known to impact on Mental Health and Wellbeing, and the current epidemic of NCDs (non-communicable diseases):
 - e.g.
 - SNAPS screening amongst GPs (smoking, nutrition, alcohol, physical activity and sleep)
 - Lifestyle Factor screening and inclusion in treatment by psychologists: Sleep, Diet, Exercise, Alcohol, Smoking, Recreational Drugs and Caffeine.
 - In both professions, systematic assessment of and intervention with these crucial lifestyle factors remains sub-optimal – yet crucial to successful treatment of presenting issues.
 - **Current development of “Lifestyle Medicine” as an approach is attempting to address these deficits – but Psychology still has a relatively low profile in this movement.**

- **Why is it beneficial to integrate mental health care into primary care?**

- 1) **Primary mental health care and Comorbidity**

Co-morbid/co-existing conditions such as:-

- mental health conditions with alcohol & other drug disorders;
- physiological conditions co-morbid with common mental disorders of anxiety, depression and stress, and
- Co-morbid and chronic illness (diabetes, hypertension, etc.) that is exacerbated by behavioral problems –

are now the “norm” in primary care rather than the exception.

- 2) **Primary care is the first port of call** for most people in our community. In Australia, for example, 80% of the population consult their GP in any one year; 90% in any two year period. It’s therefore where people “go” and can be seen early if they have problems. It therefore provides the opportunity for **early intervention and**

prevention of greater misery further down the track (e.g. hospitalisation of patients whose panic attacks have destroyed their confidence and lives, rather than learning appropriate coping strategies within a week or two of first onset, etc.)

- 3) Primary care / colocation with general health issues is **stigma free**, whilst there is still stigma attached to going to secondary and tertiary mental health facilities.
- 4) **Being seen “in situ”** in the general health setting **results in less attrition** of those referred – still quite high when referred out to secondary or tertiary facilities/settings (patients often don’t get to the practitioner).
- 5) **Equity of access:** patients find it easier to access care in settings they are familiar with. Complex “pathways to care” and private practice funding models often mean that those in greatest need do not get appropriate help. “Bulk-billing” in general practice can also enhance options for treatment of the less-well-off and sometimes more disturbed patients.
- 6) **Better communication between professionals through sharing of electronic notes:** with patient permission, the psychologist can access the doctor’s (and others’) notes; the doctor can access the psychologist’s notes – so physiological and psychological treatment is interwoven, with easy inter-professional communication facilitated between sessions.

7) What clients/conditions benefit from this integration

The whole range of mental health issues:

- i. low prevalence, “deep-end” of psychosis, eating disorders, mood swings commonly referred to as bipolar conditions can all benefit from appropriate symptom management and learning of coping skills
- ii. predominantly the common mental disorders of depression and anxiety (The fact that they are classified as “common” does not mean they are not severe – suicidality (whether active or passive) is often present in those presenting in primary care and needs to be carefully and appropriately managed.
- iii. Early stage behavioral health issues: e.g., sleep problems, adjustment to chronic stress and trauma

8) Which practitioners should be involved?

Given the complexity of so many general and mental health conditions, it is optimal to have a full multi-disciplinary team involving:

- a. GPs/family physicians as coordinators of care – they often provide the “primary care psychiatry” in conjunction with feedback from psychologists – managing the physiological side of mental health presentations
- b. Psychologists: both for psychotherapeutic intervention and treatment compliance issues & behavioural management in comorbid physiological conditions.
- c. With chronic illnesses such as diabetes, Parkinson’s Disease, asthma, cardiovascular disease, obesity, etc. – there should optimally be:
 - i. Nurse practitioners
 - ii. Dieticians
 - iii. Physiotherapists and sports physiologists

working in parallel with appropriate trained (clinical) psychologists and doctors.

9) What is needed to set up integrated primary care?

- a. **Frame of mind:** As a psychologist, it is **crucial to have an understanding of and commitment to this type of model:** It is often much easier (and possibly more lucrative) to sit in private practice silos and see patient-after-patient as a sole practitioner, with referrals out from GPs/family physicians.
- b. **Be committed to team-based care and explore where in your local community you can practice** (even several sessions or days per week) “in situ” in general practice. It can provide a good referral base (with possible articulation to the private practice setting) – but establishes a better team-based approach with:
 - i. easy access to the GP for informal consults in relation to patient progression
 - ii. possibilities of both formal and informal case conferencing
 - iii. shared notes enabling a truly integrated bio-psychosocial approach.

10) What role should psychologists play in integrated primary care

- **Psychologists should play a core role.**
 - As indicated earlier, the medical model is still the predominant paradigm in many western countries
 - This is both due to the power of big pharma and its marketing strategies, but also due to the lack of alternative ways of framing the issues and providing optimal, evidence-based treatment using a true bio-psycho-social model – rather than purely medical/physiological.
 - We need the “*right treatment, at the right time in the right place*”.

11) Where has it been tried?

- There are different models of primary care:
 - Norway
 - Australia
 - Canada
 - The UK under the national health system
 - United States as part of health care reform starting in 2010

Positive messages:

- **It is extremely exciting work** – very demanding as psychologists are expected to work at the same pace as the doctors in primary care - challenging, interesting and stimulating.
- **Fulfilling:** as there is a definite feeling that, with enhancing new complex models of care, we are working to fulfil the necessary **public health objectives** of our countries – “Bigger Picture Involvement”

The model:

- **Enhances care for the patients/clients:** research evidence indicates better outcomes for patients with complex needs
- **Improves the working life of referring General Practitioners/Family Physicians** who find it extremely difficult to manage the complex mental

health profile of their practices, with too little training, too little time and too little support.

- **Enhances the psychologists' experience of Practice** as it is relevant and contributes to the bigger picture of truly equitable and effective mental health service delivery in our communities.

(June 2019)

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LINKS:

- [**UNITED NATIONS INTEGRATED CARE INITIATIVE**](#)

Previous Newsletters:

- [January](#)
- [March](#)
- [April](#)
- [May](#)