The medical system in this country is divided into primary care and specialty care. Mental health is for the most part a specialty service dependent on referrals, often from primary care providers. The authors propose a new model where psychologists work in collaboration with primary care medical teams. This integrated, coordinated model enables psychologists to help patients they would not otherwise see in a mental health system. Examples of patients in this category are seniors, those with somatizing disorders, and those experiencing the challenges of dealing with a chronic illness. This model also enables psychologists to provide consultation to the medical teams. In this article, the authors discuss the world of the primary care medical team and present the rationale for integration or collaboration. They describe the barriers to collaborative practices and ways to overcome these barriers. Finally, they present practical strategies that psychologists can use on a regular basis to increase their collaboration with primary care. These strategies can be used by those who work in colocated practices as well as those who work in separate locations. © 2009 Wiley Periodicals, Inc. J Clin Psychol 65:235–252, 2009.

Keywords: primary care; mental health; integrated practice

In this article, we provide information and a rationale to psychologists for collaborating with medical professionals in primary care medical settings. We wish to increase all psychologists’ knowledge about the rapidly growing field of primary care mental health and the skills needed to work in this arena. We strongly encourage movement towards integrating ourselves into the greater health care arena, colocated with primary care medical professionals. Although medicine has long been divided into specialty care and primary care, mental health care is still
mostly specialty care, dependent on referrals from others. Patients do call independently; however, most often there is a referral, frequently from primary care medical professionals.

We will first provide the case for primary care mental health and then describe primary care medical practice today. We will then outline the barriers to mental health care in this setting as well strategies to overcome these barriers. This article is written for those currently in collocated settings as well as those who practice in separate locations. Although we strongly encourage the development of collocated models, they are currently not the norm. We will provide suggestions to those psychologists not collocated in medical practices of how they can develop attitudes to a more collaborative mindset and coordinate their care more effectively.

In our view, psychologists, due to market pressures and other factors, have had a tendency to draw boundaries around themselves as having unique skills apart from other mental health disciplines. Although this has been helpful in creating public awareness of the unique skill set of psychologists, a side effect of this effort has been to isolate us from the rest of the health care field. Collaboration with medical professionals, particularly in primary care is a critical need for psychology and for health care in general. The bottom line is that mental health care is part of overall health care.

Why Psychologists Should Collaborate

Many psychologists are surprised to learn that less than one third of patients with diagnosable mental health conditions ever meet with a psychologist or other mental health professional. Even the majority of those with significant symptoms of depression and anxiety will get treatment solely from their primary care medical professional (Miranda, Hohnmann, & Attikiss, 1994).

Research on mental health issues in primary care reflects the centrality of these issues in patients' lives and how unlikely it is that patients who need mental health services ever access them. Consider the following facts:

- Twenty-five to thirty percent of visits to primary care physicians have depression, anxiety, alcohol abuse, and somatoform disorders as part of the presenting issue (Ansseau, Dierick, & Buntink, 2004; Kahn, Halbreich, & Bloom, 2004; Ormel et al., 1994).
- Primary care medical professionals prescribe 60%–70% of the psychotropic medications prescribed in the United States (Lewis, Marcus, Olfson, Druss, & Pincus, 2004; Miranda et al., 1994).
- The incidence of depression rises as patients seek more intensive medical care, from 5% in the general population to 10% in medical outpatient settings, to 15% in medical inpatient settings (Katon, 2003).
- Although only 20% of people who commit suicide had contact with a psychologist in their last month, 45% have had contact with a primary care medical professional (Luoma, Martin, & Pearson, 2002).
- Sixty-eight percent of patients with a diagnosable mental health condition will seek care from a primary care medical professional, whereas only 28% of such patients will see a psychologist (Miranda et al., 1994).
- Thirty-two percent of undiagnosed, asymptomatic adults say they would first turn to their primary care medical professional for assistance with a mental health condition.
issue, while only 4% stated they would approach a psychologist (National Mental Health Association, 2000).

- One in three patients who present in an emergency department for chest pain has depression or panic disorder (American Psychiatric Association, 1998).

Recent studies have examined the prevalence of psychological disorders in primary care; these are listed in Table 1. Each of these studies used the Patient Health Questionnaire (PHQ; Gunn & Matzkin, 2008; Mauksch, Tucker, & Katon, 2001; Spitzer, Kroenke, & Williams, 1999) to look at the common psychological disorders and how often they present in primary care. The significantly higher numbers in the first two studies reflect the effect of poverty on the prevalence of mental health disorders. Both of these studies were done in clinics that were “safety net” clinics serving a poor population of patients.

In our collective 40+ years of experience in primary care settings, one of the most striking discoveries has been that few people whose lives are negatively affected by psychological symptoms ever obtain psychotherapy or meet with a psychologist in any capacity. Even when patients do ultimately connect with a psychologist, the frequent lack of collaboration between the psychologist and the patients’ medical professionals reduces the effectiveness of both the medical and the psychotherapeutic treatments.

Primary care medical professionals often do not have the time or skills to deal adequately with these psychological problems so they often welcome and genuinely need assistance from psychologists. Unfortunately, they rarely have established relationships with psychologists and therefore do not know to whom to refer. In recent years, managed care panels have contributed to this difficulty in referring and developing relationships with psychologists who are on the right panels for the patients.

The research and experience described above reflect the reality that our specialty oriented mental health care system simply does not reach the vast number of patients who need its services. In fact, if the definition of emotional distress is expanded the number of patients is much higher as you shall see in the following section.

The World of Primary Care

It is useful for psychologists to understand the challenges that primary care medical professionals face on a daily basis and the way primary care is different from specialty care. The term primary care has been defined variously by different authors. Commonly, it is said to be the first place a person takes any nonemergent medical

<table>
<thead>
<tr>
<th>Problem</th>
<th>PHQ 3000¹</th>
<th>Marillac 500²</th>
<th>Concord 500³</th>
</tr>
</thead>
<tbody>
<tr>
<td>Major depression</td>
<td>10</td>
<td>24</td>
<td>17</td>
</tr>
<tr>
<td>Anxiety</td>
<td>6</td>
<td>16</td>
<td>17</td>
</tr>
<tr>
<td>Substance abuse</td>
<td>7</td>
<td>21</td>
<td>10</td>
</tr>
<tr>
<td>Somatization</td>
<td>7</td>
<td>17</td>
<td>17</td>
</tr>
</tbody>
</table>

Note. PHQ = Patient Health Questionnaire.

¹Spitzer et al. (1999)
²Mauksch et al. (2001)
³Gunn & Matzkin (2009)
problem, the physician who is their main doctor over time, and the doctor who helps a person navigate the complexities of the medical system for care that cannot be provided their main doctor. The differences in descriptors of primary care and specialty care are outlined in Table 2.

Primary care is filled with the medically commonplace, but because something is common does not mean it is not complex. Consider the top 10 presenting complaints in adult primary care: chest pain, fatigue, dizziness, headache, swelling, back pain, shortness of breath, insomnia, abdominal pain, and numbness (Kroenke & Mangelsdorff, 1989). Kroenke and Mangelsdorff followed the people in the study who presented these complaints for one year. In that year, about 15% of them were found to have a biological pathology of some type underlying the complaint. Most of these complaints were followed and many were resolved without an abnormal finding on exam or on a lab test. To be a medical provider in this environment requires a substantial tolerance for uncertainty. For those living in the dichotomized world of physical versus psychological explanation of phenomena, this picture can lead to a misstatement that is common in the literature of behavioral health needs in primary care that 70% of visits to primary care are for problems that are psychosocial in nature. This does not adequately represent the experience of either the physician or the patient. Following is an example of a representative morning schedule in primary care (Table 3). This example was first created by Thomas Campbell, MD (personal communication, May, 2001). We have modified and extended it a bit.

Now here is the same list with representative mental health, psychosocial, and behavioral health needs highlighted (Table 4).
For every need listed, there is a reasonable behavioral health intervention available. It would seem that a health psychology practice near this primary care site would get a number of referrals out of this morning’s work. However, the average number of referrals out of an array like this would be 0 to 1.

Let us look at the list a little more closely. The first patient is a 56-year-old woman with diabetes who is anxious about the course of her disease. She has heard about people going blind and losing limbs. She knows that her obesity is a contributory factor, yet she has had a hard time losing weight. She is worried about her weight and about what she eats most of the time. It is consuming her life. On the other hand, she sees her worry as a natural response to her medical situation and would never accept a referral for help to be less anxious.

The 19-year-old man is coming for a physical to get a license to drive a truck. He is not concerned about his smoking and would not accept a referral to a smoking cessation course. If anything, the challenge for his doctor is to try to make some connection with him so he will come back to the doctor more often. This might make a conversation about his smoking possible. From an epidemiological perspective, his greatest risk is from accidents. It would be more useful to lower the chance that he will drive to exhaustion in his truck or take substances while driving.

The next patient is a 33-year-old woman who is an immigrant from South America. Although a screening test would identify her as meeting criteria for a diagnosis of major depression, the concept of an emotional disorder would make no sense to her. In her culture, people are either considered sick or crazy. She is not crazy, like some of the homeless people she has seen talking to themselves, so to her, she is sick. It would make more sense to her for someone to tell her that a former girlfriend of her husband had put a curse on her than to tell her that she has an emotional disorder related to chemical processes in her brain. She is not going to follow through on a referral or treatment, though out of respect for the doctor, she will certainly agree to go for counseling or to take medication when she is in the consulting room.

The 7-year-old boy has an earache. At the end of the visit, his mother says that she is concerned that he has started wetting the bed. She does not offer the information that she and the child’s father have recently separated because she feels bad enough about it without entertaining the idea that their stress is contributing to the child’s problems. She expects a medical definition of the problem and sees the physician as the person who should address it. A behavioral health referral would not be acceptable.

The 67-year-old man who can’t sleep tells the doctor he drinks five or six beers a night when he is asked about alcohol use. The doctor has to ask because he was

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Table 4

*Typical Morning in Practice: Issues Behind the Chief Complaints*

<table>
<thead>
<tr>
<th>Age</th>
<th>Chief Complaint</th>
</tr>
</thead>
<tbody>
<tr>
<td>56-Year-old diabetic with poor control</td>
<td>Anxious</td>
</tr>
<tr>
<td>19-Year-old smoker for annual physical exam</td>
<td>Smoking cessation</td>
</tr>
<tr>
<td>33-Year-old with multiple somatic complaints</td>
<td>Depression</td>
</tr>
<tr>
<td>7-Year-old with otitis media</td>
<td>Enuresis</td>
</tr>
<tr>
<td>67-Year-old with insomnia</td>
<td>Alcohol abuse</td>
</tr>
<tr>
<td>70-Year-old with sinusitis</td>
<td>Family violence</td>
</tr>
<tr>
<td>52-Year-old with hypertension</td>
<td>Cardiac risk factors</td>
</tr>
<tr>
<td>45-Year-old with tinnitus</td>
<td>Hypochondrias</td>
</tr>
<tr>
<td>38-Year-old with acute asthma</td>
<td>Nonadherent to medications</td>
</tr>
<tr>
<td>28-Year-old with chest pain and shortness of breath</td>
<td>Panic disorder</td>
</tr>
</tbody>
</table>


going to prescribe a sleeping medication. The patient has been a little worried that his alcohol use might hurt his health, so he is willing to tell about it to see what the doctor says. He is thinking he might cut back at some point. He mistakes the physician’s nonjudgmental response as meaning there is little to worry about. He is relieved and is not interested in any behavioral health referral to reduce drinking.

The 70-year-old woman with a sinus infection has been shoved around by her 16-year-old grandson when she told him he couldn’t have any more money. The doctor asked her about the bruises on her shoulder, but she says she fell. She may tell the physician a minimized version of what happened, but would never accept a referral for behavioral health help. She is worried that social workers will come and take him away from her.

The 52-year-old man has hypertension and high cholesterol. He is a type A personality who is driven in his work and stressed a lot of the time. He could benefit from stress management and relaxation work in addition to help with motivational interviewing about his diet. However, his health insurance company does not pay for behavioral health care where there is not psychiatric diagnosis. He will not accept a referral.

The 45-year-old woman with ringing in her ears has come back often for symptoms that the physician sees as minor. She sees each symptom as the figurative “tip of the iceberg” of a deadly, if undiagnosed, disease. She would not accept a referral for help with this worrying because she would feel blamed and discounted by the doctor.

The 38-year-old woman with frequent asthma exacerbations is struggling with family issues. Her physician has told her she must be in a smoke-free environment. Her husband thinks she uses her asthma as a weapon to try to make him quit smoking. He is not about to go for counseling about their relationship or about his smoking. She will not take a referral.

The 29-year-old man with chest pain has panic disorder. His physician was suspicious after his first trip to the emergency room with chest pain and shortness of breath. A person his age is at very low risk for heart disease. After doing some tests, the doctor is now confident that he has panic attacks. He comes today with a mild one, but he still wants more tests. When he is told the diagnosis of panic, he is torn about whether to take the selective serotonin reuptake inhibitor (SSRI) his physician prescribed and go for behavioral health treatment she suggests, or to find another doctor who will do more tests.

This is a taste of how mental health needs present in primary care. The fact that there are evidence-based or well-accepted ways that a psychologist could help each of them is only relevant if the clinician can work with the patients. When the psychologist is part of the primary care practice team, and can be presented as working with the physician, instead of being a referral destination from the physician, a much higher percentage of patients will allow the psychologist to be involved in their care. However, even if a psychologist is not colocated in the practice, they can create a relationship with the primary care provider that can be coordinated whenever clinically necessary.

Barriers to Collaboration

One of the most creative clinicians and thinkers in the field of integrated health care and primary care mental health is C. J. Peek, PhD. Dr. Peek, a psychologist, created pilot clinics having colocated services for Health Partners, a large health manage-
ment organization (HMO) in Minnesota. The clinics were very successful and his model for them continues to this day. Dr. Peek’s conceptual model, the Three World View, holds that for integration to be successful it has to align the clinical systems, the operational systems, and the financial systems (Peek & Heinrich, 1995). If any one of these systems is encountering significant barriers, the overall system will not work. Dr. Peek, currently an organizational consultant in health care, has added a fourth dimension, training, to his model. Training both behavioral health and health care clinicians and staff to see problems in a comprehensive, biopsychosocial context is critical to success in integrated care. Some examples of areas in which these clinical, operational, financial, and training barriers play a role are given below.

Clinical Barriers

Differing treatment philosophies. In the biomedical model, the medical professional directs treatment decisions and bears responsibility for motivating the patient toward positive outcomes. Treatment and cure traditionally have been understood to be the medical professional’s responsibility, even when patients are not cooperative in treatment. Although medical professionals may get frustrated and angry with noncompliant patients, they rarely terminate treatment. The medical professional/patient relationship is evolving towards more of a partnership, but most medical professionals still feel a sense of overarching responsibility for care outcome.

In contrast, in the mental health world, the patient and psychologist share responsibility for change, but the onus is on the patient to create change. When patients do not progress in psychotherapy because of lack of motivation or chronically missed appointments these issues become the treatment focus. Sometimes psychologists will terminate their therapeutic relationship when the patient is unwilling or unable to actively participate in treatment.

Action versus process orientation. Medicine is action oriented. Medical training emphasizes action over discussion and dialogue. Patients hold the expectation that their medical professional will “do something,” and may feel that their appointment was not helpful unless they leave with a prescription for medication, diagnostic tests, or a referral to a specialist. Medical professionals focus on outcome, and ideally strive to practice evidence-based medicine in which they use current research evidence to guide their treatment decisions.

Psychotherapy tends to be more process oriented. Psychotherapy patients expect only that the psychologist will listen to them and offer insights and ideas about how to solve their difficulties. Psychologists are trained to assess and understand behavior and contextual factors to help people effect change. Often, the focus is on patterns of behavior and process, as much as the final outcome.

Different professional languages. An obvious difference between these cultures is that medical professionals and psychologists have different languages (Seaburn, Lorenz, Gunn, Gawinski, & Mauksch, 1996). For example, medical professionals use the term myocardial infarction or MI for a heart attack, while psychologists might refer to “undifferentiated ego mass,” or an “enmeshed family” in describing an abnormally close family system. Psychologists who experience difficulty understanding “med-speak” may be unaware that their own jargon is equally noncommunicative. Ideally, both psychologists and medical professionals should avoid jargon in their communication. However, psychologists may need to learn some med-speak to enhance collaboration.
Confidentiality. The medical culture is organized around referrals and consultation with others. In contrast, the mental health culture values strict confidentiality. Medical professionals often engage in “curbside consults” in which they discuss their patients passing in the halls of hospitals or at professional meetings. Informal phone consultation regarding a patient is not uncommon. In this culture of openly sharing patient information, medical professionals may be confused and skeptical about psychologists who do not routinely communicate and seem secretive about their patients. Medical professionals often complain, “I never hear anything from psychologists or psychiatrists” after they make the referral. Although managed care tried to encourage psychologists to communicate in writing to the patient’s primary care medical professional, regular communication never became common practice.

Operational Barriers

Space. One of the most practical and consistent barriers within a primary care practice is space. Psychologists and medical professionals may have a desire to work more collaboratively and colocate services; however, there may simply not be the space to house a behavioral health service.

Roles and logistics. Most psychologists are not familiar with the various layers of professionals in the medical system, or the differences in training and philosophy between them. Nor are they familiar with the logistics of the medical office. Only a few graduate programs in psychology have expanded their curricula to include behavioral health and specific training in the workings of the larger medical system. Thus, many psychologists may be unfamiliar with the medical hierarchy, training, and philosophy of different specialties, and the role of midlevel providers such as advanced practice nurses and physician assistants. As a result, psychologists may be less able to cater their collaboration to the different styles of, for example, family physicians and internists, if they do not understand how these disciplines differ in training and culture.

Similarly, most medical professionals are confused by the vast array of disciplines, training, skills, and specialties in mental health. Psychologists with different theoretical orientations further confuse the medical professional. Although medical professionals clearly understand why, when, and how to refer to medical subspecialists, they may be uncertain about the specifics of a psychotherapy referral. Ultimately, they may have difficulty matching the patient’s needs to the most appropriate psychologist.

Financial Barriers

Insurance reimbursement structure. Like the government, insurance companies often have completely separate systems and funding pools for physical and mental health treatment. “Carved out” mental health may be provided by a smaller company that manages only mental health and substance abuse issues. Some insurance companies have higher patient copayments for mental health treatment, negatively impacting access to mental health treatment. In addition, a referral process that requires patients to choose a psychologist based on input from the behavioral health arm of the company can prevent the medical professional from managing the referral process directly by helping the patient select a psychologist.
Insurance reimbursement systems also impede collaboration by creating intense time pressure. The current reimbursement structure emphasizes volume and medical procedures over taking time to talk to patients. Medical professionals see a large volume of patients in any given day and are frequently rushed and behind schedule. No matter how psychosocially oriented, they genuinely may not have time for lengthy discussions about patients’ emotional lives and stressors. The perception and reality that medical professionals are busy may increase the psychologist’s discomfort initiating contact. One psychologist surveyed said “Most physicians seem very impatient when they are contacted by phone, even though I keep the contact short, organized and try to speak their language” (American Psychological Association, 2006).

Most medical professionals and psychologists are pressured by insurance companies to see more patients in less time for less reimbursement. High patient volume and cost control measures such as precertification generate more documentation. These factors leave many professionals feeling that they have no time for collaboration. The lack of insurance reimbursement for phone calls or electronic mail communication regarding patient care serves as a further disincentive to collaboration. Although patients value collaboration between their healthcare professionals, they are usually unwilling to pay for nonreimbursed services.

Fortunately many of these large system issues are slowly beginning to change. Integrative, mind body approaches to treatment of acute and chronic illnesses like heart disease and pain utilize a team approach that often includes psychologists. Health psychology has become an important area of study and specialty (Chesney & Antoni, 2002). Parity legislation, which would require insurers to reimburse mental health and substance abuse treatment at the same rate as physical health, has been introduced in many states and at the federal level. In some states, serious mental illness (SMI), which may include schizophrenia, bipolar disorder and depression, is already reimbursed at the same rate as medical problems. These examples suggest a paradigm shift toward a more integrative approach to treatment of the whole person.

Training

Separate training and practice settings. Many of the cultural differences between medicine and mental health stem from the fact that psychologists and medical professionals usually train and practice separately. Psychologists train in universities and colleges that have little or no educational overlap with medical or nursing schools. The only contact with the medical world most psychologists have during their education and training is with psychiatrists. Similarly, medical professionals trained in many specialties may have limited exposure to psychologists.

Overcoming Barriers

A prime example of a mental health disorder that has received considerable attention is depression. There is a now a national screening day for depression and in recent years an increased emphasis on looking at this disorder in the same way we look at medical disorders. This has allowed many people and many physicians to begin conversations about depression and other psychological disorders that previously were difficult to identify or discuss in primary care. The common language about depression has been a great improvement over the situation before screening because previously the differences in concepts and language were not discovered. This is part
of the reason why so many people suffering from depression went undiagnosed and untreated.

Large randomized trials testing integrated models, usually focused on depression management, have consistently shown that using care managers (nurses, psychologist, social workers, etc.) have been a key part of creating successful outcomes (Katon, Von Korff, & Lin, 1997). Now that care management has been instituted for a few years in a number of different settings, we are beginning to see anecdotally the need to expand the role. Primary care practices want better screening for substance abuse. They want ways of identifying and addressing anxiety. They want screening for attention deficit–hyperactivity disorder (ADHD), developmental delays, and depression for children. They want better programming for smoking cessation and for obesity. They want behavioral health input as part of group medical visits for diabetes, for asthma, and for pain. They want nonpharmacological approaches to insomnia. The need, in the long run, is for primary care behavioral health clinicians to work alongside primary care physicians. A number of health systems has put these components together in their operation. An example of one that has both a clinical and a research objective is the Intermountain Health Care model in Utah. This system provides routine assessment and stratification of patients depending on the acuity of their symptoms. It has shown increased quality and satisfaction, as well as demonstrated cost neutrality (Reiss-Brennan, Brior, Cannon, & James, 2006).

However, not all practices can start with the integration of a behavioral health person into the practice. Sometimes, the behavioral health resources is added as a program coordinated with the primary care practice or as a service colocated in the primary care practice (Blount, 2003). A coordinated resource is one that, as it sounds, works together with primary care practice from a separate location. This could be something as simple as a psychologist in private practice who is assiduous about gathering health as well as mental health information on intake, who always requests permission to notify the primary care physician of a patient’s involvement in care, and as often as possible exchanges information about care with the physician. Some clinics and systems have tried to simply colocate behavioral health services in primary care clinics and encourage referrals. Although this seems logical at first, in the longer term it has raised many problems with complex cases, with comorbidity and with different problem definitions between patients and professionals that made adding a behavioral health component rather than referring out sensible in the first place. It has also led to “parallel play” between professionals with little time to collaborate.

Overcoming the financial barriers continues to be a major issue in creating integrated or collaborative practices. No matter how much you streamline your collaborative practices, the bottom line is that collaboration does take time. In some cases, the time invested in collaboration pays off in reducing frustration, crisis intervention, and improving professional satisfaction. However, there is no monetary compensation because the current reimbursement structure does not pay psychologists to collaborate.

As psychologists become more collaborative, they can expect to serve more patients with psychological and social issues negatively impacting their medical conditions. When treating patients in this category it is helpful to be aware of the new health and behavior CPT (current procedural terminology) codes, which may open the door to reimbursement for psychotherapy and psychoeducation for patients with medical diagnoses. Basically, the new health and behavior codes allow psychologists, nurses, licensed social workers and, in some states, licensed counselors
to bill for services that address social and behavioral aspects of physical health problems as diagnosed by a medical professional. The interested reader is referred to *Behavioral Consultation in Primary Care* (Robinson & Reiter, 2007) for detailed, state of the art instructions on the use of these codes, including how to choose the appropriate CPT and diagnostic codes, and necessary documentation. It should be noted that some private insurers may not reimburse these codes, but Medicare currently reimburses for five of the six Health and behavior codes (Robinson & Reiter, 2007). It is our hope that psychologists will experiment with using these codes, as the more frequently they are used, the more likely they will be adopted by more insurers and create expanded opportunities for psychologists to be part of health care provision.

Knowledge, Skills, and Attitudes of a Collaborative Psychologist

In the following section, we describe practical tools and strategies psychologists can use to begin or further their ability to collaborate with medical professionals. They are effective by professionals that are colocated or ones that desire greater coordination, but are not located together. As was mentioned earlier, the most important step towards collaboration is to find a way to colocate within a primary care practice. The ability to assist the medical professionals and staff with patients like those described earlier is greatly enhanced with co-location. Being colocated allows for easy communication through shared charts and hallway consultations. It allows the psychologist to offer a biopsychosocial explanation of illness to the patient. It allows for the psychologist to address the common psychosocial dilemma of chronic illness, provide consultations for somatizing patients, and address lifestyle issues such as smoking or obesity. However, given the barriers discussed earlier, co-location may not be possible. The steps below describe a way for psychologists who have not been involved in thinking and acting collaboratively to create more coordinated care practices. They are described in more detail in a book to be released this fall by APA Press (Ruddy, Borresen, & Gunn, 2008).

**Step 1: Making a Commitment to Collaborate**

As with most changes in behavior, it takes motivation to step outside one’s comfort zone and practice differently. The first step is to assess one’s own level of motivation. A collaborative psychologist must be willing to adapt their practice to aspects of the medical system culture that are different from the mental health culture. Some psychologists feel this puts mental health in a “one down” position to the medical system. However, an alternate perspective is to see oneself as a systems consultant and become curious about how to intervene effectively in the medical culture.

**Step 2: Establishing a Collaborative Mindset**

Once psychologists have committed themselves to becoming more collaborative, they must make a critical shift in their assessment, conceptualization, and treatment planning process. Psychologists must expand their thinking and processes to actively assess patient’s collaborative needs. What role can collaboration play in this particular clinical presentation? How do the patient’s medical and mental health care currently synergize each other and what can be done to improve their combined power?
Psychologists who actively assess for the patient’s collaboration needs will find that the appropriate level of collaboration will vary across cases, from a minimum of a form letter at the beginning and end of treatment, to contact after each session. This has been previously referred to and described in detail as the “spectrum of collaboration” (Seaburn et al., 1996). Ongoing communication tends to be more important when the medical professional is prescribing psychotropic medication, the patient has a chronic or life threatening illness, presents with somatic symptoms, has chronic pain, and/or, substance abuse issues. It is essential that psychologists evaluate these issues during the assessment process.

Psychologists with a collaborative mindset recognize that the time and energy spent on collaboration can ultimately save time and energy spent on patient care. This can help to maintain motivation to prioritize collaboration even when it is challenging.

**Step 3: Creating a Collaborative Practice Toolbox**

To maintain collaborative relationships, whether colocated or coordinated, collaborative practices must be integrated into daily practice patterns. Becoming collaborative is a process. Each psychologist must experiment with various practice management techniques to determine which fit best with their practice style and in their community. As with any behavioral change, attempting a collaboration “practice overhaul” probably is not realistic. Rather, it is recommended that psychologists start with those techniques that seem least time consuming or difficult and allow their collaboration practices and style to evolve with time and experience.

Communication is one of the key elements of collaboration (Seaburn et al., 1996), thus it is helpful to create a “tool box” of communication aids. To reduce time spent collaborating, streamline communication by creating form letters for common points of communication. Such form letters allow the psychologist to simply add relevant information to a preexisting letter, distilling written communication into its easiest form. They are most useful at the beginning and end of treatment.

*Postreferral/intake letter.* It is recommended that psychologists have a standard “thank you for the referral” letter to be sent after the first appointment. Even a letter that discloses only that the patient followed through on the mental health referral helps the medical professional because in the current system they often have no way of knowing if or when the patient connected with a psychologist. A form letter with a space for diagnosis and a few words about treatment plan can be even more helpful and takes little extra time and energy.

*Termination letter.* The communication tool box should also include a letter to be used to alert the medical professional when treatment has been terminated. The letter can simply state that treatment has stopped, or can go into more detail about the treatment and future options. This letter should describe the patient’s progress, and symptoms or warning signs the patient and medical professional should monitor for early detection of relapse. If the termination is mutually agreed upon between the patient and the psychologist, they can cocreate the termination letter. Writing this letter is a therapeutic exercise in and of itself, as it reviews material that the patient and psychologist would generally discuss as part of the termination process. Such cocreation of letters to the patient’s medical professional is one way to reduce the out of session time involved in collaboration.

Psychologists who create a structure for easy communication with medical professionals will find ongoing clinical collaboration much easier to maintain. In
addition, basic collaboration techniques tend to evolve into a routine as professionals establish a relationship over time and multiple shared patients.

**Step 4: Finding Partners for Collaborative Care**

The fourth step is to find medical professionals who are receptive to collaboration. This may entail some rejection from those medical professionals who do not focus on psychosocial concerns and mental health issues in their practice. However, they are in the minority. A recent survey of family physicians indicated that 13.5% already have mental health professionals providing services in their office, and an additional 60.2% indicated they value collaborative care to the point they would consider having an in-house psychologist (Chantal, Brazeau, Rovi, Yick, & Johnson, 2005).

The process of finding collaboration partners is similar to the networking psychologists use to expand their referral network. Ask colleagues, friends, and even one’s own medical professional who is known to be psychosocially focused and/or particularly skillful in working with distressed patients. As Doherty, McDaniel, and Baird (1996) review in their model, medical professionals fall along a continuum of styles regarding the integration of psychosocial issues in medical practices. Those medical professionals who are already psychosocially focused are more likely to be receptive and helpful in further networking.

Some psychologists facilitate networking by giving professional presentations on a topic that medical professionals would find of interest. Topics could include depression in primary care, managing chronically ill patients, or increasing patient compliance to medical regimens. Many medical and nursing professional associations have ongoing lecture series and would welcome this assistance. Also, it is likely that the medical professionals who would choose to attend a conference on psychosocial issues are more interested in detecting and treating these issues in their practices.

**Step 5: Making Contact Within Your Current Referral Network**

The best source of potential collaborators is the medical professionals who currently refer to you. Many psychologists who do not regularly collaborate may not know the names and contact information of their current patients’ medical professionals. To begin, ensure that all patients routinely disclose the name, phone number, and address of their primary care medical professional during the intake process, and routinely request a release of information to each patient’s primary care medical professional. Although patients rarely have concerns when this request is presented in a routine manner with a rationale regarding the importance of collaboration, their wishes must be respected if they express reluctance. If this becomes a treatment issue (e.g., the medical professional is prescribing psychotropic medication, the patient has medical issues that impact his or her mental health care, etc.) then the topic can be addressed as a therapeutic issue.

After obtaining the necessary information and permissions, contact the medical professionals of current and recent patients. Many collaborative psychologists first send a letter, followed up by a phone call in which they discuss shared patients and then focus on opportunities for future networking. There is one important caveat to relying on letters for communication. Psychologists who use letters as a primary mode of communication should be aware that the medical professional may not always have the opportunity to read the letter when it is received in the office. Patient correspondence generally is reviewed by a medical professional prior to filing, but it may not be reviewed by the medical professional that works most closely with the
patient. When this occurs, the primary medical professional does not have the opportunity to read the letter until the next patient visit, and may not read the letter then, if he or she is unaware of it. Some psychologists attempt to avoid this problem by adding a note at the top of the letter requesting that the medical professional who works most closely with the patient review it prior to filing. However, if later conversation reveals the medical professional is unaware of the letter do not interpret this as disinterest in collaboration.

**Step 6: Making Contact Outside Your Current Referral Network**

If there is no pattern of referrals or current shared patients with a medical professional, a letter of introduction can serve as a first contact. This letter should provide educational background, types of patients seen in the practice, office hours and location, and accepted insurance plans. Emphasize a desire to collaborate and communicate about shared patients. Suggest a face-to-face meeting and offer a means of arranging it. Be aware that sending letters alone tends to be a low-yield exercise because it puts the onus on the medical professional to make first contact, and is likely to get little attention in the volumes of paperwork most medical professionals receive in a day.

In first meeting with a medical professional, the conversation should focus on pragmatic issues. Psychologists can market their services by emphasizing how they can make the primary care medical professionals’ jobs easier and enhance patient care. A solution-oriented approach to the first meeting will reassure the medical professionals that the psychologist will use a similar, pragmatic approach with their patients. Patients often complain that psychologists “just listen” and do not offer any suggestions or pragmatic help. If the primary care medical professional perceives the psychologist as grounded and helpful, they will refer with confidence.

Finally, most psychologists underestimate how much a personal conversation facilitates relationship development. Medical professionals often need to convince and cajole patients to follow through on a mental health referral. It is much easier for them to do so when they can personally vouch for the psychologist. Making a psychotherapy referral has been likened to arranging a blind date. Patients are often ambivalent about the referral and anxious about talking to a new person. When a medical professional can reassure the patient that they have spoken with the psychologist and have found them personable and/or have received positive feedback from other patients, it can erode the patient’s ambivalence and anxiety, facilitating the referral.

When the needs assessment reveals that a practice has an established relationship with a psychologist, be mindful of respecting that relationship to avoid upsetting a colleague. In fact, if this colleague practices collaboratively, they may be a valuable resource to you. Gathering the names of psychologists who receive many primary care referrals may help you discern which local psychologists practice collaboratively. You may choose to contact these psychologists to join or form a supervision group or negotiate other means of working together to learn from and support each other in providing collaborative care.

**Step 7: Collaboration Follow-Through: The Moment of Truth**

Although the initial conversation with medical professionals is critical to laying the groundwork for collaboration, it is the follow up that will create and maintain a
mutually beneficial working relationship. In this section we will review critical junctures for collaboration.

When the initial conversation focused on a consultation regarding a shared patient, send a follow-up note reviewing details of the patient’s clinical presentation and treatment plan and review the collaboration agreement, both for the specific patient, and in general. This type of follow-up letter helps in the following ways:

1. It communicates to the medical professionals that their concerns and requests were heard and internalized.
2. It helps the psychologist keep track of agreements made with different medical professionals and offices.
3. It reminds the medical professionals that they have a potential ally in caring for their patients.

Create a collaboration tracking system to ensure that the follow-up collaboration is consistent with the collaboration agreement. Some psychologists track collaborative contacts separately from progress notes, listing the contact information for medical professionals, copies of letters sent, and notes regarding any verbal communication in a segregated section. Some psychologists create space on their normal progress notes to track communication with medical professionals, such as a separate prompt or check box. One advantage of integrating the collaboration tracking system into routine paperwork is that the prompt can also serve as a reminder to the psychologist to make contact. Psychologists must be mindful of customizing the collaboration to the patient’s needs as they learn more about the patient, and the interplay of their emotional and physical health. As noted earlier, sometimes the minimal collaboration of a form letter at the beginning and end of treatment is not sufficient. When ongoing collaboration is necessary, sending routine letters that briefly update information and review salient issues is the least time consuming. Such letters give the medical professional an overview of the patient’s mental health care, allowing them to use medical care contacts to support the issues being discussed. In addition, it informs the medical professional of ongoing stresses that may be relevant to the patient’s medical care. These letters often need such a high level of specificity that form letters are less helpful than at the beginning and end of treatment.

Although letters are the least time consuming form of collaboration, even multiple letters can be insufficient when the clinical presentation calls for reciprocal conversation. Common situations include patients with medical conditions affecting their mental health, patient, or family questions about the patient’s medical condition, or patients who have expressed dissatisfaction with their medical or mental health care. In these clinical presentations, occasional phone conversations help the professionals solve problems and/or share perspectives more effectively. Alternatively, some professionals have started to use e-mail as a means of reciprocal conversation; however, care must be taken to ensure confidentiality. In this manner, the psychologist receives information about the patient’s health status, medical professional’s impressions of coping and treatment progress and other information the medical professional may have gleaned during medical visits. Often, when a patient has regular medical visits, their medical professional knows them (and their larger system) extremely well. Input from the medical professional can enhance care
by giving history or context, ongoing assessment, and an alternate perspective. The following questions can frame the conversation with the medical professional:

1. What is the medical professional’s primary concern for this patient?
2. What would constitute therapy “success” for this patient?
3. How well does the medical professional know this patient and his or her social situation?
4. Does the medical professional have any advice about developing a working relationship with this patient?
5. Are there any medical problems now or in the past that might be relevant to the patient’s psychological distress?
6. How well does the patient follow medical advice? If this is an issue, how can the psychologist help the medical professional with these issues?
7. Does the patient require psychotropic medication?
8. How would the medical professional like to proceed with communication and collaboration regarding this patient?

Not all of these questions must be addressed with every patient. However, they give a template of the types of issues that can be helpful to discuss, particularly with more complex situations.

Finally, it is essential to advise medical professionals when their patient terminates mental health treatment prematurely because it may be the only notification the patient is no longer receiving services they receive. Medical professionals can play an important role in facilitating ongoing care for patients who have difficulty engaging in psychotherapy. When the patient terminates psychotherapy prematurely, the medical professional can address the patient’s decision in subsequent medical appointments, and may be able to refer to another psychologist and/or encourage a return to treatment if advisable. Because many patients use mental health treatment episodically, medical professionals are in a unique position to help patients realize when it would be helpful to return, and to keep this possibility open at all times. The more the medical professional knows about the patient’s previous experiences with mental health, and their level of satisfaction with previous psychologists, the better prepared they are to intervene productively. Collaborative communication during mental health services facilitates re-referral if necessary in the future.

Summary and Recommendations

In this article, we have provided an evidence-based rationale for increasing collaboration between psychologists and medical professionals. We have included practical examples of steps psychologists can take to increase their ability to collaborate effectively. We have strongly encouraged a move towards co-location as a vehicle to provide the highest level collaboration. However, recognizing the difficulties, we have encouraged practices that can make any psychology practice more collaborative. We believe that integrating health and mental health care is critical at this time and urge all psychologists to look for ways within their practice to incorporate some of the ideas shared in this article. Here are some further recommendations to consider.

1. Develop relationships with medical professionals case by case: Every referral is an opportunity to develop or further the relationship with a referring provider.
2. See all comers, especially the difficult cases: Talk with medical professionals about their most challenging cases and be willing to help or problem solve even if the patient will not see you directly.

3. Practice flexibility and creativity: Experiment with short visits, consultation sessions, and brief, focused interventions.

4. Act like a guest and like someone who should be at the table: Be respectful, as an outsider, to the medical culture while, at the same time, feel comfortable in the value added of a psychologist providing optimal health care.

5. Be open and available: Ask routinely for patient permission to communicate with the medical professional. Communicate freely as needed. Be available and be willing to be interrupted as needed.

6. Schmooze the staff: The nursing and office staff in a medical culture can help greatly to communicate and add directly to the treatment plan. They also need help in dealing with difficult situations.

7. Advocate for financial reimbursement: Every locale is different in the willingness of public or private reimbursement for consultation session in a medical setting and care coordination. Be active in advocating for the Health and Behavior Codes to be utilized in your area.

8. Practice relentless follow-up: If patients drop from treatment, communicate with medical professionals about your impressions and your willingness to be involved again.

References


