PARTNERSHIPS IN MENTAL HEALTH: EFFECTIVE REFERRAL AND COLLABORATION BETWEEN FAMILY PHYSICIANS AND PSYCHOLOGISTS

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Abstract

This study looked at physicians' perceptions of the existing process of referral and collaboration between themselves and psychologists. Specifically, this study sought to identify the barriers to referral and collaboration in an effort to improve referral and collaboration between these two fields. A total of nine family physicians were interviewed. Overall, the barriers that were identified by physicians included a lack of feedback provided by psychologists, a low level of collaboration with psychologists, physicians' perception of the financial inaccessibility of psychological care, the lack of information that physicians have on psychologists, and physicians not knowing the resources that were available. Addressing these barriers appears to involve some combination of improving psychologists' feedback and collaboration with physicians, providing physicians with information and education on psychologists and their services, and improving the financial accessibility for patients to receive psychological services.

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Chapter 1

Introduction

It has been stated that up to 60% of all visits to primary care physicians are psychological in nature (Newman & Rozensky, 1995). In order for these patients to receive the services they need, it is essential that the process of referral and collaboration between physicians and psychologists is operating effectively. The research, however, suggests that this may not be the case. For example, on average, general practitioners decide not to send 88% of the patients they find as having psychological symptoms for secondary care (Huxley, 1996). This low level of referral and collaboration between physicians and psychologists can have a negative effect on the quality of patient care, increase health care costs, and create patient overload for physicians. In addition, the importance of collaborative practices has been recognized and supported by organizations such as the American Psychological Association, the Canadian Psychological Association and the Canadian Register of Health Service Providers in Psychology (CRHSPP).

It is important that we identify what is and what is not working so that we can improve the working relationship between physicians and psychologists. Specifically, it is important to determine what is and is not working from the perspective of the physician because the decision of whether or not to refer is ultimately decided by them (Seager, 1994).

This project will explore Lethbridge physicians' perceptions of the existing process of referral and collaboration between themselves and psychologists. Ultimately, this research hopes to determine how we can improve and thus increase the level of referral and collaboration between these two fields.

This chapter provided an introduction to the importance of improving the process of referral and collaboration between physicians and psychologists. Chapter 2 provides a review of the literature related to this topic. Chapter 3 provides information on the population, procedure, instrument, data collection, and methods of data analysis. Chapter 4 will present the results of this project. Chapter 5 will then elaborate on the results presented in Chapter 4 by outlining the implications of these findings.

Chapter 2

Review of the Literature

This chapter includes a review of the relevant literature regarding the importance of physician referral and collaboration with psychologists, the natural alliance that exists between physicians and psychologists, the current rates of physician referrals to psychologists, the barriers to effective referrals, the factors that facilitate effective referrals, and reviews the existing research on how to improve physician-psychologist collaboration.

Importance of Physician Referral and Collaboration with Psychologists

Low levels of referral and collaboration between physicians and psychologists can have a negative impact on a variety of areas. Specifically, the areas that may be affected include the quality of patient care, health care costs and patient overload for physicians.

Quality of patient care. With regards to the quality of patient care, there are several critical issues that arise. First, a large percentage of psychological problems are seen by physicians (Newman & Rozensky, 1995) rather than by psychologists (Hunsley, Lee & Aubry, 1999). The type of treatment that is most often provided in the primary care setting appears not to consist of psychotherapy (Glied, 1998) but rather to consist of some combination of psychotropic drugs, advice, and reassurance (Orleans et al., 1985). Studies have looked at the effectiveness of treating psychological problems with medication, psychotherapy or some combination of both and the results are mixed. Much of the research, however, suggests that treating psychological illness with a combination of psychotherapy and medication produces the best results (Racy, 1996).

Another problem with patients presenting the majority of their psychological issues in the doctor's office is that many of these psychological problems are overlooked

by physicians (Eisenberg, 1992). This may be due to a variety of factors including lack of physician training (Katon & Sullivan, 1990), time restraints placed on the physician by heavy caseloads (Orleans et al., 1985) or the limited physical space of the medical environment which may not facilitate the processes involved in adequately addressing and exploring patients' emotional problems (Drotar, 1982).

Since up to 60% of all visits to primary care physicians are psychological in nature (Newman & Rozensky, 1995), it is important to look at the quality of patient care that is being offered in these settings. Family physicians are often the first professionals in a position to identify these problems, and whether or not the patient receives the help they need largely depends on the physician (Pray, 1991; Seager, 1994). Family practitioners have reported that of the 20% of their patients that they identify as having significant psychological problems, they treat most of them themselves (Orleans et al., 1985). However, many of the problems that patients bring to physicians could benefit from psychological consultation. Such problems can include depression, anxiety, stress-related disorders, psychosomatic illnesses, drug and alcohol abuse, domestic violence, and adjustment problems related to chronic and traumatic illnesses (Magill & Garrett, 1988). Other problems may include marital or sexual problems, psychophysiologic and pain disorders, chronic pain and adjustment reactions (Orleans, George, Houpt & Brodie, 1985).

It does not appear, however, that individuals suffering from psychological issues are receiving the benefits of psychological care. Hunsley et al. (1999) have noted that there is an underutilization of psychological services, especially by those with the greatest mental health needs. They found that in Canada the majority of individuals with

psychological issues, including those that were using psychoactive medications, had not seen a psychologist in the last year. For example, of the individuals who reported being so unhappy that they felt life was not worthwhile, only 10% had seen a psychologist. This study also found that 87% of those who were likely to meet the criteria for a diagnosis of depression did not receive psychological services.

Considering that the majority of individuals suffering from psychological problems are presently receiving care from their family physician rather than from a psychologist, it is important to look at the type of care that they are receiving from their physician.

The types of services provided to patients with psychological problems by physicians have been found to consist of some combination of psychotropic drugs, advice, and reassurance (Orleans et al., 1985). Typically, counselling interventions are not even seen in the primary care setting (Glied, 1998). One study found that psychotherapy was involved in fewer than 1% of the mental health issues seen by a physician. This same study, however, reported that 6% involved a prescription for psychotropic drugs (Glied, 1998). In fact, it has been suggested that psychotropic drugs may be over prescribed by physicians (Peters, 2000). In a recent article Peters (2000) suggests that when physicians identify depression in seniors they tend to prescribe anti-anxiety drugs or antidepressants. In this article it is estimated that 35% of seniors take psychotropic drugs which the author suggests puts them at risk for adverse side effects and interactions with other medications. It is also noted that the majority of them do not receive psychotherapy, which may be all they need.

The effectiveness of different treatments for psychological illnesses. The research surrounding the effectiveness of treating psychological illness with medication alone, with psychotherapy alone or some combination of the two mixed.

Some of the research has found cognitive psychotherapy to be more effective in the treatment of depression than treatment with medication alone. Blackburn, Bishop, Glen, Whalley, and Christie (1981) looked at depressed patients seen either in general practice or in an out-patient department. Patients were randomly assigned to cognitive therapy, antidepressants or a combination of the two. They found that in general practice, cognitive therapy alone was more effective in the treatment of depression than drug treatment alone. They also found combination treatment to be superior to drug treatment alone in both hospital and general practice.

Friedli, King, Lloyd, and Horder (1997) also compared the services provided by psychotherapists and primary care physicians to individuals suffering from emotional difficulties. Although they did not find any significant differences between the efficacy of the two treatment types, they did find that patients who had received psychotherapy were more satisfied with the care they received than those who only received care from their primary care physician.

Other research has pointed to medication as being superior to psychotherapy in the treatment of depression. The results of The National Institute of Mental Health (NIMH) Treatment of Depression Collaborative Research Program (Elkin et al., 1989) looked at 250 outpatients with Major depressive disorder that were randomly assigned to one of four groups; interpersonal therapy alone, cognitive behavior therapy alone, impramine plus clinical management, and placebo plus clinical management. Clinical

management (CM) was used in this study to standardize clinical care. It provided guidelines for the management of medication and side effects, review of the patients medical status, allowed for the provision of support, encouragement and direct advice for the patient if necessary and prohibited any psychotherapeutic interventions. It was found that for the severely depressed outpatients, impramine plus clinical management was the most effective treatment. There were, however, no significant differences across treatments for the less severely ill patients.

It has also been suggested by some research that neither psychotherapy nor pharmacotherapy are superior, but rather that they are equally effective in the treatment of psychological problems. Susman (1996) reported on a presentation given by Guy Sapirstein and Irving Kirsch at the annual American Psychological Association (APA) meeting in Toronto. Sapirstein and Kirsch looked at the effectiveness of antidepressants including tricyclics, monoamine oxidase inhibitors and selective serotonin reuptake inhibitors such as Prozac for the treatment of depression. They examined 39 studies involving a total of 3,252 depressed patients and concluded that psychotherapy alone was as beneficial as any of the antidepressants. They found there to be no significant difference in outcomes between those patients that were treated with medication alone and those who solely received psychotherapy.

Besides the methodological problems that have been noted as plaguing many of the studies cited above (Hollon, Shelton & Davis, 1993), the mixed results may also be due to the possibility that different disorders and varying degrees of disorders respond better to different treatments. For example, Racy (1996) points out that most milder

forms of psychological illness will require only psychotherapy whereas more severe problems such as severe anguish or anxiety often require medication.

The majority of the research, however, seems to suggest that treating psychological illness with a combination of psychotherapy and medication produces the best results (Racy, 1996). One study examined the effects of treating chronic depression with nefazodone alone, cognitive-behavioral psychotherapy alone, and a combination of both (Keller et al., 2000). The results showed that the overall rate of response to treatment of either the drug or psychotherapy alone was 48% while patient response to combined therapy was 73%. This study also found that the relapse rate for another depressive episode was only 52% for the two treatments combined, whereas it was 67% for psychotherapy alone and 71% for drug treatment alone, showing that combined treatment produces a more stable effect than either treatment alone.

A study done by Ashworth, Wastie, Reid, and Clement (2000) also supports the view that a combination of psychotherapy and medication is superior to medication alone when treating depression. This study looked at two groups of people. One consisted of people who were taking antidepressants and the other group consisted of people who were also on antidepressants but who had also received psychotherapy. They found that 53% of those that had been receiving the combined treatment were able to stop taking their medications and remain off them for the following year. In contrast, only 9% of those taking the medication alone were able to stop taking the antidepressants.

Studies have also found combined treatment to be more effective than treatment with medication alone for the treatment of anxiety. Mitchell (1999) compared the effects of medication alone (n=26) and the combination of medication and cognitive-behavioral

group therapy (n=30) in the treatment of panic disorder. There was found to be significant differences in posttest anxiety scores between the two groups. The individuals in the medication plus therapy group had lower posttest anxiety scores than those who had received medication alone.

Thus it seems that combining medication and psychotherapy may be the most effective method for treating psychological disorders. If this is the case, then physician referrals to psychologists become a critical issue in increasing the quality of patient care.

There are also a large number of psychological issues presented in primary care that can not be resolved simply by medication. For example, anorexia nervosa may be treated largely by psychological means (Kalb, 1985). As well, although substance abuse is treated in a multi-disciplinary manner, the treatment regime is largely psychological (Houpt et al., 1980). Other disorders such as hypertension may be better treated by helping patients to alter their lifestyles rather than a strict reliance on drug therapy (Miller, 1983). Domestic Violence is another issue that is often seen in primary care that can not be resolved through medication. The extent of physical abuse has been estimated to affect two to four million women each year (Shields, Baer, Leininger, Marlow & Dekeyser, 1998). In addition to physical injury, these women experience injury to their psychological and emotional well-being. Symptoms such as high anxiety, insomnia, feelings of isolation and fear, sexual dysfunction, depression, and increased substance abuse are common (Shields et al., 1998). A 5-year follow-up study of 117 battered women found that battered women are more likely to seek hospital care than women who have not been victims of domestic violence (Bergman & Brismar, 1991). Although primary care may effectively tend to the physical injuries, the emotional and

psychological injuries may be better treated with psychological interventions. Victims of domestic violence may also benefit from seeking care outside of the primary care sector as physicians will typically only spend 10 to 20 minutes with each patient compared to an average of 50 to 60 minutes spent by psychologists (McDaniel, 1995). When undergoing the psychological trauma associated with domestic violence, the brief interventions provided in the primary care setting may not be enough.

Another problem with patients presenting the majority of their psychological issues in the doctor's office is that many of the psychological problems are often overlooked by physicians (Eisenberg, 1992). Maguire, Julier, Hawton, and Bancroft (1974) conducted a study on the recognition of psychological disturbances by medical staff in a British general hospital. In this study, it was found that half of the incidences of psychological disturbance were missed. Similarity, Knights and Folstein (1977) examined physician identification of emotional disturbances and cognitive impairment in a sample of inpatients. They found that physicians failed to identify 35% of those suffering from serious emotional problems and 37% of those with serious cognitive impairment.

More recently, Dulean et al. (1990) examined a sample of children who were ultimately diagnosed with a psychological disorder. They found that their pediatricians had failed to identify these disturbances in 83% the children. This missed diagnosis rate was 87% for those children whose parents had not raised the issue, and more surprisingly, 67% for children whose parents had raised the issue with their physicians.

This tendency for physicians to miss psychological diagnoses in their patients may be due to a variety of factors such as physicians receiving insufficient training in the

recognition of psychological issues (Katon & Sullivan, 1990; Pace, Chaney, Mullins & Olsen, 1995), they may not have the time required to adequately assess psychological issues (Orleans et al., 1985), and the environment of a medical clinic may not be accommodating to the processes involved in adequately addressing patients' emotional problems (Drotar, 1982)

Another area that needs to be considered is the amount of training physicians receive with regards to psychological issues. Although most physicians do receive some training in mental health, it should not be assumed that they are as qualified as psychologists to provide mental health services (Pace et al., 1995). A survey of physicians in West Virginia found that almost half of them did not feel that they had received an adequate amount of training or preparation to deal with emotional issues (Vasquez, Nath & Murray, 1988). Medical students receive very little exposure to the current theories and practices of psychology (Meyer, Fink & Carey, 1988). They may receive more training in biological assessment, diagnosis, and treatment, but psychologists tend to receive greater training in the theory and foundations of human behavior (American Psychological Association, 1994). The nature of the training that psychologists receive tends to place a greater emphasis on the importance of self, relationship, and self-awareness, whereas medical training tends not to focus on these relationship skills (Baumann, 1999). It has also been noted that the little training that physicians do receive in the behavioral sciences tends to come from psychiatrists, which may result in physicians having a limited view of the roles and skills of psychologists (Meyer et al., 1988).

The limited exposure that physicians receive to psychology may be one of the factors that contribute to missed diagnoses of psychological problems. For example, it has been noted that patients often present their psychological problems to physicians in the form of physical or somatic complaints (Weyrauch, 1984). Without a comprehensive background in psychology, they may not possess the knowledge or the skills necessary to properly screen for the social and psychological symptoms that accompany these physical complaints (Katon & Sullivan, 1990).

Physicians are also under strict time constraints that may not allow for the proper assessment of psychological issues. It has been reported that physicians see, on average, up to 40 patients a day (Khalili & Kane, 1996; Orleans et al., 1985). This may not allow for a sufficient amount of time to accurately assess psychological problems considering that physicians spend only ten to twenty minutes with each patient (McDaniel, 1995). Psychologists on the other hand tend to see fewer patients each day and will spend a substantially longer period of time with each one (Drotar, 1982). Research has supported the notion that physicians do not have the time to deal with psychological issues (Khalili & Kane, 1996; Orleans et al., 1985). One study found that 72% of the physicians surveyed reported that they did not have time to be treating psychological disorders (Orleans et al., 1985). Khalili & Kane (1996) also have reported that of the physicians that were interviewed, 83% indicated that they referred patients to psychologists because they did not have the time required to provide psychological counselling.

In addition to the issues of training and time constraints, Drotar (1982) has made note of the fact that most medical environments do not facilitate the processes involved in adequately addressing patients' emotional problems. Often, physical space is limited

which results in the areas available to patients being crowded and congested. This, in conjunction with the close proximity of rooms, lack of sound proofing, and frequent interruptions can hinder the opportunity for privacy and patient-physician transactions. Drotar also refers to the fact that diagnosis and treatment usually take place under strict time constraints which leaves little time for adequate exploration of psychological issues. Physicians also see a larger number of patients each day compared to psychologists, and they see them for a much shorter period of time.

Since physicians do not appear to have the time or the means to be offering psychological services to their mental health patients, it should be expected that they would provide psychological referrals for their patients so that they can receive the care they need. This, however, does not seem to be the case. A large percentage of psychological problems are still being seen by physicians (Newman & Rozensky, 1995) rather than by psychologists (Hunsley, Lee & Aubry, 1999). In addition to the impact this has on the quality of patient care, the high prevalence of psychological problems seen in primary care has a substantial economic impact as well (Levenson, Hamer & Rossiter, 1990; Swift, 2000; Thomas & Natacha, 2001).

Health care cost. Mental illnesses exert an enormous cost burden on our health care system (Levenson et al., 1990; Swift, 2000; Thomas & Natacha, 2001) and this cost is continuing to rise (Moore, Mao, Zhang & Clarke, 1997; Stephens & Joubert, 2001). The increasing rates of mental illness are a problem that is being experienced worldwide (Gabriel & Liimatainen, 2001). One way to mitigate the impact this has on the cost of health care may be to increase the amount of psychological services that are being

provided (Mumford, Schlesinger, Glass, Patrick & Cuerdon, 1984; Smith, Rost & Kashner, 1995).

In 1996, schizophrenia alone cost Canada $1.2 billion in health care and non-health care costs and another $1.23 billion in lost productivity (Swift, 2000). In 1998, depression and distress cost Canadians $14.4 billion (Thomas & Natacha, 2001). Although the cost of health care is rising there is little evidence that the quality of health care has risen in comparison (Cyr, King & Ritchie, 1995). The total cost for mental disorders in Canada has risen from $7.8 billion in 1993 (Moore et al., 1997) to $8.4 billion in 1998 (Stephens & Joubert, 2001).

The rates of mental health problems are on the rise worldwide. A recently published article by Gabriel and Liimatainen (2001) looked at the incidence of mental health problems in the work place across several countries. They found that clinical depression has become one of the most common illnesses in the United States affecting one in ten working age adults each year. In the U.K. three out of every ten employees experience mental health problems each year and in Germany depression is responsible for almost 7% of premature retirements and depression-related work incapacity. They also reported that the rates of depression in Poland are rising and in Finland, over 50% of the workforce experiences some kind of stress-related symptom such as anxiety, depressive feelings, physical pain, social exclusion or sleep disorders.

These high rates of mental disorders can have devastating effects on the cost of health care. In a study done by Levenson et al. (1990) psychological illness was shown to be associated with longer hospital stays and higher costs for medical inpatients. They found that patients suffering from depression, anxiety, or cognitive dysfunction have a

40% longer median length of hospital stays than patients with low levels of psychopathology. Anxiety and depressive disorders were also shown to increase the overall utilization and cost of health care services. The authors make note of the possibility that the greater utilization of health care services may have occurred because the population was medically sicker and may have had high levels of psychopathology as a consequence of this. They suggest, however, that this is unlikely because the group of patients with anxiety and depressive disorders did not differ from the group of patients not suffering from these disorders in terms of their demographics, discharge diagnosis and diagnosis-related group (DRG). The two groups also did not differ in the distribution of DRG weights, which suggests that the patients were comparably distributed in terms of disease severity across the groups. The author, therefore, concluded that the greater utilization of medical care was associated with higher levels of psychopathology and not to the severity or type of medical illness.

Additional evidence is provided by a study done in the United States which looked at the baseline costs for a sample of consecutive primary care patients. The types of physical illnesses suffered by the patient sample were not specified. It was found that the baseline costs for primary care patients with anxiety or depressive disorders was $2,390 for a 6-month period compared to $1,397 for patients with no anxiety or depressive disorder (Simon, Ormel, VonKorff & Barlow, 1995). The cost of care almost doubles for primary care patients with anxiety and depressive disorders.

With both the cost of health care and the rates of mental illness rising, finding a way to reduce the cost and prevalence of mental health issues becomes a pressing issue. Increasing the use of psychological services has been suggested as being part of the

solution for the high incidence of mental health problems as well as for the rising cost of health care. For example, the use of psychological services, in conjunction with primary care, has been shown to reduce the overall cost of medical services. Mumford et al., (1984) conducted a meta-analysis of 58 cost-offset studies. They found that 85% of the studies reported a decrease in the use of medical services following psychotherapy. Psychological interventions were also found to reduce inpatient hospitalization by an average of 1.5 days. It has also been found that psychological interventions for somatization disorders produce a $289 reduction in medical costs per person (Smith et al., 1995). As well, it has been suggested that psychologists are more effective than physicians in controlling the overall cost of mental health care (Holmes & Partha, 1998). Most hourly psychologist fees are less than the fees for physicians (Enright, 1985).

Both the cost of health care and the rates of mental illness are rising (Moore et al., 1997; Stephens & Joubert, 2001). Increasing psychological referrals may be one way to mitigate the effects of both (Mumford et al.,1984; Smith et al., 1995). In addition to these cost benefits, referring patients with psychological problems to psychologists could help to decrease patient overload for physicians.

Patient overload for physicians. The levels of occupational stress for physicians are rising (Arnetz, 1997; Shearer, 2001) and levels of job satisfaction are decreasing (Shearer, 2001). Having to deal with heavy caseloads has been frequently identified as a contributing factor (Arnetz, 1997; Firth-Cozens & Greenhalgh, 1997). A large proportion of these caseloads are made up of patients with psychological issues (Cummings, 1991; Goldberg et al., 1976; Magill & Garrett, 1988). Reasons for why these issues are being presented to physicians and not to psychologists have been proposed (McDaniel, 1995;

Pace et al., 1995), however, it seems that this high prevalence of psychological issues in primary care may actually have some negative effects (Houpt et al., 1980; McDaniel, 1995; Rosen & Wiens, 1979). Increasing psychological referrals may be one way to help decrease the impact of these negative effects.

Occupational stress is a growing concern amongst physicians (Arnetz, 1997). A recent survey of 361 family physicians in the United States found that 31% were worried that they were burning out and 48% had experienced an increase in stress-related symptoms over the last year (Shearer, 2001). Overall, there has been found to be an increase in stress that has led to an overall decline in job satisfaction among physicians in recent years (Shearer, 2001). A factor that has been frequently identified by physicians as contributing to their occupational stress is work overload (Arnetz, 1997; Firth-Cozens & Greenhalgh, 1997). In a study conducted by Firth-Cozens and Greenhalgh (1997) it was reported that 85% of the doctors attributed their stress to tiredness and to the pressure of overwork. Similarly, Arnetz (1997) conducted a study examining physicians' perception of their work, organization and professional development and found high workload to be one of the factors that was identified as being dissatisfactory.

A large proportion of a physician's workload consists of patients presenting with psychological problems (Cummings, 1991; Goldberg, Haas, Eaton & Grubbs, 1976; Magill & Garrett, 1988). One Canadian study found that 61% of patients went to their family physicians when seeking care for emotional problems while only 16% went to a psychologist (Bland, Newman & Orn, 1990).

A number of factors have been suggested to explain why physicians are targeted by those in need of psychological services. It may be that society defines all symptoms,

whether they are physical, behavioral or emotional, as warranting medical care. Other factors could be easier access, confidentiality concerns, stigmatization associated with the use of mental health services, and prior, long-standing patient-physician relationships (Pace et al., 1995). It may also be that people are hesitant in approaching a psychologist (McDaniel, 1995). The patient may be looking to their family physician, with whom they have built a trusting relationship, to indicate whether or not they need a psychological referral.

In addition to increasing physicians' already stressful workload, there may be some additional negative consequences associated with physicians receiving and treating the majority of mental health issues. Studies have indicated that individuals suffering from emotional problems make inappropriate use of medical services (Houpt et al., 1980; Rosen & Wiens, 1979). Patients with psychological disorders have been found to use medical services almost twice as often as patients who do not suffer from psychological disorders (Goldberg & Blackwell, 1970). It has also been suggested that an emotional burden may be placed on physicians who treat psychological illnesses (Houpt et al., 1980; McDaniel, 1995). As noted previously, heavy workloads are a major source of stress for physicians (Arnetz, 1997; Firth-Cozens & Greenhalgh, 1997). Referral to psychologists may help to decrease occupational stress for physicians by decreasing their workload. A psychologist can also help with patients whose behavior is confusing or frustrating for the physician (Enright, 1985).

In addition to the benefits for the patient, physician, and cost of health care outlined above, there also seems to be a natural alliance that exists between physicians and psychologists.

Natural Alliance

There have been many arguments put forth promoting the collaborative physician-psychologist relationship. One such argument points to the fact that mental and physical illnesses are often interrelated (Fischer, Heinrich, Davis, Peek & Lucas, 1997).

Physical illness and psychological illness. Several ways that physical illness can cause psychological problems have been identified (Goldberg & Huxley, 1992) and research supporting examples of these have been documented (Anderson, Freedland, Clouse & Lustman, 2001; Fischer, Heinrich, Davis, Peek & Lucas, 1997; Houpt et al., 1980; Wells, Golding & Burnam, 1988). There is also research which suggests that the presence of psychological illness is associated with deteriorations in physical health (De Groot, Anderson, Freedland, Clouse & Lustman, 2001; Glassman & Shapiro, 1998). Psychological interventions may help to lessen the effects that physical and psychological illnesses have on each other.

Goldberg and Huxley (1992) have identified five ways in which physical illness can cause psychological problems. First, patients may experience psychological distress related to the diagnosis of their physical illness. Second, the psychological problems may be a direct consequence of the physical disease such as with neurological diseases or problems related to hormonal disturbances. Third, chronic pain that occurs as a symptom of the physical disease can lead to an increased risk for depression. Fourth, many of the drugs that are used to treat the physical illness cause psychological and emotional side effects. Lastly, the severe disability that can result from chronic physical illness can destroy an individual's quality of life. This has wide spread implications for the individual's psychological health.

Research has found that many patients that suffer from chronic disease are at an increased risk for depression (Anderson et al., 2001; Fischeret al., 1997; Wellsetal, 1988). For example, depression is often experienced after a myocardial infarction (Houpt et al., 1980). The presence of depression has also been found to be associated with poorer prognosis and a more rapid progression of illnesses such as ischemic heart disease (Glassman & Shapiro, 1998) and diabetes (De Groot et al., 2001). Patients who suffer from emotional difficulties may also be at an increased risk for a deterioration in physical health. For example, one study found that women with high depression scores were more likely to have malignant tumors at subsequent investigation (Davis, Davies & Delpo, 1986).

It seems as though physicians and psychologists have a lot to offer by working with each other in the way of increasing quality of patient care (Magill & Garrett, 1988; Orleans et al.), patient health (Anderson et al., 2001; De Groot et al., 2001; Fischer et al., 1997; Glassman & Shapiro, 1998; Wells et al., 1988), decreasing the cost of health care (Mumford et al., 1984; Smith et al., 1995), and decreasing occupational stress for physicians. Unfortunately, however, physicians still seem to have low rates of psychological referral.

Low Level of Referrals

Despite the benefits physicians receive by increasing their levels of psychological referrals, the majority of psychological issues are still being treated in primary care settings (Bland et al., 1990; Huxley, 1996; Regier, Boyd & Burke et al., 1988; Vasquez et al., 1988). In an effort to understand why physicians are not making referrals to psychologists, it is important to look at the processes involved in referral. Goldberg and

Huxley (1996) have developed a model to explain how individuals come to be defined as having psychological problems and how these individuals eventually reach mental health services. Their model consisted of five levels separated by four filters. The third level represents the individuals that are receiving care from their physician and have been identified as having a mental or emotional disorder. Level four represents those that are attending a psychiatrist or psychologist. The third and fourth levels are separated by Filter 3, which is whether or not the patient is referred by their physician to psychological treatment. Goldberg and Huxley deemed this filter the least permeable of all the filters. They looked at one-year period prevalence of mental illness using rates per 1000. At level three, 101 people were identified as having psychological problems by their physician. Of these people only 23 made it to the fourth level (Huxley, 1996). In other words, physicians did not refer 88% of the people that they had identified as having mental or emotional problems to a mental health specialist.

Other research has also indicated that physicians do not frequently make referrals to psychologists. An Epidemiologic Catchment Area (ECA) study by Regier et al. (1988) concluded that the one month prevalence of at least one psychological disorder for those of 18-years of age and older was 15.4%. Based on this finding they estimated that in the United States 56% to 59% of people with mental health disorders are seen only by their physicians while only 8% to 12% use mental health services. Another study conducted in the United States reported that only 34% of the physicians who were actively treating psychological problems referred their patients to mental health professionals (Vasquez et al., 1988).

A Canadian study has reported similar findings. In a sample of 865 households it was found that 61% of those who sought care for an emotional problem saw a family physician while only 16% saw a psychologist (Bland et al., 1990). Colenda (1998) suggests that when compared to other medical services, mental health services are underutilized by all age groups. This is surprising when one considers the benefits that the use of psychological services can have for the patient, the physician, and the cost of health care. In addition, both physicians and psychologists have expressed their dissatisfaction with the current state of collaboration between the two fields (Fischer et al., 1997; McDaniel, 1995). This necessitates an examination of the common barriers to referral and collaboration.

Common Barriers to Referral and Collaboration

Many studies have looked at the factors that effect physician referral to psychologists (Bray & Rogers, 1995; Kamerow, Pincus & Macdonald, 1986; Meyer, Fink & Carey, 1988; Orleans et al., 1985; Pray, 1991). Some of the more common barriers to referral and collaboration that have been reported are that physicians and psychologists receive different training, work in different theoretical paradigms, use different language, different working styles, lack of accessibility to different providers and varying expectations for assessment and treatment (McDaniel et al., 1990; McDaniel et al., 1992).

Stabler (1988) noted that medical training is based on concrete scientific findings with an emphasis on gathering data to create concrete solutions to specific, well defined problems. For psychologists a greater emphasis is placed on the integration of theoretical and practical knowledge and it is rare for them to work with directly observable, concrete, well defined problems (Pace et al., 1995). Physicians and psychologists receive

different training that consists of dramatically different focuses. Pace et al. (1995) suggest that training for physicians is based primarily on the biomedical model, whereas for psychologists training is primarily based on the biopsychosocial model. They also make note of the fact that the language used by the two disciplines differ, which can contribute to communication problems between the two fields. In the medical field the language used is predominantly problem-focused whereas the field of psychology uses language that is predominantly process-oriented (McDaniel, Campbell & Seaburn, 1995; Pace et al., 1995). For example, psychologists tend to place a greater emphasis on the individuals personal experience and the process of the psychological assessment whereas physicians deal mostly in statements of fact and specifically outlined treatment regimes (Stabler, 1988). Also, physicians and psychologists may not understand each others technical terminology (Enright, 1985; McDaniel, 1995).

Another barrier to referral may be the physicians' inability to identify the psychological problem. A study by Pray (1991) identified several psychological problems that had low identification rates. Some of these problems were chemical dependency, single-parent pregnancy, ineffective parent-infant bond, suicide attempts, child abuse or neglect, spouse abuse, and elder abuse or neglect. These low rates of identification may be a result of the inadequate training physicians receive regarding the identification of psychological problems (Abramson & Mizrahi, 1986).

The differences in working styles between physicians and psychologists can also act as a barrier to referral and collaboration. A session with a physician is typically dominated by the physician and action-oriented whereas a session with a psychologist is more patient-centered and process-oriented (McDaniel, 1995). These differences may

largely be due to the fact that physicians will typically treat four to five times more patients in a day than psychologists, spending on average ten to twenty minutes with each patient. Psychologists, on the other hand will typically see less patients in one day but will spend an average of fifty to sixty minutes with each one (McDaniel, 1995).

Physicians have also expressed concern that consultations with psychologists may jeopardize the patient-physician relationship. They have also commented that they received little or no feedback from psychologists when patients were referred for consultation or treatment. Other concerns expressed by physicians are that some psychologists are not willing to treat medicated patients, psychologists may not be familiar with medical factors, and they do not know how to determine which psychologists are good (Meyer et al., 1988).

One survey of 350 family physicians identified the most common obstacles for making referral for psychological treatment as being patient resistance to psychological referral, inadequate insurance reimbursement for mental health services, lack of coordination between primary and mental health care and limited training on the part of the physician (Orleans et al., 1985). Additional factors that have been identified as barriers to collaboration are a lack of accessibility between the physician and psychologist for consultation, managed care and reimbursement issues, inability of patients to pay for services, and patient resistance to referrals (Bray & Rogers, 1995).

Facilitating Factors

There have also been a variety of factors that have been found to facilitate referral and collaboration between physicians and psychologists. McDaniel (1995) has offered several suggestions for psychologists that are interested in increasing the number of

referrals they receive from physicians. First, it is suggested that psychologists need to use medical conventions regarding communication about patients. This may include writing a brief report that includes an assessment and recommendations after the first session. Psychologists may also want to phone the physician to discuss the case and inquire as to whether the physician has additional information that will help the psychological treatment of the patient, or if the treatment plan needs to be negotiated with the physician. It is also pointed out that each physician varies in the amount of information they wish to gain from psychologists through written reports. It is suggested that psychologists ask the physicians about the frequency and length of reports they wish to receive.

Crane (1986) suggests that providing physicians with information regarding signs that might indicate a referral for therapy is appropriate may be facilitative to increasing referrals and collaboration. Information should also be provided on how to frame potential referrals so that patients are more likely to accept them.

A survey of family physicians conducted by Marandola (1995) found that physicians prefer to receive information regarding the psychologists' specialties through personal interaction and case collaboration between physicians and psychologists letters or one-to-one communication. It was also found that increasing the frequency of increased the frequency of referrals. Also the availability of psychologists was a significant predictor of physician referral. This study concludes, however, that referral is largely dependant on personal and professional association. It is, therefore, suggested that psychologists who want to increase their referrals from physicians should become well acquainted with their local primary care givers.

The responsibility for the facilitation of collaboration does not rest solely on the psychologist. There are many physician characteristics that can improve the collaborative process. One survey of family physicians found that the physicians who refer to family therapists are more likely to have multiple sources of information on family therapy and consequently are better informed about the usefulness of psychological referral (Detchon & Storm, 1987). It is also important that physicians become educated about the services provided by psychologists (Huszti & Walker, 1991).

There are a variety of factors that influence referral and collaboration between physicians and psychologists. The responsibility of improving the process rests with both the physician and the psychologist.

Research on Improving Collaboration

An example of effective physician-psychologist collaboration occurred through the Linkage Project (Bray & Rogers, 1995). This project trained psychologists and family physicians in a variety of collaborative practices and was effective in establishing linkages between physicians and psychologists, improving the care of a wide range of medical and psychological problems. The project focused on alcohol and other drug abuse problems to narrow the scope of the pilot program and for funding reasons. One of the reasons for increased referrals was that the training had improved the recognition of drug and alcohol problems for physicians. This is a crucial and valuable benefit of collaborative practice as it has been found that 41% of the psychological disorders brought to physicians are not identified (Huxley, 1996).

Although the focus of the training was for alcohol and drug related problems, the training also improved referral and collaboration in other areas such as attention deficit

disorder, marital problems, anxiety, depression and habit modification. Factors that were identified as having facilitated referral and collaboration were regular contact between the physician and psychologist, being in close proximity of each other, and having regularly scheduled meetings with each other be it by phone, lunch or breakfast appointments, and the use of faxes for referrals. In addition, familiarity with the other professional's support staff helped to facilitate direct contact for case discussion. The participants of this project indicated that collaboration enhanced the effectiveness of both physicians and psychologists, resulted in better diagnosis and treatment of medical and psychosocial problems, increased feelings of self efficacy and job satisfaction and enhanced treatment options for patients. The success of the Linkage project supports the idea that improved collaboration between physicians and psychologists would benefit everyone involved.

In addition to the benefits of collaboration mentioned above, it has been stated that collaboration can offer the physician support within a job that has demands, expectations and requirements that can often be emotionally taxing for the physician. This support can be in the form of relief in knowing that the psychologist will tend to the emotional needs of the patient and their family as well as emotional support for the physicians themselves (McDaniel, 1995). Similarly, psychologists can benefit from collaboration through increased referrals and support from physicians when dealing with patients that have difficult or untreatable medical problems.

Summary

Even in light of the past research, there seems to be a missing piece to the puzzle. A Canadian study that surveyed 48 physicians working in Newfoundland reported that of

the physicians interviewed, 91% reported having had occasion to refer to a psychologist and of these physicians, 40% reported having a psychologist with whom they were comfortable referring patients. However, the average number of patients referred over the last year was only 13 (Khali & Kane, 1996). It would seem that if a physician is seeing patients that could benefit from a psychological referral, and they have a psychologist with whom they are comfortable referring to, and the rates of referral are still low, there must be other factors that influence whether or not a patient is referred. For example, it could be suggested that the unidentified factor is that physicians are not referring because they do not understand extended health care insurance coverage for psychologists and therefore how psychologists are paid. Very little research has looked at whether or not the physicians' perception of the patient being able to pay for the services influences whether or not they refer. However, the survey of the Newfoundland physicians found that one of the reasons that they did not refer to psychologists was because patients were seen as being unable to pay for these services (Khali & Kane, 1996). It has also been stated that many physicians are unaware of insurance coverage for psychological services and that when informed on this issue they tend to increase their requests for psychological services (Enright, 1985). More research is required to determine whether or not these perceptions are indeed a factor that influences referral as well as the extent to which this factor actually affects referral patterns.

Research Goal

The aim of this project is to ascertain the effectiveness of the current process of referral and collaboration between physicians and psychologists. Ultimately, this research

hopes to determine how we can improve and thus increase the level of referral and collaboration between these two fields. Specifically, the two research goals are:

1. To determine physicians' views of their current levels of referral and collaboration.
2. To determine ways to improve the process of referral and collaboration between physicians and psychologists.

The method for addressing these questions is presented in Chapter 3.

Chapter 3

Method

This chapter discusses the methodology that will be used in this project. A description of the population, procedure, instrument, and methods that were used in collecting and analyzing the data is provided.

Population

The population for this project was to consist of 30 to 50 family physicians currently working in Lethbridge, Alberta. However, only a total of nine physicians were actually interviewed. The writer's initial goal of interviewing 30 to 50 physicians was not met, as the other physicians that the writer attempted to contact either turned down the invitation to participate, or did not respond to the many phone calls and messages left by the writer.

Procedure

All family physicians were contacted by phone to request one hour of their time to participate in a one-on-one interview. An attempt was made to speak with each physician rather than their receptionist. It was intended to help increase the physicians' commitment to the project and avoid the possibility of messages not being passed on by the receptionist or received by the physician. A sample script outlining the initial telephone call is presented in Appendix C.

All of the interviews were conducted in person in a location chosen by the physician for their convenience.

Physician Interview

A review of the literature revealed that there were no standardized instruments available for this project. Therefore, the Physician Interview was developed based on the information provided from past research. In addition, ideas were provided by other surveys and questionnaires that were used in similar research (Dymond, 1999; Kalb, 1985). This resulted in an abundance of potential questions which were then compared and irrelevant questions were eliminated. The Physician Interview was then given a trial run and was refined based on the feedback acquired from the trial run as well as the feedback from the research supervisor.

The Physician Interview (shown in Appendix A) is divided into the following four parts:

Part I: Demographic information. This section requested information regarding the age of the physician, the year the physician graduated from medical school, the number of years they have been in practice, and their gender.

Part II: Definition of psychological health. This section attempted to acquire an understanding of how the respondent defines psychological health and psychological issues. This was done to ensure that both the interviewer and interviewee are using the same terminology to refer to various concepts (ex. psychological issues).

Part III: Referral. This section requested information regarding the physicians current process of referral, their satisfaction with that process and their attitudes and beliefs about the process.

Part IV: Collaboration. This section requested information regarding the physicians' current level of collaboration with psychologists, their satisfaction with the collaboration, and their attitudes and beliefs about the collaboration.

Data Collection

Each interview took approximately one hour. A semi-structured interview format was chosen based on the low response rates for surveys and questionnaires in past related research (Inman & Bascue, 1983; Kalb, 1985; Kushner et al., 2001; Meyer et al., 1988; Pray, 1991; Vazquez et al., 1988;). A semi-structured format was chosen to ensure that all of the pertinent questions were covered but that there was still the opportunity of exploration (Mertens, 1998). In addition, conducting the interview in person provides the interviewer with the opportunity to clarify any confusion regarding the questions as well as the opportunity to encourage full responses (Palys, 1997).

Interviewee responses were recorded by the researcher during the interview. Responses were reflected back continuously during the interview to ensure accuracy of the data. In addition, 20% of all the participants were randomly selected after all the interviews were completed for a validity check. This consisted of an additional telephone call and a letter (shown in Appendix D) requesting the participants to examine the results of their interview and notify the researcher of any coding errors. No errors were found based on the 20% sample, therefore, further validation was deemed unnecessary.

Data Analysis

The interview consisted of three types of questions; open-ended questions (ex. Describe for me, from beginning to end, a referral that you would consider effective),

closed-ended questions (ex. Do you refer to psychologists?) and Likert-scales (ex. How effective would you rate your current referrals to psychologists?).

Constant comparison and thematic coding was used to analyze the responses for the open-ended questions. Responses were coded into categories. The frequency and percentage of each category of responses was calculated and is presented in tabular form.

The process began with reading and rereading the transcripts to identify emergent categories. This process allows for interesting and unexpected categories to emerge (Pope et al., 2000).

The process used to create the categories was based on the processes described by Runte (Personal Communication, October, 2001), and Ryan and Bernard (2001) called cutting and sorting. Three copies of the notes from each interview were made. One copy was kept intact and used as a master copy of the interview (Runte, Personal Communication, October, 2001). This copy was used to check the accuracy and context of the interview material. With the second copy, responses to the open-ended questions were cut into sections and sorted into categories. Where responses fit in more than one category, the third copy was used (Runte, Personal Communication, October, 2001). The categories were continuously added and refined to reflect as many of the variations in the responses as possible. This helped to ensure that the categories were inclusive (Pope et al., 2000).

Model and contrary examples were drawn for each category to help define the inclusion and exclusion criteria. The inclusion and exclusion criteria, however, were continuously modified to fit what emerges from the data. This was also used to demonstrate the construct validity of each category (Krathwohl, 1993). After the

responses were categorized, each response was reexamined to ensure that it fits into the category. By coding the responses into categories the information from the transcriptions were more available for analysis and for significant issues to emerge (Krathwohl, 1993). Each category was labeled with a descriptive word or phrase. This allowed the researcher to identify redundancies as well as categories that could be combined (Krathwohl, 1993). The categories were then used to define concepts and to find associations between the categories in an effort to provide explanations for the findings.

Frequencies and percentages were calculated for the responses to the closed-ended questions. The mean, standard deviation and range were calculated for the participants' ratings on the Likert-scales and are presented in tabular form.

This chapter discussed the population, procedure, instrument, and methods that were used in collecting and analyzing the data. Chapter 4 will present the results of this project. Chapter 5 will then elaborate on the results presented in Chapter 4 by outlining the implications of these findings.

Chapter 4

Results

This chapter outlines the results obtained in this study. The responses to each of the four parts of the Physician Survey are presented in sequential order. A total of nine physicians were interviewed. The writer's initial goal of interviewing 30 to 50 physicians was not met, as the other physicians that the writer attempted to contact either turned down the invitation to participate, or did not respond to the many phone calls and messages left by the writer.

The reader should note that, at times, participants may have replied with more than one response to each question; therefore, the total number of coded responses does not always equal nine.

Part I: Demographic Information

This section requested information regarding the age of the physician, the year the physician graduated from medical school, the number of years he or she had been in practice, and the physician's gender.

The ages of the physicians ranged from twenty-nine years old to fifty-three years old, with a mean age of forty-three years old (Table 1). None of the physicians interviewed graduated in the same year, with the graduating years ranging from 1975 to 1998, with a mean year of 1986 (Table 2). Likewise, none of the physicians reported having the same number of years in practice, with years in practice ranging from 2 years to 24 years, with a mean of 14.11 years (Table 3). Of the 9 respondents, 55.6% (n=5) were male and 44.4% (n=4) were female.

Table 1

Age of Physicians

AGE	n	%
29	1	11.1
38	1	11.1
40	2	22.2
45	2	22.2
47	1	11.1
50	1	11.1
53	1	11.1
TOTAL NUMBER OF PHYSICIANS THAT RESPONDED	9	100.0

Table 2

Year Graduated from Medical School

YEAR GRADUATED	n	%
1975	1	11.1
1980	1	11.1
1981	1	11.1
1984	1	11.1
1985	1	11.1
1986	1	11.1
1990	1	11.1
1995	1	11.1
1998	1	11.1
TOTAL NUMBER OF PHYSICIANS THAT RESPONDED	9	100.0

Table 3

Number of Years in Practice

YEARS IN PRACTICE	n	%
2 years	1	11.1
5 years	1	11.1
10 years	1	11.1
14 years	1	11.1
15 years	1	11.1
16 years	1	11.1
20 years	1	11.1
21 years	1	11.1
24 years	1	11.1
TOTAL NUMBER OF PHYSICIANS THAT RESPONDED	9	100.0

Part II: Definition of Psychological Health

This section attempted to acquire an understanding of how the physicians' defined psychological health and psychological issues. This was done to ensure that both the interviewer and interviewee were using the same terminology to refer to various concepts. The writer did not begin with a preconceived definition of either "psychological" or "personal" issues, but rather, adopted the definitions used by the physicians. The first two questions (#'s 1 & 2) of Part II asked each physician "How do you define 'psychological issues'?" and "How do you define 'personal issues'?." The responses that emerged are outlined in Tables 4 and 5.

Table 4

Responses that Emerged for the Question, "How do you define 'psychological issues'?"

RESPONSE	n	%
That it affects the individual either psychologically, mentally, emotionally, socially, personally, vocationally	7	77.8
Included physiology/biochemical as well as environment	2	22.2
TOTAL NUMBER OF PHYSICIANS THAT RESPONDED	9	100.0

Table 5

Responses that Emerged for the Question: "How do you define 'personal issues'?"

RESPONSE	n	%
Private and/or confidential issues	3	33.3
Issues that are a part of one's personal life	3	33.3
Similar to psychological issues, but not yet a part of the Mental Health System	2	22.2
Issues that affect the wellbeing of the person	1	11.1
TOTAL NUMBER OF PHYSICIANS THAT RESPONDED	9	100.0

Seven (77.8%) of the physicians defined 'psychological issues' using some or all of the following descriptors; psychological issues were defined as issues that affected the individual either psychologically, mentally, emotionally, socially, personally, vocationally, while two (22.2%) of the respondents defined it as including a physiological or biochemical component as well as environment.

Of the definitions provided for 'personal issues', three physicians (33.3%) defined it as issues that are private and/or confidential, two (22.2%) defined it as issues that are a part of one's personal life, two (22.2%) defined it as issues that are similar to psychological issues, but not yet a part of the Mental Health System, and one (11.1%) physician defined it as issues that affect the well being of the person.

All nine (100.0%) of the physicians indicated that they felt that there was a connection between physical health and psychological health. In describing how they saw physical health and psychological health as being connected, five (55.5%) of the physicians' responded that physical health and psychological health are connected in all ways and both impact each other and four (44.4%) of the physicians' responded that psychological problems often manifest themselves physically and/or affect physical health. The inclusion criteria for the second category of responses, was that psychological health is affecting physical health rather than physical and psychological health affecting each other as in the first category of responses. In addition to the directional components of the definitions that were provided by the physicians, two (22.2%) physicians added that physical and psychological health affect each other through the immune system. The inclusion criterion for this category of responses was the mentioning of the immune

system. One (11.1%) physician added that the affect is in the patient's perception of whether they are sick and whether they are compliant to treatment (Table 6).

Table 6

Responses that Emerged for the Question: "In what ways do you see there being a connection between physical health and psychological health?"

RESPONSE	n	%
Physical health and psychological health both impact each other	5	55.6
Psychological problems affect physically health	4	44.4
Physical and psychological health affect each other through the immune system	2	22.2
Patient perception of whether they are sick and their compliance to treatment	1	11.1
TOTAL NUMBER OF PHYSICIANS THAT RESPONDED	9	100.0

Part III: Referral

This section requested information regarding the physicians' patient load, patient issues, current services provided by the physician, current process of referral, their satisfaction with that process, and their attitudes and beliefs about referral to psychologists, and their knowledge of patient coverage.

As shown in Table 7, three (33.3%) of the physicians reported that they saw either between 11 to 20 patients a day and three (33.3%) reported that they saw between 21 and 30 patients a day. Two physicians (22.2%) indicated that they saw between 31 and 40 patients a day and one physician (11.1%) indicated that he or she saw between 41 and 50 patients a day. When asked how many patients they saw in an average month, almost half (n=4; 44.4%) indicated that they saw between 200 and 400 patients a month. Others reported that they saw between 401 to 600 a month (n=2; 22.2%), between 601 to 800 a month (n=1; 11.1%), and between 801 and 1000 a month (n=2; 22.2%).

Table 7

Number of Patients Seen…

…in an average day?		
NUMBER OF PATIENTS	n	%
15	1	11.1
17	2	22.2
21	1	11.1
25	1	11.1
30	1	11.1
35	1	11.1
38	1	11.1
43	1	11.1
TOTAL NUMBER OF PHYSICIANS THAT RESPONDED	9	100.0
…in an average month?		
NUMBER OF PATIENTS	n	%
200	1	11.1
220	1	11.1
400	2	22.2
500	1	11.1
600	1	11.1
700	1	11.1
858	1	11.1

As shown in Table 8, the majority of physicians (n=6; 66.7%), indicated that they consider up to 20% of the patients they see to be candidates for psychological referral. One (11.1%) reported that between 21% and 40% of his or her patients were candidates for psychological referral, one (11.1%) indicated that it was between 41% and 60% of his or her patients, and one (11.1%) reported that between 81% and 100% of his or her patients are candidates for psychological referral.

Table 8

Responses to the Question "What percentage of your patients would you consider as being candidates for psychological referral?"

PERCENTAGE OF PATIENTS	n	%
5%	1	11.1
10%	3	33.3
20%	2	22.2
35%	1	11.1
60%	1	11.1
100%	1	11.1
TOTAL NUMBER OF PHYSICIANS THAT RESPONDED	9	100.0

All of the physicians identified depression (n=9; 100.0%) as being one of the most common psychological concerns that they saw in their practice. Other commonly seen psychological concerns that were identified included anxiety/panic disorders (n=8; 88.9%), marriage/relationship issues (n=3; 33.3%), stress (n=3; 33.3%), drug/alcohol issues (n=3; 33.3%), personality disorders (n=1; 11.1%) , bereavement/grief (n=2; 22.2%), schizophrenia/psychotic disorders (n=2; 22.2%), bipolar (n=1; 11.1%), physical issues brought on by emotional triggers (n=1; 11.1%) such as asthma, exema, or migraines, adjustment disorders (n=1; 11.1%), problems of living (n=1; 11.1%) such as parenting issues, workplace issues, financial problems, and personal balance between home and work responsibilities, and chronic mental illness (n=1; 11.1%; Table 9).

In response to the question "What percentage of the patients that you identify as having psychological problems do you provide psychological services for in an average month?" over half (n=5; 55.6%) reported they provide psychological services for between 80% and 100% of those patients. One physician (11.1%) reported providing psychological services for between 60% and 79% of those patients, while three

physicians (33.3%) indicated that they provided psychological services for 50% or less of their patients that they identify as having psychological problems (Table 10).

Table 9

Common Psychological Concerns Seen in Practice

PSYCHOLOGICAL CONCERN	n	%
Depression	9	100.0
Anxiety/Panic Disorders	8	88.9
Marriage/Relationship Issues	3	33.3
Stress	3	33.3
Drug/Alcohol Issues	3	33.3
Personality Disorders	1	11.1
Bereavement/Grief	2	22.2
Schizophrenia/Psychotic Disorders	2	22.2
Bipolar	1	11.1
Physical Issues brought on by Emotional Triggers	1	11.1
Adjustment Disorders	1	11.1
Problems of Living	1	11.1
Chronic Mental Illness	1	11.1
TOTAL NUMBER OF PHYSICIANS THAT RESPONDED	9	100.0

Table 10

Responses to the Question, "What percentage of the patients that you identify as having psychological problems do you provide psychological services for in an average month?"

PERCENTAGE OF PATIENTS	n	%
10	1	11.1
25	1	11.1
50	1	11.1
62	1	11.1
80	2	22.2
100	3	33.3
TOTAL NUMBER OF PHYSICIANS THAT RESPONDED	9	100.0

Some of the comments that were made in response to this question were that "people are often more comfortable talking with their physicians because the relationship is already there," or "a lot of patients will resist referral, I do, however, try to work with all of them both myself and refer them." Other physicians stated, "I attempt to be

supportive to all of my patients, but I never do intensive psychotherapy," "I co-care with many of them," and "it's so hard to engage the patient in the idea to talk to someone else."

When providing these psychological services themselves, over half (n=5; 55.6%) of the physicians indicated that they spent an extra 20 minutes with each patient. Others indicated that they spent an extra 12 minutes (n=1; 11.1%), 23 minutes (n=1; 11.1%), 30 minutes (n=1; 11.1%), and 40 minutes (n=1; 11.1%) with each patient (Table 11).

Table 11

Responses to the Question, "When providing psychological services yourself, how much time would you spend, on average, with each patient?"

EXTRA TIME SPENT WITH EACH PATIENT	n	%
12 minutes	1	11.1
20 minutes	5	55.6
23 minutes	1	11.1
30 minutes	1	11.1
40 minutes	1	11.1
TOTAL NUMBER OF PHYSICIANS THAT RESPONDED	9	100.0

In an average month, four (44.4%) of the physicians reported that they spent between 3 and 10 hours providing psychological services, two (22.2%) reported it to be between 12 and 16 hours, one (11.1%) indicated it was 23 hours, one (11.1%) indicated 78 hours, and one (11.1%) indicated 96 hours (Table 12).

Table 12

Responses to the Question, "How many hours would you say that you spend providing psychological services yourself in an average month?"

TIME SPENT	n	%
3 hours	1	11.1
4 hours	1	11.1
6 hours	1	11.1
10 hours	1	11.1
12 hours	1	11.1
16 hours	1	11.1
23 hours	1	11.1
78 hours	1	11.1
96 hours	1	11.1
TOTAL NUMBER OF PHYSICIANS THAT RESPONDED	9	100.0

All of the physicians (n=9; 100.0%) indicated that they refer to psychologists. In the next question, (#9, Part III), the physicians were asked, "How many patients in an average month would you estimate that you refer to a psychologist?" The percentage of patients referred was calculated by dividing the number of patients each physician stated that they referred in an average month by the number of patients that each physician reported that they saw in an average month. The percentage of the patients seen who were referred to a psychologist ranged from 0.5% of the patients (n=1; 11.1%) to 3.3% of the patients (n=1; 11.1%). Three (33.3%) of the physicians indicated that they were not sure how many patients they referred to a psychologist in an average month, with the explanation being that the patients who do not have coverage are referred to an agency such as Lethbridge Family Services or Alberta Mental Health, and they are not sure if it is a psychologist that the patient sees (Table 13).

Table 13

Responses to the Question, "How many patients in an average month would you estimate that you refer to a psychologist?"

PERCENTAGE OF PATIENTS	n	%
0.5%	1	11.1
1.0%	1	11.1
1.1%	1	11.1
2.5%	1	11.1
2.8%	1	11.1
3.3%	1	11.1
I don't know	3	11.1
TOTAL NUMBER OF PHYSICIANS THAT RESPONDED	9	100.0

As shown in Table 14, over half (n=5; 55.6%) of the physicians interviewed reported that they preferred referring to a psychologist rather than providing psychological services themselves, and none of the physicians indicated that they preferred providing psychological services themselves over referring. Of the physicians, one (11.1%) indicated that he or she preferred shared care. Three (33.3%) of the physicians reported that they preferred neither referring out nor providing the services themselves, but offered 'other' responses which included "I don't necessarily prefer referring to psychologists but I do prefer referring out," or "I would prefer the professional expertise, but it's very rare that people are willing to make the financial investment," and "if its really simple, and they just need a pill, I will do it myself. If it's a big issue that will take time, I'll refer."

Table 14

Responses to the Question, "Do you prefer providing psychological services yourself or referring to psychologists?"

RESPONSE	n	%
Referring	5	55.6
Shared care	1	11.1
Other	3	33.3
TOTAL NUMBER OF PHYSICIANS THAT RESPONDED	9	100.0

As shown in Table 15, when asked the question "Under what circumstances/diagnoses do you prefer to provide psychological services yourself?," some of the responses that emerged were that physicians preferred providing psychological services for depression (n=2; 22.2%), for anxiety (n=1; 11.1%), for chronic physical illness (n=1; 11.1%), under no circumstances, referring is always preferred (n=2; 22.2%), shared care is preferred (n=1; 11.1%), when the patient does not want to or has a phobia of seeing a psychologist (n=1; 11.1%), for simple cases and/or basic issues (n=2; 22.2%), such as working with sleep or detoxification issues.

Table 15

Responses to the Question, "Under what circumstances/diagnoses do you prefer to provide psychological services yourself?"

RESPONSE	n	%
Depression	2	22.2
Anxiety	1	11.1
Chronic physical illness	1	11.1
Under no circumstances	2	22.2
Shared care is preferred	1	11.1
Patient does not want to see a psychologist	1	11.1
Simple/basic issues	2	22.2
TOTAL NUMBER OF PHYSICIANS THAT RESPONDED	9	100.0

As shown in Table 16, there were many circumstances/diagnoses that were identified where physicians preferred to refer to a psychologist. These circumstances and/or diagnoses included relationship and marital issues (n=4; 44.4%), schizophrenia/psychosis (n=2; 22.2%), anxiety disorders (n=2; 22.2%), with violence/abuse/crisis situations (n=2; 22.2%), anytime the patient has coverage and/or can afford it (n=2; 22.2%), phobias (n=1; 11.1%), personality disorders (n=1; 11.1%), bipolar (n=1; 11.1%), substance abuse (n=1; 11.1%), major depression (n=1; 11.1%),

when kids are involved (n=1; 11.1%), in most to all circumstances (n=1; 11.1%), when the problem can not be handled in the physicians' office (n=1; 11.1%), when there is a good psychologist available (n=1; 11.1%), and for problems that are going to take a lot of time (n=1; 11.1%).

Table 16

Responses that Emerged for the Question, "Under what circumstances/diagnoses do you prefer to refer to a psychologist?"

RESPONSE	n	%
Relationship/Marriage Issues	4	44.4
Schizophrenia/Psychosis	2	22.2
Anxiety disorders	2	22.2
Violence/Abuse/Crisis	2	22.2
Anytime the patient has coverage/can afford it	2	22.2
Phobias	1	11.1
Personality disorders	1	11.1
Bipolar	1	11.1
Substance Abuse	1	11.1
Major Depression	1	11.1
When kids are involved	1	11.1
In most to all circumstances	1	11.1
When the problem can not be handled in the physicians' office	1	11.1
When there is a good psychologist available	1	11.1
For problems that are going to take a lot of time	1	11.1
TOTAL NUMBER OF PHYSICIANS THAT RESPONDED	9	100.0

The most common barriers that were identified for physicians providing psychological services themselves were a lack of training and/or skill in the area (n=7; 77.8%), a lack of time (n=6; 66.7%), and a lack of interest in the area (n=2, 22.2%). One physician responded that the gender (n=1; 11.1%), age (n=1; 11.1%), and personality (n=1; 11.1%) of either the physician or the patient, can be a barrier to physicians providing psychological services themselves (Table 17). For example, this physician suggested that if a female patient was sexually assaulted by a male, that his being a male would be a barrier for him providing that patient with psychological services.

Table 17

Responses that Emerged for the Question, "What barriers are there to you providing psychological services yourself?"

RESPONSE	n	%
Lack of training and/or skill in the area	7	77.8
Lack of time	6	66.7
Lack of interest in that area	2	22.2
Gender	1	11.1
Age	1	11.1
Personality	1	11.1
TOTAL NUMBER OF PHYSICIANS THAT RESPONDED	9	100.0

As shown in Table 18, the majority (n=7; 77.8%) of the physicians reported that they did not feel that they had time to be providing psychological services themselves, while only 22.2% (n=2) indicated that they felt they did.

Table 18

Responses to the Question, "Do you feel that you have time to be providing psychological services?"

RESPONSE	n	%
Yes	2	22.2
No	7	77.8
TOTAL NUMBER OF PHYSICIANS THAT RESPONDED	9	100.0

In response to the question, "What percentage of psychological and emotional issues do you feel that you are able to correctly identify/diagnose?," only two physicians (22.2%) felt that it was less than half. The majority (n=7; 77.8%) reported that they felt that they could correctly identify/diagnose 70% or more of psychological and emotional issues (Table 19).

Table 19

Percentage of Psychological and Emotional Issues that Physicians Feel they can Correctly Identify/Diagnose

PERCENT IDENTIFIED	n	%
30 percent	1	11.1
50 percent	1	11.1
70 percent	1	11.1
75 percent	3	33.3
80 percent	2	22.2
100 percent	1	11.1
TOTAL NUMBER OF PHYSICIANS THAT RESPONDED	9	100.0

As shown in Table 20, the psychological issues that physicians reported that they felt confident in recognizing/diagnosing were depression and other mood disorders (n=7; 77.8%), anxiety disorders (n=5; 55.6%), post-traumatic stress disorders (n=1; 11.1%), stress (n=1; 11.1%), grief (n=1; 11.1%), relationships issues/family violence (n=1; 11.1%), everything except personality disorders (n=1; 11.1%), and one physician (11.1%) reported that he or she felt confident in recognizing/diagnosing all psychological issues.

Table 20

Responses to the Question, "Which psychological issues do you feel competent in recognizing/diagnosing?"

PSYCHOLOGICAL ISSUE	n	%
Depression and other Mood disorders	7	77.8
Anxiety disorders	5	55.6
Post-Traumatic Stress disorders	1	11.1
Psychotic disorders	1	11.1
Stress	1	11.1
Grief	1	11.1
Relationship issues/Family violence	1	11.1
All except personality disorders	1	11.1
All of them	1	11.1
TOTAL NUMBER OF PHYSICIANS THAT RESPONDED	9	100.0

The psychological issues that physicians indicated they did not feel competent in recognizing/diagnosing were personality disorders (n=5; 55.6%), schizophrenia/psychotic disorders (n=3; 33.3%), bipolar (n=1; 11.1%), relationship/sexual issues (n=1; 11.1%), learning disabilities (n=1; 11.1%), and attention deficit/hyperactivity disorder (ADHD) (n=1; 11.1%; Table 21). Several physicians (n=4; 44.4%) reported issues that they did not like treating rather than "did not feel competent in recognizing and diagnosing," however, as this was not the question, those results will not be reported here.

Table 21

Responses to the Question, "Which psychological issues do you not feel competent in recognizing/diagnosing?"

PSYCHOLOGICAL ISSUE	n	%
Personality disorders	5	55.6
Schizophrenia/Psychotic disorders	3	33.3
Bipolar	1	11.1
Relationship/Sexual issues	1	11.1
Learning Disabilities	1	11.1
ADHD	1	11.1
TOTAL NUMBER OF PHYSICIANS THAT RESPONDED	9	100.0

Question #19 of Part III asked the physicians to indicate how qualified they felt providing psychological services compared to a psychologist on a 4-point Likert-type scale, with 1 indicating 'not qualified', 2 indicating 'partially qualified', 3 indicating 'moderately qualified', and 4 indicating 'very qualified'. The mean score for question #19 was 1.89, meaning that the average rating fell between the 'not qualified' and 'partially qualified' ratings. Of the physicians, 33.3% (n=3) reported that they felt 'not qualified', 44.4% (n=4) reported that they felt 'partially qualified', and 22.2% (n=2) reported that they felt 'moderately qualified' (Table 22).

Table 22

Ratings in Response to the Question, "How qualified do you feel you are to provide psychological services compared to a psychologist?"

RATING	n	%
Not qualified (1)	3	33.3
Partially qualified (2)	4	44.4
Moderately qualified (3)	2	22.2
Very qualified (4)	0	0
TOTAL NUMBER OF PHYSICIANS THAT RESPONDED	9	100.0

Mean=1.89; Range=2; Standard Deviation=.78

In Part III, question #20, physicians were asked to rate how well they felt their education prepared them for the diagnosis and treatment of psychological disorders on a 4-point Likert-type scale, with 1 indicating 'not well', 2 indicating 'somewhat well', 3 indicating 'moderately well', and 4 indicating 'very well'. The mean score was 2.25, meaning that the average rating fell between the 'somewhat well' and 'moderately well' ratings. Of the physicians, 11.1% (n=1) chose a rating of 'not well', 44.4% (n=4) chose a rating of 'somewhat well', and 33.3% (n=3) indicated that it prepared them 'moderately well' (Table 23). One of the participants chose not to answer this question, and instead commented on the differences between the 'diagnosis' and the 'treatment' of psychological disorders. This physician suggested that it be two different questions, and chose a rating of 2.5 for treatment and a 4 for diagnosis.

Table 23

Ratings in Response to the Question, "How well do you feel your education prepared you for diagnosis and treatment of psychological disorders?"

RATING	n	%
Not well (1)	1	11.1
Somewhat well (2)	4	44.4
Moderately well (3)	3	33.3
Very well (4)	0	0
Other	1	11.1
TOTAL NUMBER OF PHYSICIANS THAT RESPONDED	9	100.0

Mean=2.25; Range=2; Standard Deviation=.71

In Part III, question #21, physicians were asked to rate how well they felt their education prepared them for referral and collaboration with psychologists. The mean score was 2.22, meaning that the average rating fell between the 'somewhat well' and 'moderately well' ratings. Of the physicians, 22.2% (n=2) chose a rating of 'not well' and 44.4% (n=4) chose a rating of "somewhat well'. Others indicated that they felt it had prepared them 'moderately well' (22.2%; n=2) or 'very well' (11.1%; n=1; Table 24).

Table 24

Ratings in Response to the Question, "How well do you feel your education prepared you for referral and collaboration with psychologists?"

RATING	n	%
Not well (1)	2	22.2
Somewhat well (2)	4	44.4
Moderately well (3)	2	22.2
Very well (4)	1	11.1
TOTAL NUMBER OF PHYSICIANS THAT RESPONDED	9	100.0

Mean=2.22; Range=3; Standard Deviation=.97

The majority (n=6; 66.7%) of physicians reported that they did not feel that there needed to be an increase in the amount of education and training that physicians receive regarding the identification and diagnosis of psychological problems, while only three (33.3%) felt that there did (Table 25). Some of the comments that were put forth by these physicians included:

Table 25

Responses to "Do you feel that there needs to be an increase in the amount of education and training that physicians receive regarding the identification/diagnosis of psychological problems in patients?'

RESPONSE	n	%
Yes	6	66.7
No	3	33.3
TOTAL NUMBER OF PHYSICIANS THAT RESPONDED	9	100.0

One physician stated, "It would be nice, but I don't know how one would do it, med school really isn't the place. I think it should be done in the workplace, hands on." Another physician indicated that "It's not an educational thing, it's a personality thing. Either you have it and you are interested in that kind of thing, or you don't." Another physician's opinion was "No, not more so than any other field, but it needs to be an intentional part of program."

In response to question #23 (Part III), "Do you feel that there needs to be an increase in the amount of education and training that physicians receive for treating psychological issues?," 44.4% (n=4) said yes, 44.4% (n=4) said no, and 11.1% (n=1) reported that "it depends what country you train in, where I trained, no" (Table 26).

Table 26

Responses to the Question, "Do you feel that there needs to be an increase in the amount of education and training that physicians receive for treating psychological issues?"

RESPONSE	n	%
Yes	4	44.4
No	4	44.4
Other	1	11.1
TOTAL NUMBER OF PHYSICIANS THAT RESPONDED	9	100.0

As shown in Table 27, when describing how they made a referral, two (22.2%) of the physicians indicated that they would first determine whether a referral to a psychologist would be beneficial for the patient and enlist patient willingness. The physicians indicated that, they would either suggest to the patient that he or she look in the phonebook (n=2; 22.2%), give the patient one to several different psychologists' names and phone numbers and get the patient to call (n=6; 66.7%), or have the office referral booking desk set up the appointment (n=2; 22.2%).

Table 27

Responses that Emerged for the Question, "Describe for me how you make a referral?"

RESPONSE	n	%
First determine whether a referral would beneficial for the patient and patient willingness	2	22.2
Suggest the patient look in the phonebook	2	22.2
Provide patient with one to several names and phone numbers and have the patient phone	6	66.7
Have the office referral booking desk set up the appointment	2	22.2
Refer the patient to where they are covered	3	33.3
Try to match patient and psychologist personality	1	11.1
Try to match patient problem with psychologist specialty	1	11.1
Consider individual needs of the patient, i.e. privacy	1	11.1
Send a letter of referral to the psychologist	1	11.1
TOTAL NUMBER OF PHYSICIANS THAT RESPONDED	9	100.0

In the physicians descriptions of a referral, when looking at where to refer, the responses included: refer the patient to where they are covered (n=3; 33.3%), try to match patient and psychologist personality (n=1; 11.1%), try to match patient problem with psychologist specialty (n=1; 11.1%), or that the physician considers the individual needs of the patient, i.e. privacy (n=1; 11.1%). Only one (11.1%) physician reported that he or she sends or provides a letter of referral to the psychologist.

In response to question #25 (Part III) which reads 'To whom do you make a referral?', the majority of the physicians' (n=8, 88.9%) responses were that "it depends on the patients level of coverage," stating that if the patient is not covered, he or she will refer to government run and/or paid agencies, and if the patient is covered, then he or she will refer to a private psychologist. Three (33.3%) of the physicians indicated that where he or she refers depends on the patient profile, i.e. the issue, individual personalities of

the patient/psychologist and/or privacy issues of the patient. One (11.1%) of the physicians reported that he or she is not familiar with the resources in the area, and one (11.1%) physician referred them to the phone book (Table 28).

Table 28

Responses that Emerged for the Question, "To whom do you make the referral?"

RESPONSE	n	%
Depends on patient coverage	8	88.9
Depends on the patient profile	3	33.3
Not familiar with the resources in the area	1	11.1
Refers to the phone book	1	11.1
TOTAL NUMBER OF PHYSICIANS THAT RESPONDED	9	100.0

In response to question #26 (Part III) "How do you decide when to refer?," three (33.3%) of the physicians reported that they decide to refer depending on either patient willingness or receptiveness to the referral (n=3; 33.3%), two (22.2%) indicated that they will refer if the issue is beyond his or her scope and/or he or she is not sure of the diagnosis, two (22.2%) indicated that their decision to refer was based on patient need/severity, and two physicians indicated that they will refer anybody with a "psychiatric condition" and/or "who is on psychotropic medication." Other responses were "by instinct or gut reaction" (n=1; 11.1%), if the issue needs a lot of time (n=1; 11.1%), if the patient has coverage (n=1; 11.1%), when the patient is ready to benefit from non-pharmacological therapy (n=1; 11.1%), and/or if the patient is uncomfortable with the physicians approach (n=1; 11.1; Table 29).

In response to the question "How do you know where to refer?," the most common responses were "by word of mouth and colleagues" (n=4; 44.4%), and that the physician was "not familiar with the psychologists in the area" (n=4; 44.4%). Other responses were from past experience (n=2; 22.2%), that it depended on patient coverage

(n=2; 12.5%), to a government agency (n=2; 22.2%), and try to match the patients issue and personality with the psychologists specialty and personality (n=2; 22.2%; Table 30).

Table 29

Responses that Emerged for the Question "How do you decide when to refer?"

RESPONSE	N	%
Based on patient willingness or receptiveness to the referral	3	33.3
Issue beyond scope of the physician and/or he or she is not sure of the diagnosis	2	22.2
On patient need/severity of the issue	2	22.2
Anybody with a psychiatric condition and/or who is on psychotropic medication	2	22.2
By instinct or gut reaction	1	11.1
If the issue needs a lot of time	1	11.1
If the patient is covered	1	11.1
Patient is ready to benefit from non-pharmacological therapy	1	11.1
Patient is uncomfortable with physician's approach	1	11.1
TOTAL NUMBER OF PHYSICIANS THAT RESPONDED	9	100.0

Table 30

Responses that Emerged for the question "How do you know where to refer?"

RESPONSE	n	%
By word of mouth or colleagues	4	44.4
Not familiar with the psychologists in the area	4	44.4
From past experience	2	22.2
Depends on patient coverage	2	22.2
To a government agency	2	22.2
Try to match the patients issue and personality with the psychologists specialty and personality	2	22.2
TOTAL NUMBER OF PHYSICIANS THAT RESPONDED	9	100.0

Question #28 of Part III asked the physicians "How effective would you rate your current referrals to psychologists?," with 1 indicating 'not effective', 2 indicting 'partially effective', 3 indicating 'moderately effective', and 4 indicating 'very effective'. The mean score for question #28 was 2.44, meaning that the average rating fell between the 'partially effective' and 'moderately effective' ratings. Of the physicians, 22.2% (n=2) reported his or her current referrals to be 'not effective', 22.2% (n=2) reported them to be

'partially effective', 44.4% reported them to be 'moderately effective', and 11.1% (n=1) reported them to be 'very effective' (Table 31).

Table 31

Ratings in Response to the Question, "How effective would you rate your current referrals to psychologist?"

RATING	n	%
Not effective (1)	2	22.2
Partially effective (2)	2	22.2
Moderately effective (3)	4	44.4
Very effective (4)	1	11.1
TOTAL NUMBER OF PHYSICIANS THAT RESPONDED	9	100.0

Mean=2.44; Range=3; Standard Deviation=1.01

As shown in Table 32, the most frequent barrier to effective referrals between physicians and psychologists, as identified by physicians, was that physicians did not know the resources that were available (n=6; 66.7%). Other responses included the patient not being able to afford psychological services (n=3; 33.3%), that it takes a long time for a patient to get in to see a psychologist (n=2; 22.2%), the lack of feedback received from the psychologist (n=2; 22.2%), the psychological services not being effective for the patient (n=2; 22.2%), the lack of respect that physicians have for psychology (n=1; 11.1%), a lack of patient follow through (n=1; 11.1%), and physicians not wanting to give up control of their patient (n=1; 11.1%).

The majority (n=7; 77.8%) of the physicians indicated that their decision of whether or not to refer does not depend on the level of collaboration that he or she has with the psychologist, while two (22.2%) indicated that it did depend on the level of collaboration (Table 33).

Table 32

Responses that Emerged for the Question, "What do you see as being the biggest barriers to effective referrals between physicians and psychologists?"

RESPONSE	n	%
Physicians not knowing the resources available	6	66.6
Patient not being able to afford psychological services	3	33.3
Long length of time to get into see a psychologist	2	22.2
Lack of feedback received from the psychologist	2	22.2
The psychological services not being effective for patient	2	22.2
The lack of respect that physicians have for psychology	1	11.1
A lack of patient follow through	1	11.1
Physicians not wanting to give up control of their patient	1	11.1
TOTAL NUMBER OF PHYSICIANS TIIAT RESPONDED	9	100.0

Table 33

Responses to the Question, "Does your decision of whether or not to refer depend on the level of collaboration you have with the psychologist?"

RESPONSE	n	%
Yes	2	22.2
No	7	77.8
TOTAL NUMBER OF PHYSICIANS THAT RESPONDED	9	100.0

However, of the physicians that indicated that their decision of whether or not to refer does not depend on the level of collaboration that he or she has with the psychologist, four (44.4%) reported that this was because they do not have a good level of collaboration with any of the psychologists, and three (33.3%) indicated that if they did have good collaboration with a psychologist, that they would refer to that psychologist more. Other physicians reported that their decision of whether or not to refer was based more on his or her previous experience with the psychologist (n=2; 22.2%), or on patient need and/or coverage (n=1; 11.1%; Table 34).

Table 34

Responses that Emerged for the Question, "Does your decision of whether or not to refer depend on the level of collaboration you have with the psychologist?"

RESPONSE	n	%
Lack of collaboration with any psychologists	4	44.4
If there were collaboration, it would affect referral	3	33.3
Referrals based on previous experience with the psychologist	2	22.2
Referrals based on patient need and/or coverage	1	11.1
TOTAL NUMBER OF PHYSICIANS THAT RESPONDED	9	100.0

When asked whether their decision to refer depended on whether or not they had referred to that psychologist before, 77.8% (n=7) stated that it did, because of the reputation and previous successes of the psychologist (Table 35). Two (22.2%) of the physicians indicated that their decision to refer did not depend on whether they had referred to the psychologist before.

As shown in Table 36, the majority of physicians (n=7; 77.8%) indicated that the decision of whether or not to refer does depend on the previous experiences he or she has had with a psychologist, while 22.2% (n=2) indicated that it did not.

Table 35

Responses to the Question, "Does your decision of whether or not to refer depend on whether you have referred to that psychologist before?"

RESPONSE	n	%
Yes	7	77.8
No	2	22.2
TOTAL NUMBER OF PHYSICIANS THAT RESPONDED	9	100.0

Table 36

Responses to the Question, "Does your decision of whether or not to refer depend on your previous experiences with that psychologist?"

RESPONSE	n	%
Yes	7	77.8
No	2	22.2
TOTAL NUMBER OF PHYSICIANS THAT RESPONDED	9	100.0

As shown in Table 37, the majority of the physicians (n=6; 66.7%) indicated that the specialty of the psychologist affected their decision of whether or not to refer to that psychologist, while 33.3% (n=3) indicated that it did not. In response to this question, 33.3% (n=3) of the physicians indicated that they would try to match the specialty of the psychologist with the patient problem. An equal number of physicians (33.3%, n=3), however, reported that they did not know the different specialties of the psychologists, and 22.2% (n=2) reported that they did not even know that psychologists had specialties. It was also reported by one physician that the decision of whether or not to refer was based more on the reputation of the psychologist than on his or her specialty (n=1; 11.1%; Table 38).

Table 37

Responses to the Question, "Does your decision of whether or not to refer depend on the specialty of the psychologist?"

RESPONSE	n	%
Yes	6	66.7
No	3	33.3
TOTAL NUMBER OF PHYSICIANS THAT RESPONDED	9	100.0

Table 38

Responses that Emerged for the Question, "Does your decision of whether or not to refer depend on the specialty of the psychologist?"

RESPONSE	n	%
Try to match specialty of psychologist with the patient problem	3	33.3
Do not know the different specialties of the psychologists	3	33.3
Did not know that psychologists had specialties	2	22.2
Based more on reputation of the psychologist than on specialty	1	11.1
TOTAL NUMBER OF PHYSICIANS THAT RESPONDED	9	100.0

In Part III, question #34, physicians were asked to rate the amount of responsibility that a psychologist assumes for ongoing care once they get a referral on a 4-point Likert-type scale, with 1 indicating 'too little', 2 indicting 'barely enough', 3

indicating 'appropriate amount', and 4 indicating 'too much'. The mean score for question # 34 was 3.67. Of the physicians 66.7% (n=6) chose a rating of 'appropriate amount' and 33.3% (n=3) indicated that it "depends" (Table 39). The three responses that emerged from the physicians' comments are that it depends on the psychologist (n=2; 22.2%), cannot comment, as he or she does not receive any feedback from the psychologist (n=1; 11.1%), and that it depends more on if the patient can afford to keep going (n=1; 11.1%).

Table 39

Ratings in Response to the Question "Please rate the amount of responsibility that a psychologist assumes for ongoing care once they get a referral?"

RATING	n	%
Too little (1)	0	0
Barely enough (2)	0	0
Appropriate amount (3)	6	66.7
Too much (4)	0	0
Depends	3	33.3
TOTAL NUMBER OF PHYSICIANS THAT RESPONDED	9	100.0

Mean=3.67; Range=2; Standard Deviation=1.00

Almost all of the physicians (n=8; 88.9%) reported that the possibility of the patient becoming upset by the referral does not influence their decision to refer, with one physician (11.1%) stating that it would influence where he or she would refer, but would not stop him or her from referring, stating "some [psychologists] are gentler than others" (Table 40).

Table 40

Responses that Emerged from the Question, "Does the possibility of the patient becoming upset by the referral to a psychologist influence your decision of whether or not to refer?"

RESPONSE	n	%
Yes	1	11.1
No	8	88.9
TOTAL NUMBER OF PHYSICIANS THAT RESPONDED	9	100.0

As shown in Table 41, when asked whether they felt that there was a shortage of available psychological services for referral or consultation, 22.2% (n=2) indicated that they did feel that there was a shortage, while 11.1% (n=1) indicated that they did not. The remaining physicians reported that they felt it was either a shortage of funding or government sponsored agencies rather than a shortage of practitioners (33.3%, n=3) or that they did not know enough about the services available to comment (33.3%, n=3). Less than half (33.3%, n=3) reported that this influenced whether or not they referred.

As shown in Table 42, when asked whether or not they felt that psychotropic medication was more cost effective in treating psychological problems than psychotherapy, 55.6% (n=5) stated that it was not, 11.1% (n=1) stated that it was, 22.2% (n=2) felt that it depended on the psychological issue, and 11.1% (n=1) felt that medication and psychotherapy were meant to be used together. When asked whether this would affect whether or not they would refer, 44.4% (n=4) indicated that it would, 44.4%, stated that it would not, and 11.1% (n=1) stated that it would depend on the psychological issue in question.

The two most common responses to this question were that it depends on the issue, in that, if medication alone works, then there is no need for the referral (n=3; 33.3%) and that medication and psychotherapy usually have to work together (n=2; 22.2%). Other responses to this question were that medication usually helps to prepare people to deal with their issues, but it doesn't solve them (n=1; 11.1%), that it may affect patient willingness to go to psychotherapy, in that, if response to medication is good, the patient often does not want to go to psychotherapy (n=1; 11.1%), and that medication is not more cost effective, but is a more effective treatment (n=1; 11.1%; Table 43).

Table 41
Reponses to the Question, "Do you feel that there is a shortage of available psychological services for psychological referral or consultation?"

RESPONSE	n	%
Yes	2	22.2
No	1	11.1
Other	6	66.7
TOTAL NUMBER OF PHYSICIANS THAT RESPONDED	9	100.0
Does this influence whether you refer?		
RESPONSE	n	%
Yes	3	33.3
No	6	66.7
TOTAL NUMBER OF PHYSICIANS THAT RESPONDED	9	100.0

Table 42
Responses to the Question "Do you feel that psychotropic medication is more cost effective in treating psychological problems than psychotherapy?"

RESPONSE	n	%
Yes	1	11.1
No	5	55.6
Meant to be used together	1	11.1
Depends on the issue	2	22.2
TOTAL NUMBER OF PHYSICIANS THAT RESPONDED	9	100.0
Does this influence whether you refer?		
RESPONSE	n	%
Yes	4	44.4
No	4	44.4
Depends on the psychological issue	1	11.1
TOTAL NUMBER OF PHYSICIANS THAT RESPONDED	9	100.0

Table 43
Responses that Emerged for the Question, "Do you feel that psychotropic medication is more cost effective in treating psychological problems than psychotherapy?"

RESPONSE	n	%
If medication alone works, no need for the referral	3	33.3
Medication and psychotherapy usually have to work together	2	22.2
Medication usually helps to prepare people to deal with their issues, but it doesn't solve them	1	11.1
If response to medication is good, the patient often does not want to go to psychotherapy	1	11.1
Medication is not more cost effective, but is a more effective treatment	1	11.1
TOTAL NUMBER OF PHYSICIANS THAT RESPONDED	8	100.0

As shown in Table 44, almost all of the physicians reported that neither the patients age (n=7; 77.8%), nor the patients gender (n=8; 88.9%), would affect whether or not they would refer. Of those that indicated that the patients age would affect whether or not they would refer, the following responses emerged: that physicians are much less likely to refer the elderly (n=2; 22.2%), that the physician could not comment, because children usually go to social services (n=1; 11.1%), and that cognitive ability is a factor (n=1; 11.1%), meaning that it is more of an issue of cognitive functioning than age, in that, a certain level of cognitive functioning is required for a patient to benefit from psychotherapy. In response to whether the patients' gender affected the referral, three physicians stated that females are more likely to go than males.

As shown in Table 44, of the physicians interviewed, 66.7% (n=6) stated that the patients' socioeconomic status would influence whether they would refer, and 33.3% (n=3) stated that it did not. The comments that emerged in response to this question included: that if the patient can not afford psychological services, then they can not access them (n=4; 44.4%), and that individuals of a lower socioeconomic status are less suitable for therapy, as they are often not as intelligent (n=1; 11.1%). For the physicians that indicated that a patient's socioeconomic status did not influence whether or not they referred, the comments that the physicians made included that a patient's socioeconomic status can be a barrier to whether they can actually access the services, but it does not influence whether or not the physician will refer (n=2; 22.2%), and that it may influence where the physicians refers, but not whether they do (n=2; 22.2%).

When asked whether a patient's employment status would influence whether or not the physicians would make a psychological referral, 55.6% (n=5) indicated that it

would and 44.4% (n=4) indicated that it would not (Table 44). The comments that were made in response to this question were that it would depend on whether the patient could afford the services (n=4; 44.4%), and whether the patient has coverage (n=3; 33.3%).

As shown in Table 44, the majority of the physicians (n=7; 77.8%) reported that the more times that a patient has brought a problem to his or her attention, the more likely they are to make a psychological referral, with the only reason given, being that it would indicate that what was being done in the physician's office was not working, making a referral necessary (n=3; 33.3%).

As shown in Table 44, the majority of the physicians (n=7; 77.8%) indicated that his or her belief or knowledge that the patients' insurance would reimburse the patient for the psychological treatment would influence whether he or she would refer, with seven physicians (77.8%) stating that the chance of a referral would increase. The remaining physicians stated that they would still refer to Alberta Mental health (n=2; 22.2%), but would prefer for the patient to be covered for psychological services, as some people will not go to Alberta Mental Health (n=1; 11.1%), and because there are a lot of people who could benefit from psychological services, that do not qualify to be seen at Alberta Mental Health (n=1; 11.1%; Table 45).

Table 44

Patient characteristics and the influence whether or not physicians refer

Patient's age?		
RESPONSE	n	%
Yes	2	22.2
No	7	77.8
TOTAL NUMBER OF PHYSICIANS THAT RESPONDED	9	100.0
Patient's gender?		
RESPONSE	n	%
Yes	1	11.1
No	8	88.9
TOTAL NUMBER OF PHYSICIANS THAT RESPONDED	9	100.0
Patient's social economic status?		
RESPONSE	n	%
Yes	6	66.7
No	3	33.3
TOTAL NUMBER OF PHYSICIANS THAT RESPONDED	9	100.0
Patient's employment status?		
RESPONSE	n	%
Yes	5	55.6
No	4	44.4
TOTAL NUMBER OF PHYSICIANS THAT RESPONDED	9	100.0
Number of times the patient has brought the problem to your attention?		
RESPONSE	n	%
Yes	7	77.8
No	2	22.2
TOTAL NUMBER OF PHYSICIANS THAT RESPONDED	9	100.0
Physicians' belief or knowledge that the patients' insurance would reimburse the patient?		
RESPONSE	n	%
Yes	7	77.8
No	2	22.2
TOTAL NUMBER OF PHYSICIANS THAT RESPONDED	9	100.0

Table 45

Responses that Emerged for the Question "Does your belief or knowledge of whether the patients' insurance will reimburse them influence whether or not you refer?"

RESPONSE	n	%
The chance of a referral would increase	7	77.8
Would refer to Alberta Mental Health	2	22.2
Some people will not go to Alberta Mental Health	1	11.1
Are a lot of people who would benefit from psychological services that Alberta Mental Health will not see	1	11.1
TOTAL NUMBER OF PHYSICIANS THAT RESPONDED	9	100.0

Question #45a of Part III asked the physicians to indicate how much of an influence the patients' level of coverage has on whether or not they would refer on a 4-point Likert-type scale, with 1 indicating 'not influential', 2 indicating 'partially influential', 3 indicating 'moderately influential', and 4 indicating 'very influential'. The mean score for question #45a was 3.56, meaning that the average rating fell between the 'moderately influential' and 'very influential' ratings. Of the physicians, 11.1% (n=1) chose the rating 'partially influential', 22.2% (n=2) chose 'moderately influential', and 66.7% (n=6) chose a rating of 'very influential' (Table 46).

Table 46

Ratings in Response to the Question, "How much of an influence does the patient's level of coverage have on whether or not you refer?"

RATING	n	%
Not influential (1)	0	0
Partially influential (2)	1	11.1
Moderately influential (3)	2	22.2
Very influential (4)	6	66.7
TOTAL NUMBER OF PHYSICIANS THAT RESPONDED	9	100.0

Mean=3.56; Range=2; Standard Deviation=.73

In question #46 of Part III, physicians were asked to rate on a 4-point Likert-scale, with 1 indicating 'not difficult', 2 indicating 'somewhat difficult', 3 indicating 'moderately difficult', and 4 indicating 'very difficult', how difficult it was to find mental health treatment for patients who were not covered for psychological services. The mean score for #46 was 2.78, meaning that the average rating fell between 'somewhat difficult' and 'moderately difficult'. Of the physicians, 33.3% (n=3) indicated that it was 'very difficult', 33.3% (n=3) indicated that it was moderately difficult, 11.1% (n=1) reported it to be somewhat difficult, and 22.2% (n=2) stated that it was not difficult (Table 47). The comments that emerged in response to this question included: the physicians indicating that he or she could always refer the patient to Alberta Mental Health (n=5; 55.6%), but that there is a long waiting list (n=2; 22.2%), or that patient satisfaction with the treatment may not be as high (n=1; 11.1%).

Table 47

Ratings in Response to the Question, "How difficult is it for you to find mental health treatment for patients who are not covered for psychological services?"

RATING	n	%
Not difficult (1)	2	22.2
Somewhat difficult (2)	1	11.1
Moderately difficult (3)	3	33.3
Very difficult (4)	3	33.3
TOTAL NUMBER OF PHYSICIANS THAT RESPONDED	9	100.0

Mean=2.78; Range=3; Standard Deviation=1.20

As shown in Table 48, when asked how they ascertain what coverage each patient has, the physicians stated that they would ask him or her (n=8; 88.9%), and if the patient did not know, the physician would get the patient to check with his or her work (n=3; 33.3%). It was also stated that the physician can sometimes tell what coverage a patient has by the patient's occupation (n=1; 11.1%).

Table 48

Reponses that Emerged for the Question, "How do you ascertain what coverage each patient has?"

RESPONSE	n	%
The physicians asks the patient	8	88.9
If patient does not know, has them check with their employer	3	33.3
Can sometimes tell by the patients occupation	1	11.1
TOTAL NUMBER OF PHYSICIANS THAT RESPONDED	9	100.0

Questions #48, 49, 50a, 50b, 50c, 50d, 50e, 50f, 50g, 50h, 50i, 50j, 50k, 51, were yes or no questions that were asked to try and determine the degree of knowledge the physicians had about the available coverage for patients (Table 49). Of the physicians interviewed, 44.4% (n=4) indicated that they knew that the city of Lethbridge had a subsidy program that covers psychological services, and 55.6% (n=5) indicated that they knew that if a patient is covered for prescriptions that he or she is likely to be covered for psychological services.

The physicians interviewed were also provided with the following list of employers, and asked to indicate whether he or she knew that all employees, full or part-time, and their family members had a 100% coverage for psychological services: any school in Southern Alberta (yes: n=8; 88.9%), Lethbridge Community College (yes: n=6; 66.7%), Costco (yes: n=2; 22.2%), London Drugs (yes: n=0; 0%), Overwaite Foods (yes: n=0; 0%), Alberta Treasury Branch (yes: n=3; 33.3%), any bank (yes: n=4; 44.4%), Safeway (yes: n=2; 22.2%), RCMP (yes: n=8; 88.9%), City Police (yes: n=7; 77.8%), and all City of Lethbridge employees (yes: n=7; 77.8%). The majority of physicians (n=7; 77.8%) indicated that they knew that Worker's Compensation will cover 100% of the cost of psychological services and 77.8% (n=7) reported that they knew that professionals

and business owners could write off psychological services as consulting fees or medical expenses.

When asked to describe a referral from beginning to end that they would consider effective, the following responses emerged: that there would be feedback and follow up from the psychologist (n=5; 55.6%), that the patient would be seen in a timely fashion (n=3; 33.3%), that the patient would have their choice of psychologists (n=3; 33.3%), that the patient issue is accurately diagnosed (n=2; 22.2%), that there is patient willingness (n=2; 22.2%), the physician continues to be involved in patient care (n=2; 22.2%), the patient follows through with the referral (n=2; 22.2%), the client is satisfied with the treatment (n=2; 22.2%), a team approach to treatment involving a psychologist and a psychiatrist is used (n=1; 11.1%), the client is co-active in their treatment (n=1; 11.1%), and the patient has 100% coverage (n=1; 11.1%; Table 50).

When asked what could be done by psychologists to improve physician referrals, the responses that emerged included: having more information on which psychologists are in the community (n=5; 55.6%), having more follow-up and communication from the psychologist (n=3; 33.3%), having more information on each psychologist's area of expertise (n=3; 33.3%), having information on psychologist's fees and who they are covered by (n=2; 22.2%), and having information on the psychologist's years of experience (n=1; 11.1%; Table 51).

Table 49

The Degree of Knowledge Physicians had about the Available Coverage for Patients

'Did you know.....'		
...that the city of Lethbridge had a subsidy program that covers psychological services?		
Response	n	%
Yes	4	44.5
No	5	55.6
TOTAL NUMBER OF PHYSICIANS THAT RESPONDED	9	100.0
... that if a patient is covered for prescriptions that he or she is likely to be covered for psychological services?		
Response	n	%
Yes	5	55.6
No	4	44.4
TOTAL NUMBER OF PHYSICIANS THAT RESPONDED	9	100.0
...that all employees, full or part-time, and their family members had 100% coverage for psychological services at...		
...any school in Southern Alberta?		
Response	n	%
Yes	8	88.9
No	1	11.1
TOTAL NUMBER OF PHYSICIANS THAT RESPONDED	9	100.0
... Lethbridge Community College?		
Response	n	%
Yes	6	66.7
No	3	33.3
TOTAL NUMBER OF PHYSICIANS THAT RESPONDED	9	100.0
...Costco?		
Response	n	%
Yes	2	22.2
No	7	77.8
TOTAL NUMBER OF PHYSICIANS THAT RESPONDED	9	100.0
...London Drugs?		
Response	n	%
Yes	0	0
No	9	100.0
TOTAL NUMBER OF PHYSICIANS THAT RESPONDED	9	100.0
...Overwaite Foods?		
Response	n	%
Yes	0	0
No	9	100.0
TOTAL NUMBER OF PHYSICIANS THAT RESPONDED	9	100.0

...Alberta Treasury Branch?		
Response	n	%
Yes	3	33.3
No	6	66.7
TOTAL NUMBER OF PHYSICIANS THAT RESPONDED	9	100.0
...any Bank?		
Response	n	%
Yes	4	44.4
No	5	55.6
TOTAL NUMBER OF PHYSICIANS THAT RESPONDED	9	100.0
...Safeway?		
Response	n	%
Yes	2	22.2
No	7	77.8
TOTAL NUMBER OF PHYSICIANS THAT RESPONDED	9	100.0
... RCMP?		
Response	n	%
Yes	8	88.9
No	1	11.1
TOTAL NUMBER OF PHYSICIANS THAT RESPONDED	9	100.0
...City Police?		
Response	n	%
Yes	7	77.8
No	2	22.2
TOTAL NUMBER OF PHYSICIANS THAT RESPONDED	9	100.0
...all city of Lethbridge employees?		
Response	n	%
Yes	7	77.8
No	2	22.2
TOTAL NUMBER OF PHYSICIANS THAT RESPONDED	9	100.0
...that Worker's Compensation will cover 100% of the cost of psychological services?		
Response	n	%
Yes	7	77.8
No	2	22.2
TOTAL NUMBER OF PHYSICIANS THAT RESPONDED	9	100.0
...that professionals and business owners can write off psychological services as consulting fees or medical expenses?		
Response	n	%
Yes	7	77.8
No	2	22.2
TOTAL NUMBER OF PHYSICIANS THAT RESPONDED	9	100.0

Table 50

Responses that Emerged for the Question, "Describe for me, from beginning to end, a referral that you would consider effective."

RESPONSE	n	%
There would be feedback and follow up from the psychologist	5	55.6
That the patient is seen in a timely fashion	3	33.3
That the patient would have their choice of psychologists	3	33.3
The patient issue is accurately diagnosed	2	22.2
The patient is willing	2	22.2
The physician continues to be involved in patient care	2	22.2
The patient follows through with the referral	2	22.2
Client is satisfied with the treatment	2	22.2
There is a team approach to treatment	1	11.1
The client is co-active in their treatment	1	11.1
The patient would have 100% coverage	1	11.1
TOTAL NUMBER OF PHYSICIANS THAT RESPONDED	9	100.0

Table 51

Responses that Emerged for the Question, "What could be done to improve your referrals by psychologists?"

RESPONSE	n	%
More information on what psychologists are in the community	5	55.6
More follow-up and communication	3	33.3
More information on psychologists' areas of expertise	3	33.3
Information on psychologists' fees and who they are covered by	2	22.2
Information on the psychologist's years of experience	1	11.1
TOTAL NUMBER OF PHYSICIANS THAT RESPONDED	9	100.0

As shown in Table 52, when asked what could be done by physicians to improve their referrals to psychologists, the responses included: increasing the physicians' knowledge on the psychologists and resources that are available in the community (n=7; 77.8%), learning more about patient coverage (n=3; 33.3%), having the physicians office set up the appointment for the patient with the psychologist (n=1; 11.1%), and educating patients to dispel the myths around counselling (n=1; 11.1%).

Table 52

Responses that Emerged for the Question, "What could be done to improve your referrals by you?"

RESPONSE	n	%
Increase physicians' knowledge about psychologists and resources	7	77.8
Have physicians learn more about patient coverage	3	33.3
Have the physicians' office set up the appointment for the patient with the psychologist	1	11.1
Have physicians educate patients to dispel the myths around counselling	1	11.1
TOTAL NUMBER OF PHYSICIANS THAT RESPONDED	9	100.0

As shown in Table 53, all of the physicians interviewed (n=9; 100.0%) stated that he or she would benefit from referring out patients with psychological issues. Two most common responses were that physicians' have a "lack of training" in the area of psychology, and thus referring to a psychologist leads to better patient care (n=7; 77.8%), and that the physicians have a "lack of time" to be treating psychological issues (n=5; 55.6%). One (11.1%) physician did note a downside to psychological referral as being that it can impede the patient/physician relationship and may be seen as a loss if the physician likes the psychological component of his or her work.

When asked to describe any clinical experiences that may have affected the physicians' willingness to refer to a psychologist, the majority of the physicians (n=5; 55.5%) reported that they did not have any clinical experiences that may have affected their willingness to refer. The experiences that were reported included: "a conflict between psychologist and patient" (n=2; 22.2%), "sometimes the patient does not benefit from the referral" (n=1; 11.1%), physicians' resentment about the fact that physicians are the only ones that have to be on call (n=1; 11.1%), and one (11.1%) physician reported that his or her experience with psycho-educational assessments was a positive one, which increased his or her psycho-educational assessment referrals (Table 54).

Table 53

Responses to "Could it benefit you to refer out patients' with psychological issues?"

RESPONSE	n	%
Yes	9	100.0
No	0	0
TOTAL NUMBER OF PHYSICIANS THAT RESPONDED	9	100.0

Table 54

Responses that Emerged for the Question, "Describe any clinical experiences that may have affected your willingness to refer to psychologists?"

RESPONSE	n	%
Did not have any clinical experiences that may have affected their willingness to refer	5	55.5
A conflict between psychologist and patient	2	22.2
Sometimes the patient does not benefit from the referral	1	11.1
Physicians' resentment about the fact that physicians are the only ones that have to be on call	1	11.1
Past experience with psycho-educational assessments was a positive one, thus increasing psycho-educational assessment referrals	1	11.1
TOTAL NUMBER OF PHYSICIANS THAT RESPONDED	9	100.0

As shown in Table 55, the majority of the physicians (n=7; 77.8%) interviewed reported that there were no deeper issues that would prevent them from referring to a psychologist. Two physicians (22.2%), however, did note that their own personal opinion of a psychologist has influenced their decision of whether or not to refer.

When asked what percentage of the patients that they refer to psychologists actually follow through with getting counselling, the majority (n=6; 66.7%) of the physicians reported it to be less than 50%. The remaining physicians estimated it to be 70% of the patients (n=1; 11.1%), 75% of the patients (n=1; 11.1%), and 85% of the patients (n=1; 11.1%), that follow through with the referral (Table 56). The physicians' comments in response to this question included: that the physician could not be sure of how many patients actually follow through with counselling because they either do not

receive any feedback (n=1; 11.1%), or because the majority of physician referrals are to an organization, where the service providers may or may not be a psychologist (n=1; 11.1%). A comment was also made that follow through is more likely if the patient can afford or are covered for private psychological practice, as many who go to Alberta Mental Health "get sick of waiting" (n=1; 11.1%,).

Table 55

Responses that Emerged for the Question, "What deeper issues may prevent you from referring to psychologists?"

RESPONSE	n	%
Have no deeper issues	7	77.8
Physicians' personal opinion of a psychologist has influenced referral	2	22.2
TOTAL NUMBER OF PHYSICIANS THAT RESPONDED	9	100.0

Table 56

Responses to the Question "Of the patients that you do refer to psychologists, what percentage follow though with getting counselling?"

RESPONSES	n	%
Less than 50%	6	66.7
70%	1	11.1
75%	1	11.1
85%	1	11.1
TOTAL NUMBER OF PHYSICIANS THAT RESPONDED	9	100.0

Part IV: Collaboration

This section requested information regarding the physicians' current collaboration with psychologists, their satisfaction with that collaboration, and their attitudes and beliefs about collaboration.

When asked to define effective collaboration between physicians and psychologists, the physicians responses included that the physicians would like for there to be contact between themselves and the psychologist only if it was needed, for example, the patient was not getting better or was getting worse (n=4; 44.4%; Table 57). Other

physicians indicated that they would like to receive regular feedback from the psychologist (n=2; 22.2%), and still others indicated that they would prefer to receive feedback from the patient (n=2; 22.2%). Other responses that emerged in defining effective collaboration included receiving recommendations (n=2; 22.2%), having a good match between patient and psychologist (n=1; 11.1%), and that "the patient gets better" (n=1; 11.1%). One physician (11.1%) reported that his or her current level of collaboration with psychologists was "good the way it is."

Table 57

Responses that Emerged for the Question, "How would you define effective collaboration between physicians and psychologists?"

RESPONSE	n	%
Contact between the physician and the psychologist only if needed	4	44.4
Receive regular feedback from the psychologist	2	22.2
Would prefer to receive feedback from the patient	2	22.2
Receiving recommendations	2	22.2
There being a good match between patient and psychologist	1	11.1
That the patient gets better	1	11.1
It is good the way it is	1	11.1
TOTAL NUMBER OF PHYSICIANS THAT RESPONDED	9	100.0

Table 58 reports that the physicians identified the biggest barrier to effective collaboration between physicians and psychologists, as being a lack of interdisciplinary communication (n=5; 55.6%). The physician responses that were grouped into this category included two physicians who spoke to the idea of "a lack of communication," and three physicians who indicated that "physicians and psychologists are functioning independently." A "lack of time" was also identified as being a barrier to effective collaboration between physicians and psychologists (n=4; 44.4%), as was physicians' negative attitudes towards psychologists (n=1; 11.1%), physicians' lack of knowledge

about the psychologists that are available (n=1; 11.1%), and economic pressure, which spoke to the idea that time is money (n=1; 11.1%).

Table 58

Responses that Emerged for the Question, "What do you see as being the biggest barriers to effective collaboration between physicians and psychologists?"

RESPONSE	n	%
A lack of interdisciplinary communication	5	55.6
A lack of time	4	44.4
Physicians' negative attitudes towards psychologists	1	11.1
Physicians' lack of knowledge about the psychologists that are available	1	11.1
Economic pressure, i.e. "that time is money"	1	11.1
TOTAL NUMBER OF PHYSICIANS THAT RESPONDED	9	100.0

Two questions in Part IV (#s 3a & 3c) asked the physicians, "How would you rate your current level of collaboration with psychologists in general?," and "How would you rate your current level of collaboration with psychologists that you currently refer to?" Tables 59 and 60 present the physicians' ratings to these questions.

The mean for question #3a, "How would you rate your current level of collaboration with psychologists in general?," was 1.89. Thus, the average rating falls between the "not effective" and the "somewhat effective" ratings, with the majority of the physicians choosing either "not effective" (n=4; 44.4%) or "somewhat effective" (n=3; 33.3%). One physician (11.1%) rated the effectiveness of his or her current level of collaboration with psychologists in general as being "moderately effective" and one physician (11.1%) rated them as being "very effective." The reasons that were given for the ratings included the lack of feedback and collaboration from psychologists (n=4; 44.4%), or that the psychologist will only phone the physician occasionally (n=1; 11.1%).

The mean rating for question #3c, "How would you rate your current level of collaboration with psychologists that you currently refer to?" was 2.56. Therefore the

average rating fell between the "somewhat effective" and the "moderately effective" ratings, with the majority of physicians choosing either "somewhat effective" (n=5; 55.6%) or "moderately effective" (n=3; 33.3%). One physician (11.1%) chose the rating "very effective" (Table 60). Many of the physicians who rated their current level of collaboration with the psychologists they currently refer to as less than "very effective," reported that it was because they were still not happy with the amount of feedback received from the psychologist (n=3; 33.3%). The physician that rated the collaboration as "very effective" reported that he or she only refers to the psychologists that do provide feedback (n=1; 11.1%). The one physician who did not choose a rating reported "I am more likely to refer to an agency than a private psychologist" (n=1; 11.1%).

Table 59

Responses to the Question "How would you rate your current level of collaboration with psychologists in general?"

RATING	n	%
Not effective	4	44.4
Somewhat effective	3	33.3
Moderately effective	1	11.1
Very effective	1	11.1
TOTAL NUMBER OF PHYSICIANS THAT RESPONDED	9	100.0

Mean=1.89; Range=3; Standard Deviation=1.05

Table 60

Responses to the Question "How would you rate your current level of collaboration with psychologists you currently refer to?"

RATING	n	%
Not effective	0	0
Somewhat effective	5	55.6
Moderately effective	3	33.3
Very effective	1	11.1
TOTAL NUMBER OF PHYSICIANS THAT RESPONDED	9	100.0

Mean=2.56; Range=2; Standard Deviation=.73

When asked "How much collaboration would you like to see between physicians and psychologists?" the majority of the physicians' responses were that they would like to see "more" collaboration (n=7, 77.8%; Table 61). Of these physicians, some of the specific comments were: "I would like to know what [the psychologists'] specialty is, an outline of where the patient is at, what their doing with them and if prescriptions are recommended," "I'd like to see them attend lunches and meetings like with the pharmaceutical companies, it would be good to have that perspective there" , and "I'd like to know how often they're going and the plan, their treatment, the game plan." Two of the physicians' (22.2%) responses were that he or she was happy with his or her current level of collaboration (Table 61).

Table 61

Responses that Emerged for the Question, "How much collaboration would you like to see between physicians and psychologists?"

RESPONSE	n	%
More	7	77.8
Are happy with current level of collaboration	2	22.2
TOTAL NUMBER OF PHYSICIANS THAT RESPONDED	9	100.0

Table 62 shows the results for questions #5 a, b, and c, which read "Would you want there to be a signed consent from the patient so that you and the psychologist could: a) speak verbally? b) speak via voice mail? c) have reports go back and forth?." Choosing either "yes" or "no" responses, 66.7% (n=6) chose "yes" to "a) speak verbally," 55.6% (n=5) chose "yes" to "b) speak via voice mail," and 77.8% (n=7) chose "yes" to "c) have reports go back and forth."

Table 62

Responses to the Questions "Would you want there to be a signed consent from the patient so that you and the psychologist could…?"

a) speak verbally?		
RESPONSES	n	%
Yes	6	66.7
No	3	33.3
TOTAL NUMBER OF PHYSICIANS THAT RESPONDED	9	100.0
b) speak via voice mail?		
RESPONSES	n	%
Yes	5	55.6
No	4	44.4
TOTAL NUMBER OF PHYSICIANS THAT RESPONDED	9	100.0
c) have reports go back and forth?		
RESPONSES	n	%
Yes	7	77.8
No	2	22.2
TOTAL NUMBER OF PHYSICIANS THAT RESPONDED	9	100.0

Question #7a, b, c, d, e, f, g, and h, asked the physicians to indicate "yes" or "no" to the question, "Would you want to receive information regarding a) patient diagnosis; b) patient status; c) treatment plan; d) prognosis; e) expected length of treatment; f) answers to your specific questions; g) recommendations; h) test data?." Table 63 shows the results, with physicians indicting "yes" most frequently to "f) answers to your specific questions" (n=8; 88.9%) and "g) recommendations" (n=8; 88.9%).

Table 63

Patient Information Requested by Physicians

...a) patient diagnosis?		
Response	n	%
Yes	7	77.8
No	2	22.2
TOTAL NUMBER OF PHYSICIANS THAT RESPONDED	9	100.0
...b) patient status?		
Response	n	%
Yes	7	77.8
No	2	22.2
TOTAL NUMBER OF PHYSICIANS THAT RESPONDED	9	100.0
...c) treatment plan?		
Response	n	%
Yes	7	77.8
No	2	22.2
TOTAL NUMBER OF PHYSICIANS THAT RESPONDED	9	100.0
...d) prognosis?		
Response	n	%
Yes	5	55.5
No	4	44.4
TOTAL NUMBER OF PHYSICIANS THAT RESPONDED	9	100.0
...e) expected length of treatment?		
Response	n	%
Yes	6	66.7
No	3	33.3
TOTAL NUMBER OF PHYSICIANS THAT RESPONDED	9	100.0
...f) answers to your specific questions?		
Response	n	%
Yes	8	88.9
No	1	11.1
TOTAL NUMBER OF PHYSICIANS THAT RESPONDED	9	100.0
...g) recommendations?		
Response	n	%
Yes	8	88.9
No	1	11.1
TOTAL NUMBER OF PHYSICIANS THAT RESPONDED	9	100.0
...h) test data		
Response	n	%
Yes	6	66.7
No	3	33.3
TOTAL NUMBER OF PHYSICIANS THAT RESPONDED	9	100.0

Table 64 shows the responses that emerged from questions #8a & b, which read, "What could be done to make your current level of collaboration with psychologists more effective: a) by psychologists? and b) by you?." With regards to what could be done by psychologists, the majority (n=7, 77.8%) of the physicians indicated that they would like to receive more feedback, with one (11.1%) of these physicians also stating that he or she would like for there to be more interdisciplinary interface as well. One (11.1%) physician indicated that he or she was happy with their current level of collaboration, and one physician (11.1%) stated "do what needs to be done when it needs to be done."

Table 64

Responses that Emerged for the Questions, "What could be done to make your current level of collaboration with psychologists more effective…?"

…a) by psychologists?		
RESPONSE	n	%
Would like to receive more feedback	7	77.8
Would like for there to be more interdisciplinary interface	1	11.1
Happy with their current level of collaboration	1	11.1
"Do what needs to be done when it needs to be done"	1	11.1
TOTAL NUMBER OF PHYSICIANS THAT RESPONDED	9	100.0
…b) by you?		
RESPONSE	n	%
Providing more information and more feedback	4	44.4
Although providing more information and more feedback is what would be ideal, that he or she probably would not do it because of lack of time	1	11.1
Improving the initial referral	1	11.1
Nothing that could be done by physicians to improve collaboration	2	22.2
Happy with the current level of collaboration	1	11.1
"Do what needs to be done when it needs to be done"	1	11.1
TOTAL NUMBER OF PHYSICIANS THAT RESPONDED	9	100.0

With regards to what could be done by the physicians themselves to improve collaboration, many (n=4; 44.4%) of the physicians indicated that they could provide more information and feedback to the psychologist. These comments included both the idea of providing more feedback continuously, as well as providing more information at the time of referral. One of the physicians (11.1%) indicated that although providing more feedback continuously and providing more information at the time of referral would be the ideal, he or she probably would not do it, stating "I could contact them if I wanted to but it won't happen, I have no time." One physician (11.1%) spoke to improving the initial referral, stating "I could also ask psychiatrists who they recommend for a patient with the following set of circumstances," and two of the physicians (22.2%) reported that that there was nothing that could be done by them to improve collaboration. Again, one physician (11.1%) indicated that he or she was happy with the current level of collaboration, and one physician (11.1%) responded with "do what needs to be done when it needs to be done."

The final question of Part IV asked "Do you have any additional ideas or comments that we have not touched on that you think would be important in improving the effectiveness of referral and collaboration between physicians and psychologists?." Of the nine physicians that were interviewed, six (66.7%) provided a response to this question (Table 65). Two (11.1%) of the physicians' responses were that physicians would like to have a referral list with all pertinent information, such as "the psychologists names, specialty areas, and their fees." Two (22.2%) physicians spoke to the lack of interdisciplinary collaboration. These two responses were: "There needs to be more of a push for the team approach instead of the turf approach. People get into the turf stuff and

it falls apart," and "There is a distance between the two professions, but I'm not sure where it comes from. I think that they are starting to come together because it's what clients' are demanding and that clients continue to push this to occur."

Table 65

Responses that Emerged for the Question, "Do you have any additional ideas or comments that we have not touched on that you think would be important in improving the effectiveness of referral and collaboration between physicians and psychologists?"

RESPONSE	n	%
For the physicians to have a referral list with all pertinent information, such as "the psychologists names, specialty areas, and their fees	2	22.2
There is lack of interdisciplinary collaboration	2	22.2
Psychologists "swamp the system with paper work"	1	11.1
Have physician's office set up the appointment	1	11.1
There are many others are involved in the referral process besides physicians	1	11.1
TOTAL NUMBER OF PHYSICIANS THAT RESPONDED	7	100.0

One physician commented that psychologists "swamp the system with paper work" (n=1, 11.1%). This comment was: "With regards to psychologists, don't swamp the system with paper, like the stuff in question 7. It's like they are trying to justify their profession with all of the paper work when the real justification is between them and their client."

With regards to the response of having the physician's office set up the appointment, the comment was:

> If we has a real referral process with psychologists like we do with cardiologists where the secretary makes the appointment for the patient on such and such a day then the patient would be like 98% chance of going, but when I say to the patient 'you could really benefit from some psychological service, here's a few names' then about 80-90% don't go. It's like if they have to go home and make the call it won't happen.

The final response to question #9 included the idea that many others are involved in the referral process besides the physician (n=1, 11.1%). This comment was:

> I'm involved much less in the referral process then the number of patients who are referred, many of them self refer and there are also a lot of other care agencies out there who refer as well. I think therapists are really only seeing the tip of the iceberg. Most of the patients that I see who are seeing a psychologist were referred by their psychiatrist.

Table 66 shows a summary of the physicians' responses with regards to what patient problems they would refer for, and the overall ratings of importance for seeking a referral for each psychological problem. Of the nine physicians interviewed, one did not complete this portion of the interview because of the physician not having enough time. Therefore, the following means are based on an eight person sample. There were twenty-eight problems for which eight of the physicians (n=8; 88.9%) indicated that they would make a psychological referral for. These problems are listed below, as well as the importance rating (mean).

Table 66

Summary of Responses to the Question: "Below is a list of patient problems and psychological services for which you may request the services of a psychologist."

a) Please indicate all the ones you would refer for.
b) Then, using the following scale, rate every item in terms of its overall importance for you to seek a psychological referral.

1	2	3	4
Not Important	Partially Important	Moderately Important	Very Important

PATIENT PROBLEM		REFER	DON'T REFER	MEAN RATING, RANGE, & STANDARD DEVIATION
1. Adult Abuse	i) emotional	8	0	Mean=3.62; Range=1; sd=0.52
	ii) physical	8	0	Mean=3.75; Range=1; sd=0.46
	iii) sexual	8	0	Mean=3.75; Range=1; sd=0.46
2. Child Abuse	i) emotional	8	0	Mean=3.88; Range=1; sd=0.35
	ii) neglect	8	0	Mean=3.63; Range=1; sd=0.52
	iii) physical	8	0	Mean=3.88; Range=1; sd=0.35
	iv) sexual	8	0	Mean=3.88; Range=1; sd=0.35
3. Offenders	i) sexual	5	3	Mean=4.13; Range=2; sd=0.83
	ii) violent	5	3	Mean=4.25; Range=2; sd=0.71
4. Adoption		4	4	Mean=3.88; Range=3; sd=1.36
5. Affective Disorders		8	0	Mean=2.63; Range=2; sd=0.74
6. Aging/Psychogeriatrics		5	3	Mean=3.25; Range=4; sd=1.58
7. Anxiety		8	0	Mean=2.88; Range=3; sd=0.99
8.Attention/Deficit/Hyperactivity		4	4	Mean=4.00; Range=3; sd=1.31
9. Autism		6	2	Mean=3.50; Range=3; sd=1.20
10. Biofeedback		3	4	Mean=4.29; Range=2; sd=0.95
11. Brain Injuries		4	4	Mean=4.13; Range=3; sd=1.13
12. Burnout		6	2	Mean=3.50; Range=3; sd=1.07

PATIENT PROBLEM	REFER	DON'T REFER	RATING
14. Child management	6	2	Mean=3.63; Range=3; sd=1.06
15. Conduct disorders	8	0	Mean= 3.25; Range=2; sd=0.71
16. Consultation	4	4	Mean=3.88; Range=3; sd=1.25
17. Custody/Access	3	5	Mean=4.25; Range= 3; sd=1.16
18. Crisis management	6	1	Mean=3.71; Range=2; sd=0.76
19. Critical incident stress debriefing	8	0	Mean=3.75; Range=1; sd=0.46
20. Dementia	3	4	Mean=3.71; Range=3; sd=1.06
21. Depression	8	0	Mean=3.00; Range=3; sd=0.93
22. Developmental disorders	6	2	Mean=3.38; Range=3; sd=1.30
23. Diagnosis	6	2	Mean=3.00; Range=4; sd=1.51
24. Disability i)Assessment	8	0	Mean=2.88; Range=2; sd=0.64
ii) Treatment	7	1	Mean=3.25; Range=3; sd=0.89
25. Dissociative disorders	7	1	Mean=3.50; Range=2; sd=0.76
26. Divorce/Separation	8	0	Mean=3.00; Range=2; sd=0.93
27. Dual diagnosis	8	0	Mean=3.13; Range=2; sd=0.64
28. Eating disorders	8	0	Mean=3.75; Range=1; sd=0.46
29. Education/Workshops	3	5	Mean= 4.00; Range=3; sd=1.41
30. Family issues	8	0	Mean=3.13; Range=2; sd=0.64
31. Forensic Services	4	3	Mean=4.43; Range=1; sd=0.53
32. Gay/Lesbian issues	4	4	Mean=3.88; Range=3; sd=1.36
33. Grief/Bereavement	5	3	Mean= 4.13; Range=2; sd=0.83
34. Health promotion	3	5	Mean=3.88; Range=3; sd=1.55
35. Hypnosis	5	3	Mean=3.50; Range=4; sd=1.51
36. Illiteracy	4	3	Mean=3.86; Range=2; sd=1.07
37. Learning disabilities	7	1	Mean=3.50; Range=3; sd=0.93
38. Mediation	5	3	Mean=3.88; Range=3; sd=1.13
39. Men's issues	5	3	Mean=3.38; Range=3; sd=1.14

PATIENT PROBLEM	REFER	DON'T REFER	RATING
40. Mental retardation	5	3	Mean=3.38; Range=3; sd=1.41
41. Neuropsychology	8	0	Mean=3.25; Range=2; sd=0.71
42. Obsessive compulsive disorders	7	1	Mean=3.50; Range=2; sd=0.76
43. Pain management	5	3	Mean=3.50; Range=3; sd=1.41
44. Palliative care	4	4	Mean=4.00; Range=3; sd=1.20
45. Perinatal	3	5	Mean=4.13; Range=3; sd=1.25
46. Personality disorders	8	0	Mean=2.88; Range=2; sd=0.83
47. Phobias	8	0	Mean=3.75; Range=1; sd=0.46
48. Physical health problems i)autoimmune disorders	0	7	Mean=5.00; Range=0; sd=0
ii) Cancer	3	5	Mean=4.38; Range=2; sd=0.92
iii) Cardiovascular disorders	3	5	Mean=4.25; Range=3; sd=1.16
iv) degenerative disorders	1	7	Mean=4.75; Range=2; sd=0.71
v) gastrointestinal disorders	3	5	Mean=4.38; Range=2; sd=0.92
vi) HIV/AIDS	6	2	Mean=3.38; Range=3; sd=1.19
vii) metabolic	1	7	Mean=4.63; Range=3; sd=1.06
viii) renal disorders	1	7	Mean=4.75; Range=2; sd=0.71
ix) respiratory disorders	3	5	Mean=4.13; Range=3; sd=1.25
x) somatoform disorders	5	3	Mean=4.00; Range=3; sd=1.07
49. Posttraumatic stress disorder	8	0	Mean=3.63; Range=2; sd=0.74
50. Program development/Program evaluation/Quality management	2	6	Mean=4.25; Range=3; sd=1.39

PATIENT PROBLEM	REFER	DON"T REFER	RATING
51. Psychological Assessment i) adolescence	7	0	Mean=3.57; Range=1; sd=0.53
ii) adults	7	0	Mean=3.14; Range=1; sd=0.90
iii) children	7	0	Mean=3.86; Range=1; sd=0.38
52. Psychoses	6	2	Mean=3.63; Range=4; sd=1.41
53. Psychotherapy relationship i) couple/marital	8	0	Mean=3.50; Range=1; sd=0.53
ii) family	8	0	Mean=3.63; Range=1; sd=0.52
iii)group	8	0	Mean=3.63; Range=1; sd=0.52
iv) individual: adolescent	8	0	Mean=3.63; Range=1; sd=0.52
v) individual: adult	8	0	Mean=3.50; Range=1; sd=0.53
vi) individual: child	8	0	Mean=3.38; Range=2; sd=0.74
vii) play therapy	7	1	Mean=3.63; Range=2; sd=0.74
54. Rehabilitation	7	1	Mean=3.38; Range=3; sd=1.06
55. Relapse prevention/Treatment adherence	6	2	Mean=3.63; Range=2; sd=0.92
56. Relaxation training	8	0	Mean=2.88; Range=2; sd=0.64
57. School readiness	1	7	Mean=4.75; Range=2; sd=0.71
58. Sexual dysfunction	6	2	Mean=3.50; Range=3; sd=1.07
59. Sexual identity	6	2	Mean=3.88; Range=2; sd=0.83
60. Sleep disorders	4	4	Mean=3.88; Range=3; sd=1.36
61. Smoking	4	4	Mean=4.00; Range=3; sd=1.20
62. Stress	7	1	Mean=3.50; Range=3; sd=1.07
63. Substance abuse	8	0	Mean=3.38; Range=1; sd=0.52
64. Supervision/Professional training	2	6	Mean=4.38; Range=3; sd=1.19
65. Victims of crime	7	1	Mean=3.50; Range=3; sd=0.93
66. Weight loss	4	4	Mean=4.25; Range=2; sd=0.89
67. Women's issues	4	4	Mean=4.25; Range=2; sd=0.89
68. Workplace issues	7	1	Mean=3.50; Range=2; sd=0.76

The problems for which all eight physicians (88.9%) indicated that a psychological referral would be made are, emotional adult abuse (mean=3.62), physical adult abuse (mean 3.75), sexual adult abuse (mean=3.75), emotional child abuse (mean 3.88), neglect/child abuse (mean 3.63), physical child abuse (mean=3.88), sexual child abuse (mean=3.88), affective disorders (mean=2.63), anxiety (mean=2.88), conduct disorders (mean=3.25), critical incident stress debriefing (mean=3.75), disability assessment (mean=2.88), divorce/separation (mean=3.00), dual diagnosis (mean=3.13), eating disorders (mean=3.75), family issues (mean=3.13), neuropsychology (mean=3.25), personality disorders (mean=2.88), phobias (mean=3.75), posttraumatic stress disorder (mean=3.63), couple/marital therapy (mean=3.50), family therapy (mean=3.63), group therapy (mean=3.63), individual/adolescent therapy (mean=3.63), individual/adult therapy (mean=3.50), individual/child therapy (mean=3.38), relaxation training (mean=2.88), and substance abuse (mean=3.38; see Table 66).

The problems that the physicians indicted they would be the least inclined to refer for were, autoimmune disorders (0.0%; mean=5.00), degenerative disorders (11.1%; mean=4.75), cardiovascular disorders (11.1%; mean=4.63), Program development/Program evaluation/Quality management (22.2%; mean=4.25), school readiness (11.1%; mean=4.75), and Supervision/Professional training (22.2%, mean=4.38).

This chapter presented the results of this study. Chapter 5 will provide a summary of the results and will discuss the implications of these findings. Also the strengths and weaknesses of this study and some recommendations for future research will be outlined.

Chapter 5

Discussion

This research explored how Lethbridge physicians' perceive the existing process of referral and collaboration between themselves and psychologists. Ultimately, this research hoped to determine how we can improve, and thus increase the level of referral and collaboration between these two fields. This chapter provides a summary of the results and discusses the implications of the findings presented in Chapter 4. In addition, some recommendations for improving the effectiveness of referral and collaboration between physicians and psychologists, recommendations for future research, and the strengths and weaknesses of this study are also provided.

Summary of the Results and Implications of the Findings

The ages of the physicians ranged from twenty-nine years old to fifty-three years old, with a mean age of forty-three years old. None of the physicians interviewed graduated in the same year, with the graduating years ranging from 1975 to 1998, with a mean year of 1986. Likewise, none of the physicians reported having the same number of years in practice, with the years in practice ranging from 2 years to 24 years, with a mean of 14.11 years. Of the nine physicians interviewed, 55.6% (n=5) were male and 44.4% (n=4) were female. As a result of the small sample size it was not possible to determine whether the various demographic factors influenced the physician responses in any meaningful way, however, the physicians that were interviewed covered a wide spectrum across age, years in practice, and gender.

In their definitions of "psychological issues," the majority of the physicians acknowledged the multidimensional aspects of the term "psychological." Seven (77.8%) of the physicians included in their definition of a psychological issue, several or all of the following descriptors: that psychological issues are issues that affected the individual either psychologically, mentally, emotionally, socially, personally, vocationally, while two (22.2%) of the respondents added the a physiological or biochemical component to their definition.

In their definitions of "personal issues," three physicians (33.3%) defined it as issues that are private and/or confidential, two (22.2%) defined it as issues that are a part of one's personal life, two (22.2%) defined it as issues that are similar to psychological issues, but not yet a part of the Mental Health System, and one (11.1%) physician defined it as issues that affect the wellbeing of the person. Thus, the majority of the physicians saw "personal issues" as including many of the same components as "psychological issues," with perhaps a more private or less severe nature to them.

All nine (100.0%) of the physicians indicated that they felt that there was a connection between physical health and psychological health. Five (55.6%) of the physicians' saw the connection between physical and psychological health as bilateral, with both impacting each other. This is consistent with findings in the research, which has found evidence for both physical health impacting psychological health (Anderson, Freedland, Clouse & Lustman, 2001; Fischer, Heinrich, Davis, Peek & Lucas, 1997; Goldberg & Huxley, 1992; Houpt et al., 1980; Wells, Golding & Burnam, 1988), and psychological health impacting physical health (De Groot, Anderson, Freedland, Clouse & Lustman, 2001; Glassman & Shapiro, 1998). Four (44.4%) of the physicians' saw the

connection between psychological and physical health as unilateral, with one's psychological health affecting their physical health. In addition to the directional components in the physician' definitions, two (22.2%) added that the effect is through the immune system, and one (11.1%) added that the effect was through "the patient's perception" of whether they are sick, and their "compliance to treatment."

The number of patients that each physician saw, on average, each day ranged from between 11 to 20 patients a day (n=3; 33.3%) to between 41 to 50 patients a day (n=1; 11.1%). Likewise, the number of patients that each physician saw in an average month ranged from between 200 and 400 patients a month (n=4; 44.4%) to between 801 and 1000 a month (n=2; 22.2%). These differences in the number of patients seen, appears to comes from whether the physician works full or part time, the amount of on-call work they do, and the differences between the various clinics.

All of the physicians (n=9; 100.0%) indicated that they refer to psychologists. The majority (n=7; 77.8%) of the physicians reported that, of the patients seen in an average month, up to 35% were seen as being candidates for psychological referral. This is a lower estimation then what was reported by Newman and Rozensky (1995), who stated that up to 60% of all visits to primary care physicians are psychological in nature. A discouraging finding, however, is that this study found that physicians referred less than 4.0% of their patients. This is consistent with previous research and literature which indicates that there is an underutilization of psychological services (Hunsley et al.; 1999), and that, on average, general practitioners decide not to send 88% of the patients they find as having psychological symptoms for secondary care (Huxley, 1996).

Although the majority (n=7; 77.8%) of physicians in this study reported that they could correctly identify/diagnose 70% or more of psychological and emotional issues, previous research indicates that many of the psychological problems that are presented in primary care are overlooked by physicians (Eisenberg, 1992; Dulean et al., 1990; Knights & Folstein, 1977; Maguire, Julier, Hawton & Bancroft, 1974).

One of the reasons that have been cited in the research for why physicians may miss psychological diagnoses in their patients is insufficient training in the recognition of psychological issues (Katon & Sullivan, 1990; Pace, Chaney, Mullins & Olsen, 1995). The findings of the present study appear to support this, as the majority (n=7; 77.8%) of the physicians felt either 'not qualified' or only 'partially qualified' to provide psychological services as compared to a psychologist, and that their education prepared them for the diagnosis and treatment of psychological disorders only 'somewhat' (n=4; 44.4%) to 'moderately' well (n=3; 33.3%). Similarly, the majority (n=7; 77.8%) of physicians identified their lack of training and/or skill in the area of psychology as being barriers to them providing psychological services themselves.

Another reason that had been cited in the research for why physicians may miss psychological diagnoses in their patients is they may not have the time required to adequately assess psychological issues (Orleans et al., 1985). This too was supported by the findings of the present study, in that the majority (n=7; 77.8%) of the physicians reported that they did not feel that they had time to be proving psychological services themselves, and the majority (n=6; 66.7%) identified "a lack of time" as being a barrier to them providing psychological services themselves.

Considering the findings from previous research, as well as the present study's findings that the physicians themselves report not having the training, knowledge or the time to diagnose and/or treat psychological issues, the current study's finding that up to 35% of patients seen are candidates for psychological referral may be an underestimation. Therefore, the number of patients who are candidates for psychological referral and are not receiving psychological services may be even higher then what was reported in this study.

A low level of referral and collaboration, like that which was documented in this study, as well in previous research (Huxley, 1996), can have a negative effect on the quality of patient care, health care costs, and create patient overload for physicians.

To help ensure quality of patient care, psychological issues may be more appropriately addressed by psychologists, who are the professionals that are the most qualified in this area (Psychologists' Association of Alberta [PAA], 2003a). It appears, however, that many psychological concerns are not being seen by psychologists. Depression/mood disorders and anxiety/panic disorders were identified as being the most common psychological concerns that physicians saw in their practice (depression/mood disorders; n=9; 100.0%; and anxiety/panic disorders; n=8; 88.9%), the psychological issues that the physicians felt the most confident in recognizing/diagnosing (depression; n=7; 77.8%; and anxiety disorders; n=5; 55.6%), and were also identified by several physicians as being the circumstances/diagnosis for which they preferred providing psychological services themselves, rather than referring to a psychologist (depression; n=2; 22.2%; and anxiety; n=1; 11.1%). Therefore, one may conclude that there are

patients suffering from depression and anxiety, in primary care, which have not received a psychological referral.

The type of treatment that is most often provided in the primary care setting appears not to consist of psychotherapy (Glied, 1998), but rather to consist of some combination of psychotropic drugs, advice, and reassurance (Orleans et al., 1985). Typically, counselling interventions are not even seen in the primary care setting (Glied, 1998). In addition, although the research surrounding the effectiveness of treating depression and anxiety with medication alone, versus psychotherapy alone or some combination of the two, is mixed, the majority of the research seems to suggest that treating these two disorders with a combination of psychotherapy and medication produces the best results (Ashworth, Wastie, Reid & Clement, 2000; Keller et al., 2000; Mitchell, 1999).

In addition to this, there are a large number of psychological issues cited in the literature, that are presented in primary care that can not be resolved simply by medication alone, such as anorexia nervosa (Kalb, 1985), substance abuse (Houpt et al., 1980), hypertension (Miller, 1983), and domestic violence (Bergman & Brismar, 1991; Shields et al., 1998), and many of the problems that patients bring to physicians could benefit from psychological consultation, such as depression, anxiety, stress-related disorders, psychosomatic illnesses, drug and alcohol abuse, domestic violence, and adjustment problems related to chronic and traumatic illnesses (Magill & Garrett, 1988). Other problems may include marital or sexual problems, psychophysiologic and pain disorders, chronic pain and adjustment reactions (Orleans, George, Houpt & Brodie, 1985). The present study also generated a long list of psychological issues, in addition to

depression and anxiety, which are commonly seen in primary care. These issues included: marital issues (n=4; 44.4%), schizophrenia/psychosis (n=2; 22.2%), anxiety disorders (n=2; 22.2%), violence/abuse/crisis situations (n=2; 22.2%), phobias (n=1; 11.1%), personality disorders (n=1; 11.1%), bipolar (n=1; 11.1%), and substance abuse (n=1; 11.1%). Many of these issues are the same issues that have been cited previously in the literature as benefiting from psychological care (Bergman & Brismar, 1991; Houpt et al., 1980; Magill & Garrett, 1988; Orleans et al., 1985; Shields et al., 1998).

Quality of care may include such aspects as: the knowledge and training to provide care, the time to provide care, and the ability to do so in a cost effective manner. This study found that, when it comes to treating psychological issues, physicians reported having none of these. The majority (n=7; 77.8%) of the physicians felt between 'not' and 'partially qualified' to provide psychological services as compared to a psychologist, and that their education prepared them for the diagnosis and treatment of psychological disorders only 'somewhat' (n=4; 44.4%) to 'moderately' well (n=3; 33.3%). It also appears that physicians are more confident in diagnosing psychological issues then they are in treating psychological issues, in that the majority (n=6; 66.7%) of physicians did not feel that there needed to be an increase in the amount of education and training that physicians receive regarding the identification and diagnosis of psychological problems, however, fewer (n=4; 44.4%) felt that there did not need to be an increase in the amount of education and training they receive for treating psychological issues.

Physicians' lack of ability to provide psychological treatment is also evident in the fact that the majority (n=7; 77.8%) of physicians identified their lack of training and/or skill in the area as being barriers to them providing psychological services

themselves. This is further reiterated by the reports that some provinces are considering de-listing physicians from providing psychotherapy, which reflects the fact that general medical education does not provide enough of the required knowledge and skills to treat psychological issues (Psychologists' Association of Alberta [PAA], 2002).

In addition to not feeling qualified or that they have the knowledge to treat psychological issues, physicians also indicated that they do not have the time to be doing so. The majority (n=7; 77.8%) of the physicians reported that they did not feel that they had time to be proving psychological services themselves, and a lack of time (n=6; 66.7%) was also identified as being a barrier to them providing psychological services themselves. The majority (n=7; 77.8%) of the physicians indicated that, on average, he or she will spend 23 minutes or less with a patient when providing psychological services themselves. This is consistent with the literature which has reported that physicians will typically only spend 10 to 20 minutes with each patient compared to an average of 50 to 60 minutes spent by psychologists (McDaniel, 1995). These brief interventions provided in the primary care setting may not be enough.

In addition to not feeling qualified, not feeling as though they have the knowledge or skill to treat psychological issues, and not having the time, it also appears that physicians do not feel that treating psychological issues with medication versus psychotherapy is more cost effective.

Mental illnesses exert an enormous cost burden on our health care system (Levenson et al., 1990; Swift, 2000; Thomas & Natacha, 2001) and this cost is continuing to rise (Moore et al., 1997; Stephens & Joubert, 2001). One way that has been suggested to help mitigate the impact that mental health has on the cost of health care is to increase

the amount of psychological services that are being provided (Mumford et al., 1984; Smith et al., 1995). The use of psychological services, in conjunction with primary care, has been shown to reduce the overall cost of medical services (Mumford et al., 1984). Considering up to 60% of all visits to primary care physicians are psychological in nature (Newman & Rozensky, 1995), and considering physicians are reporting that they are not qualified to be treating psychological issues, a more cost effective method may be to have these psychological issues addressed by psychologists, who are the professionals that are the best equipped to treat them (PAA, 2003a).

Action has already been taken towards achieving this goal. The Psychologists' Association of Alberta Access Task Force, has recommended, that the Psychologists' Association of Alberta lobby to have psychological counselling on the list of covered services, even if the coverage is just for one session (Psychologists' Association of Alberta [PAA], 2003b). If changes are not made in this direction, patients may continue to bring psychological issues to physicians, financially burdening the health care system, when their issues could have been addressed with early psychological intervention (PAA, 2002).

The majority (n=5; 55.6%) of the physicians seemed to support this idea, in that, they did not feel that psychotropic medication was more cost effective in treating psychological problems than psychotherapy, while two (22.2%) felt that it depended on the psychological issue, and one (11.1%) felt that medication and psychotherapy were meant to be used together. Therefore, the reason for the low referral rates does not appear to be a result of the physicians believing that it is more cost effective.

Another factor that may be negatively affected by a low referral rate is physician job satisfaction. The levels of occupational stress for physicians are rising (Arnetz, 1997; Shearer, 2001) and levels of job satisfaction are decreasing (Shearer, 2001). Having to deal with heavy caseloads has been frequently identified as a contributing factor (Arnetz, 1997; Firth-Cozens & Greenhalgh, 1997). A large proportion of these caseloads are made up of patients with psychological issues (Cummings, 1991; Goldberg et al., 1976; Magill & Garrett, 1988). One Canadian study found that 61% of patients went to their family physicians when seeking care for emotional problems while only 16% went to a psychologist (Bland et al., 1990). Increasing psychological referrals may be one way to help decrease the impact of these negative effects. The Psychologists' Association of Alberta further suggests that providing funding for psychological services may increase job satisfaction reducing the stress on physicians to provide psychotherapy and other counseling services (PAA, 2002).

It appears, that the opinions of the physicians in the present study mirror the findings from the previous research, as none of the physicians preferred providing psychological services themselves over referring, with one (11.1%) indicated that he or she preferred shared care. Other comments that were provided included: "I don't necessarily prefer referring to psychologists but I do prefer referring out," "I would prefer the professional expertise, but it's very rare that people are willing to make the financial investment," and "if it's really simple, and they just need a pill, I will do it myself. If it's a big issue that will take time, I'll refer."

It was also found, that when provided a list of ninety-two different patient problems for which the patient could receive psychological services for, there were

twenty-eight problems for which all of the physicians (n=8; 100.0%) who completed this section, indicated that they would make a psychological referral.

Further, all of the physicians stated that he or she would benefit from referring out patients with psychological issues, with the reasons for this being their "lack of time" to be treating psychological issues (n=5; 55.6%), and their "lack of training" in the area of psychology, and thus referring to a psychologist would lead to better patient care (n=7; 77.8%). It appears as though the physicians in the present study recognize the benefits that they could incur by referring to psychologists therefore, this does not appear to contribute to the reason for low referrals either. Nor does it appear that the low rate of physician referral to psychologists is a result of psychologists not assuming an appropriate amount of responsibility for ongoing care, or the result of a deeper issue.

The majority of the physicians (n=6; 66.7%) felt that psychologists assume an 'appropriate amount' of responsibility for ongoing care once a referral is made. In addition, the majority (n=7; 77.8%) of the physicians reported that there were no 'deeper issues' that would prevent them from referring to a psychologist.

It was also found that most of the physicians (n=5; 55.6%) reported that they had not had any clinical experiences that have affected their willingness to refer. Four of the physicians, however, did report having had a negative experience in the past that may affect their willingness to refer. These experiences included: "a conflict between psychologist and patient" (n=2; 22.2%), "sometimes the patient does not benefit from the referral" (n=1; 11.1%), and physicians' resentment about the fact that physicians are the only ones that have to be on call (n=1; 11.1%).

In looking at the patient characteristics that influence referral, it was also found that the possibility of the patient becoming upset by the referral, the patients' age, and the patients' gender all did not influence the majority of the physician's decision to refer.

In summary, it does not appear that the reason for the low referral rate is a result of physicians believing that they can treat psychological problems themselves, because physicians have the time to be providing psychological services, or because of physicians believing that it is more cost effective. The physicians in the present study also seem to recognize the benefits that they could incur by referring to psychologists, therefore, this does not appear to contribute to the reason for low referrals either. It also appears as though the low referral rates are not a result of psychologists not assuming an appropriate amount of responsibility for ongoing care, the result of a deeper issue, or certain patient characteristics such as the possibility of the patient becoming upset by the referral, the patients' age, and the patients' gender.

However, the majority (n=5; 55.6%) of the physicians in this study still indicated, that of the patients that come in to the physicians' office with psychological problems, they are providing psychological services for between 80 % and 100% of these patients. This is a much higher estimate than what is found in previous research, which has found that family practitioners have reported that of the 20% of their patients that they identify as having significant psychological problems, they treat most of them themselves (Orleans et al., 1985).

Barriers to referral and collaboration. It was found, however, that the physicians' decision of whether or not to refer did depend on such psychologist specific factors as previous referrals, experience, and level of collaboration with psychologists, and the

specialty of the psychologist. It was also found that the physicians' referral decision depended on such patient specific factors as the patients' social economic status, employment status, and the number of times the patient had brought the problem to the physicians' attention.

This study found that the physicians' decision of whether or not to refer to a particular psychologist appeared to depend on whether or not they had referred to the psychologist before (n=7; 77.8%), on previous experiences he or she has had with that psychologist (n=7; 77.8%), and on the specialty of the psychologist (n=6; 66.7%). Three (33.3%) of the physicians, however, reported that they did not know the different specialties of the psychologists in the area, and two (22.2%) reported that they did not even know that psychologists had specialties.

Overall, physicians rated the effectiveness of their current referrals to psychologist as 'partially effective' to 'moderately effective' (mean=2.44). In addition, although the majority (n=7; 77.8%) of the physicians indicated that their decision of whether or not to refer did not depend on the level of collaboration that he or she has with the psychologist, four (44.4%) reported that this was because they do not have a good level of collaboration with any of the psychologists, and three (33.3%) indicated that if they did have good collaboration with a psychologist, that they would refer to him or her more.

Likewise, the amount of collaboration between physicians and psychologists was rated quite poorly, with the average physician rating of collaboration with psychologists in general falling between 'not' and 'somewhat' effective (mean=1.89), and the average physician rating of collaboration with psychologists that the physicians currently refer to

falling between 'somewhat' and 'moderately' effective (mean=2.56). The reasons that were given for the low ratings of collaboration with psychologists in general, were that there is no feedback or collaboration (n=4; 44.4%) or that the psychologist will only phone occasionally (n=1; 11.1%). Even with the psychologists that the physicians are currently referring to, the physicians reported that he or she was still not happy with the amount of feedback received from the psychologist (n=3; 33.3%). Therefore, one way to improve referrals appears to be to increase the amount of collaboration and feedback provided by the psychologist.

Various patient specific factors were also found to influence the physicians' referral decision. The present study found that the patients' social economic status and employment status would influence whether they would be referred, or at least where they would be referred. Further, it was found that the more times that a patient has brought a problem to the physicians' attention increased the likelihood that the patient would be referred (n=7; 77.8%).

It also appears that the physicians' perception of whether or not the patient can afford or is covered for psychological services is affecting referral. It was reported that the physicians' knowledge that the patients' insurance would reimburse the patient for the psychological treatment would increase the chance of referral (n=7; 77.8%), and that this was 'moderately' to 'very' influential' (mean=3.56) on the decision of whether or not to refer. It was also reported that for those who are not covered, it is, on average, 'somewhat" to 'moderately' difficult (mean=2.78) to find mental health treatment. It was reported that the physicians could always refer the patient to Alberta Mental Health (n=5; 55.6%), but that there is a long waiting list (n=2; 22.2%), or the patient satisfaction with

the treatment may not be as high (n=1; 11.1%). So it appears that the physicians' perception of whether or not the patient can afford or is covered for psychological services is affecting referral.

Further to this idea, several (n=2; 22.2%) of the physicians felt that there was a shortage of available psychological services for referral or consultation, and others reported that they felt it was either a shortage of funding or government sponsored agencies rather than a shortage of practitioners (33.3%, n=3). Therefore, it could be that the low rate of referral is a result of the physicians' perception of the financial inaccessibility of psychological care.

The physicians reported that they ascertain what coverage each patient has, by asking the patient (n=8; 88.9%), and if the patient does not know, having the patient check with their employer (n=3; 33.3%).

When the physicians were asked whether they knew about fifteen different ways that a patient could be covered for psychological services, the majority of the physicians indicated that they knew about eight of them, and less than half of the physicians knew about the other seven.

The majority of the physicians knew that if a patient is covered for prescriptions that he or she is likely to be covered for psychological services. The majority of the physicians also knew that the following list of employers, provide all employees, full or part-time, and their family members had a100% coverage for psychological services: any school in Southern Alberta, Lethbridge Community College, RCMP, City Police, all city of Lethbridge employees. The majority of physicians also indicated that they did know that Worker's Compensation will cover 100% of the cost of psychological services, and

that professionals and business owners can write off psychological services as consulting fees or medical expenses.

However, less than half of the physicians knew that the following list of employers, provide all employees, full or part-time, and their family members had a100% coverage for psychological services: Costco, London Drugs, Overwaite Foods, Alberta Treasury Branch, any Bank, Safeway, or that the city of Lethbridge had a subsidy program that covers psychological services. As previously noted, the majority (n=7; 77.8%) of the physicians interviewed, indicated that his or her belief or knowledge that the patients' insurance would reimburse the patient for the psychological would increase the chance of a referral, and that this was 'moderately' to 'very' influential' (mean=3.56) on the decision of whether or not to refer. Considering that many of the physicians in the present study reported having limited knowledge regarding patient coverage, especially for the lower paying jobs, it appears that many patients, who are covered for psychological services, may still not be receiving them.

Another factor that could be contributing to the low rate of referrals, is this study's finding that, of the patients that are referred to psychologists, the majority (n=6; 66.7%) of the physicians reported that less than half are actually following through with getting counselling. This low rate of follow through may be a result of the fact that it appears that there is no formalized process of referral. When making a referral, there was a wide variety of responses with regards to how, where, when the physicians referred.

When making a psychological referral, the variety of responses included such things as: determining whether a referral to a psychologist would be beneficial for the patient and enlisting patient willingness, suggesting to the patient that he or she look in

the phonebook, providing the patient with one to several psychologists' names and phone numbers, and getting the patient to call, or having the office referral booking desk set up the appointment. Only one (11.1%) physician reported that he or she sends or provides a letter of referral to the psychologist.

When looking at where to refer, the responses were also quite varied. They included: referring the patient to where they are covered, in that, if the patient is not covered, he or she will refer to government run and/or paid agencies, and if the patient is covered, then will refer to a private psychologist. Physicians also indicated that they will try to match patient and psychologist personalities, try to match patient problem with psychologist's specialty, and/or will take into consideration the individual needs of the patient, i.e. privacy when making a referral. The physicians reported that they knew where to refer based on "word of mouth" or "from colleagues," and from past experience. Many of the physicians reported that they were not familiar with the psychologists in the area (n=4; 44.4%).

A wide variety of responses were also provided in deciding when to refer. These responses included: that the decision to refer is based on patient willingness or receptiveness to the referral, that a referral will be made if the issue is beyond the physician's scope and/or he or she is not sure of the diagnosis, or that the referral depends on patient need and the severity of the issue. Other physicians indicated that they would refer anybody with a "psychiatric condition" and/or "who is on psychotropic medication," would decide to refer based on "instinct or gut reaction," if the issue needs a lot of time, if the patient has coverage, when the patient is ready to benefit from non-

pharmacological therapy, or if the patient is uncomfortable with the physician's approach.

Thus, it appears that there is no formalized referral process in place. It may be that without a set referral process, that the physicians' referrals are not as effective as they could be. This is further evidenced by this study's finding that, on average, the physicians indicated their education prepared them for referral and collaboration with psychologists only 'somewhat' to 'moderately' well (mean=2.22). The result of this is that each physician may just be improvising his or her own method of referral, which is not based on any valid or reliable means. This would follow that which was suggested by Crane (1986), that information and education should be provided to physicians on how to frame potential referrals so that patients are more likely to accept them.

In addition to the above stated problems, the physicians themselves identified several things that they see as being barriers to effective referrals. Some of the more common barriers to referral and collaboration that had been previously reported in the literature are that physicians and psychologists receive different training, work in different theoretical paradigms, use different language, different working styles, lack of accessibility to different providers and varying expectations for assessment and treatment (McDaniel et al., 1990; McDaniel et al., 1992).

The biggest barrier identified by physicians in the present study was that they did not know the resources that were available (n=6; 66.7%). This barrier, however, is an encouraging one, as many of the previously identified barriers would be more difficult to change. For example, the training each of the disciplines receives or the theoretical paradigms under which they operate would require major structural changes to overcome.

This study found, however, that physicians identified that they would like to have more information on what psychologists are in the community (n=5; 55.6%), receive more follow-up and communication from the psychologist (n=3; 33.3%), have more information on each psychologist's area of expertise (n=3; 33.3%), have information on psychologist's fees and who they are covered by (n=2; 22.2%), and have information on the psychologist's years of experience (n=1; 11.1%). If referrals can be improved by simply providing physicians with more information and education about psychologists, this would be something that could be achieved quite easily. This would be similar to what was suggested by Crane (1986), that providing physicians with information regarding signs that might indicate a referral for therapy is appropriate may be facilitative to increasing referrals and collaboration.

Another barrier that was identified was the lack of feedback that the physician received from the psychologist (n=2; 22.2%). Thus, having psychologists increase the amount of feedback they provide to physicians would be another way to improve referral and collaboration between these two disciplines.

Some barriers that were identified that are not directly under the psychologists control were the psychological services not being effective for patient (n=2; 22.2%), the lack of respect that physicians have for psychology (n=1; 11.1%), a lack of patient follow through (n=1; 11.1%), physicians not wanting to give up control of their patient (n=1; 11.1%), the patient not being able to afford psychological services (n=3; 33.3%), and that it takes a long time for a patient to get into see a psychologist (n=2; 22.2%). In addition, on average, the physicians indicated their education prepared them for referral and collaboration with psychologists only 'somewhat well' or 'moderately well'

(mean=2.22). These barriers, however, could also be addressed through increased funding for psychological services and education for physicians. For example, if physicians were better educated about the qualifications of psychologists, it may help to alleviate their concerns about psychological services not being effective for their patient, physicians not wanting to give up control of their patient, and improve their knowledge for referral and collaboration with psychologists. Likewise, increasing funding for psychological services may help increase patient follow through with counselling, help with the problems of patients not being able to afford psychological services, as well as decrease the length of time it takes for a patient to get in to see a psychologist.

What physicians say they want. When asked to describe a referral, from beginning to end, that they would consider effective, over half of the physicians (n=5) indicated that they would like for there to be feedback and follow up from the psychologist. This is similar to what had been previously suggested by McDaniel (1995), and further speaks to the importance of psychologists providing feedback to the physician after receiving a referral. Other components of an effective referral that were directly related to the psychologist, were that the patient be seen in a timely fashion (n=3; 33.3%), that the patient issue be accurately diagnosed (n=2; 22.2%), that the physician would continue to be involved in patient care (n=2; 22.2%), that a team approach to treatment be taken, involving both a psychologist and a psychiatrist (n=1; 11.1%), that the client is co-active in their treatment (n=1; 11.1%), and that the client is satisfied with the treatment (n=2; 22.2%).

Physicians also identified that they would like to have more information on what psychologists that are in the community (n=5; 55.6%), have more information on each

psychologist's area of expertise (n=3; 33.3%), have information on psychologist's fees and who they are covered by (n=2; 22.2%), and have information on the psychologist's years of experience (n=1; 11.1%). Addressing these concerns would involve providing physicians with more information and education about these issues.

Components of improving referrals that were identified, that may not be as easily controlled by the psychologist, were that the patient would have 100% coverage (n=1; 11.1%), that the patient would have their choice of psychologists (n=3; 33.3%), that there is patient willingness (n=2; 22.2%), and that the patient follows through with the referral (n=2; 22.2%). Again, many of these concerns would be alleviated, through increased funding for psychological services.

Hustzi and Walker (1991) have noted that it is also important that physicians become educated about the services provided by psychologists. The findings of the present study support this, in that, the aspects of a referral that physicians felt that they could improve were to increase their knowledge about the psychologists and resources that are available in the community (n=7; 77.8%) and learn more about patient coverage (n=3; 33.3%). Physicians also felt that it would be beneficial to have their office set up the appointment for the patient with the psychologist (n=1; 11.1%), and to educate patients to dispel the myths around counselling (n=1; 11.1%).

With regards to effective collaboration, the physicians in this study identified the biggest barrier as being a lack of interdisciplinary communication (n=5; 55.6%). This idea included there being both "a lack of communication" and that "physicians and psychologists are functioning independently." Increasing feedback from psychologists to physicians would help to mitigate these concerns. Other barriers to effective collaboration

that were identified included "a lack of time" (n=4; 44.4%), and economic pressure, which spoke to the idea that time is money (n=1; 11.1%). If patients were covered for psychological services, it would help to decrease physicians' case load, and would thus address the issue of "a lack of time." This would also allow physicians to focus more of their time and energy on the medical aspects of health care, thus addressing the concern of "time is money." Finally, increasing the amount of information and education provided to physicians may help to decrease physicians' negative attitudes towards psychologists, as well as improve physicians' level of knowledge about the psychologists that are available.

The majority of the physicians (n=7; 77.8%) would like to see an increase in the amount of collaboration there is between themselves and psychologists. With regards to how to improve collaboration, the physicians varied in their responses. Several physicians indicated that they would like for there to be contact between themselves and the psychologist only if it was needed, i.e. the patient was not getting better or was getting worse (n=4; 44.4%), while other physicians indicated that he or she would like to receive regular feedback from the psychologist (n=2; 22.2%), and still others indicated that he or she would prefer to receive feedback from the patient (n=2; 22.2%). It appears then, that improving communication between the individual physician and psychologist would be the most effective way to ensure that this need is met. This idea is similar to McDaniel's (1995), idea that each physician varies in the amount of information they wish to receive from psychologists, and it was suggested that psychologists ask the physician about what type of information they wish to receive.

Other components that were identified that could be within the psychologists' control, included receiving recommendations from the psychologist (n=2; 22.2%), and that "the patient gets better" (n=1; 11.1%). One component that was identified that may not be as easily controlled by the psychologist, was that there being a good match between patient and psychologist (n=1; 11.1%).

The physicians in the present study indicated that they would like for there to be a signed consent from the patient, so that he or she and the psychologist could have reports go back and forth (n=7; 77.8%), speak verbally (n=6; 66.7%), or speak via voice mail (n=5; 55.6%). The most common responses to the type of information that the physicians would like to see in this communication, included: receiving answers to their specific questions (n=8; 88.9%), receiving recommendations (n=8; 88.9%), patient diagnosis (n=7; 77.8%), patient status (n=7; 77.8%), and the treatment plan (n=7; 77.8%). Again, as suggested by McDaniel (1995), because of the variability in what information each physician would like to receive appears to be best determined by asking each individual physician.

With regards to what could be done by psychologists to improve collaboration, the majority (n=7, 77.8%) of the physicians indicated that they would like to receive more feedback, with one (11.1%) of these physicians also stating that he or she would like for there to be more interdisciplinary interface as well.

The main aspect that physicians indicated that they could do themselves to improve collaboration was to provide more information and more feedback (n=4; 44.4%), both at the time of referral as well as on a continuous basis. It was also noted, however, that physicians do not have enough time to provide more feedback (n=1; 11.1%), and two

(22.2%) of the physicians reported that that there was nothing that could be done by them to improve collaboration.

Overall, this study has served to confirm a number of findings from previous literature, as well as add to the existing literature.

Previous literature that has been confirmed by this study. The results of the present study that are similar to the findings in the existing literature include: the low rate of physician referral to psychologists (Hunsley et al., 1999; Huxley, 1996; Regier et al., 1988; Vasquez et al., 1990), the large number of patients with psychological problems that are receiving psychological services from their physicians (Orleans et al., 1985), the relatively short amount of time physicians spend with their patients when they are providing psychological services (McDaniel, 1995), the need to increase the amount of feedback from psychologists and improve the level of collaboration between the two fields (Bray & Rogers, 1995; Marandola, 1995), the physicians reports that they do not feel they have received an adequate amount of training to treat psychological issues (Vasquez et al., 1988), and that physicians report not having the time to be treating psychological issues (Khalili & Kane, 1996; Orleans et al., 1985).

In addition, many of the barriers to effective referral and collaboration that were identified in the present study are similar to the barriers that have been identified by previous research, such as the patient not being able to afford psychological services (Bray & Rogers, 1995; Orleans et al., 1985), that it takes a long time for a patient to get in to see a psychologist (McDaniel et al., 1990; McDaniel et al., 1992), the lack of feedback received from the psychologist (Meyer et al., 1988), and a lack of patient follow through (Bray & Rogers, 1995; Orleans et al., 1985).

Additions to the existing literature. One of the barriers to effective referral and collaboration found in the present study that had not been identified in the previous research was that physicians reported not knowing the resources that were available. This may provide a new area in which to improve the processes of referral and collaboration between these two fields through education for physicians.

In addition, both the previous research and the present study found that physicians' perception of the patient being able to pay for psychological services influences whether or not they refer, (Enright, 1985; Khali & Kane, 1996), however, the present study also investigated physicians actual level of knowledge regarding their patients' coverage for psychological services. It was found that many of the physicians in the present study reported having limited knowledge regarding patient coverage, especially for the lower paying jobs. Therefore, it appears that another aspect of improving physician referral and collaboration with psychologists would be to educate physicians about the existing coverage that is available to their patients.

Recommendations

Low physician referral rates to psychologists can have a negative effect on the quality of patient care, health care costs, and create patient overload for physicians. The physicians in this study helped to provide psychologists with some direction as to what can be done to improve the process of referral and collaboration between these two disciplines.

The results of the present study suggest that the low referral rate does not appear to be a result of physicians believing that they can treat psychological problems themselves, because physicians have the time to be providing psychological services, or

because of physicians believing that it is more cost effective. The physicians in the present study also seem to recognize the benefits that they could accrue by referring to psychologists, thus, this does not appear to contribute to the low referral rate either. It also does not appear that the low referral rates are a result of psychologists not assuming an appropriate amount of responsibility for ongoing care, the result of a deeper issue, or certain patient characteristics such as the possibility of the patient becoming upset by the referral, the patients' age, and the patients' gender.

What the physicians did indicated, was that the low referral rates are a result of the lack of information that physicians have on psychologists, the low levels of collaboration between physicians and psychologists, and the lack of feedback physicians receive from the psychologist after making a referral.

The biggest barrier identified by physicians in the present study was that they did not know the resources that were available. Specifically, they requested more information on what psychologists that are in the community, more information on each psychologist's area of expertise, information on psychologist's fees and who they are covered by, and information on the psychologist's years of experience. Therefore, a recommendation would be to provide each of the physicians with a summary chart with this information.

Another barrier that was identified was the lack of feedback that the physician received from the psychologist. Although the physicians varied in the amount and type of feedback that they would like to receive, one would be wise to follow the recommendations of McDaniel's (1995), who recognized that each physicians varies in the amount of information they wish to receive from psychologists, and therefore

suggested that psychologists ask each physician about what type of information they wish to receive. In general, however, as McDaniel (1995) notes, when providing feedback to the physician, psychologists need to take into consideration the enormous time pressures that physicians are under.

The present study found that the majority of the physicians would like to receive answers to their specific questions, recommendations, patient diagnosis, patient status, and the treatment plan, and the majority indicated that they would like to receive this information in the form of a report or by speaking verbally. Not only would it be feasible, but also beneficial, to create an information form for each physician, that would address both the issues of physicians' lack of information about psychologists as well as acquiring the amount and type of information that each physician would like to receive. As McDaniel (1995) notes, one of the more common complaints from both psychologists and physicians, are that the other is inaccessible and will not communicate. Providing physicians with such an information form may also help to remove this perception as a barrier to effective collaboration.

Related to receiving more feedback from psychologists is the finding that the majority of the physicians would like to see an increase in the amount of collaboration there is between themselves and psychologists, with the lack of interdisciplinary communication being identified as one of the biggest barriers to effective collaboration. In addition, the quality of patient care may be negatively affected by a lack of communication, in that, it may result in the patient receiving services from two different professionals that have different conceptualizations of the patient's problem (McDaniel, 1995). This study's finding that physicians see a lack of interdisciplinary communication

as being one of the biggest barriers to effective collaboration, further reiterates the idea that there is a need and a want for increased communication and collaboration between physicians and psychologists.

It also appears that the physicians' perception of whether or not the patient can afford or is covered for psychological services is affecting referral. Since whether or not a patient is covered for psychological services appears to be a mitigating factor in physician referral, and since financial factors and cost are likely to be a deciding factor in whether patients seek psychological services, it would follow that increasing patient coverage for psychological services, would increase referrals, increase patient compliance, and thus improve overall mental health.

Another factor that could be contributing to the low rate of referrals, is the current study's finding that, of the patients that are referred to psychologists, the majority (n=6; 66.7%) of the physicians reported that less than half are actually following through with getting counselling. This low rate of follow through may be a result of the fact that it appears that there is no formalized process of referral or because patients can not afford psychological services. Thus, it would likely be beneficial to look at ways to improve the referral process as well as to look at ways to increase funding and coverage for psychological services.

Need for Further Research

Physicians were interviewed in this study because of the large percentage of patients with psychological issues were suggested to be in primary care (Newman & Rozensky, 1995), and the low percentage that were being referred for psychological services (Huxley, 1996). This study focused on the perspective of the physicians, as it is

important to determine what is and is not working from the perspective of the physician because the decision of whether or not to refer is ultimately decided by them (Seager, 1994). In addition, unlike most other health professionals, including psychologists, family physicians characteristically maintain ongoing, long-term relationships with their patients, providing them with the opportunity to make more frequent observations. However, as noted by one of the physicians in the present study, physicians are not the only ones involved in the referral process, nor are they the only sources of referral. Thus, further research must look at the perceptions of psychologists, psychiatrists, patients, nurses, and other mental health care providers. Further research could also examine the perceptions of physicians other than general practitioners. They may be able to offer an alternate perspective. The task of improving patients overall mental health is a large one and it involves many different participants and players. Examining the perspective of all who are involved will help to promote and ensure further collaboration.

As one of the main limitations of this study was the small sample size, it would also be recommended that this study be repeated using a different methodological approach to either improve the richness of the data collected or to increase the sample size. For example, although a smaller sample size may be achieved through using an ethnographic approach, it may serve to increase the richness of the data collected, thus providing the researcher with a more in-depth perspective. In an effort to increase the sample size for such an approach, one may want to look at interviewing physicians who are only working part-time or who are recently retired.

Another approach, such as the use of a mail-out survey, could aim at securing a larger sample size in order to look at whether the findings of this study can be generalized

beyond this sample. Recommendations for improving the response rate to a survey would be to enlist the support of the Medical Association as well as to secure funding to provide physicians with further incentive to participate.

Considering patient coverage emerged as being a mitigating factor in physician referral, further research may want to look at ways to increase the number of patients that have coverage for psychological services.

Limitations of this Study

The main limitation of this study was the small sample size. As a result, this research may serve better as an instigator for further research, rather than as a source from which to draw conclusions.

In addition, the physicians that were interviewed were all general practitioners that practiced in Lethbridge, Alberta; thus, the results can not be generalized to physicians that work in a different specialty or to outside of Lethbridge, most notably, smaller or larger centres.

As is for any research involving interviews, the data collected in this study was collected via self reports. There is always the risk that the self reports of the physicians may not be accurate. Thus, when looking at the numbers that emerged from this study, it is important to keep this in mind.

The physician interview was specifically designed for this study, and therefore, has not been standardized. As a result, the physician interview does not possess any measures of validity or reliability. Consideration should be made for this when attempting to generalize the findings of this study to physicians outside of this investigation.

Conclusion

This study looked at physicians' perceptions of the existing process of referral and collaboration between themselves and psychologists. Specifically, this study sought to identify the barriers to referral and collaboration in an effort to improve referral and collaboration between these two fields.

Overall, the barriers that were identified by physicians included a lack of feedback provided by psychologists, a low level of collaboration with psychologists, physicians' perception of the financial inaccessibility of psychological care, the lack of information that physicians have on psychologists, and physicians not knowing the resources that were available.

Addressing these barriers appears to involve some combination of improving psychologists' feedback and collaboration with physicians, providing physicians with information and education about psychologists and their services, and improving the financial accessibility for patients to receive psychological services.

The Psychologists' Association of Alberta Access Task Force, recommended, in their Final Report, that the Psychologists' Association of Alberta engage in lobbying to have psychological counselling on the list of covered services, even if the coverage is just for one session (PAA, 2003b). Increasing the public's access to psychologists, through increased funding would reduce the number of visits to family physicians for psychological issues, and would allow both physicians and psychologists to provide services in their area of expertise (PAA, 2003a). Having physicians and psychologists providing services in their area of expertise would serve to improve the quality of patient care, decrease health care costs, and decrease patient overload for physicians.

It is recommended that further research in this area look at the perceptions of other people involved in the referral process, such as psychologists, psychiatrists, patients, nurses, other mental health care providers, as well as the perceptions of physicians other than general practitioners.

Further research is also recommended to look at ways to increase patient funding and coverage for psychological services to help improve the financial accessibly to psychological services, improve the quality of patient care, decrease health care costs, and decrease patient overload for physicians.

It would also be recommended that this study be repeated with a larger sample size in order to look at whether the results of this study can be generalized beyond the sample. Using a different methodological approach would also be recommended to either improve the richness of the data collected or increase the sample size.

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Appendix A
Physician Interview

Demographic Information:
Age:___

Year graduated from medical school:____

Years in Practice:____

Gender:____

Part I: Definition of Psychological Health:

1. How do you define 'psychological issues'?

2. How do you define 'personal issues'?

3. Do you see a connection between physical health and psychological health?
   a) yes/no.

   b) if yes, in what ways?

   c) if no, why not?

Part II: Referral

1. How many patients do you see in an average day?

---

2. How many patients do you see in an average month?

---

3. What percentage of those patients you would consider as being candidates for psychological referral?

---

4. What are the common psychological concerns that you see in your practice?

---

5. What percentage of the patients that you identify as having psychological problems do you provide psychological services for in an average month?

---

6. When providing psychological services yourself, how much time would you spend, on average, with each patient?

---

7. How many hours would you say that you spend providing psychological services yourself in an average month?

---

8. Do you refer to psychologists?
- Yes/No

9. If yes, how many patients in an average month would you estimate that you refer to a psychologist?

10. If no, why not?

11. Do you prefer providing psychological services yourself or referring to psychologists?

12. Under what circumstances/diagnoses do you prefer to provide psychological services yourself?

13. What barriers are there to you providing psychological services yourself?

14. Under what circumstances/diagnoses do you prefer to refer to a psychologist?

15. Do you feel that you have the time to be providing psychological services?
- Yes/No

16. What percentage of psychological and emotional issues do you feel that you are able to correctly identify/diagnose?

_____

17. Which psychological issues do you feel competent in recognizing/diagnosing?

_____
_____
_____
_____
_____
_____
_____

18. Which psychological issues do you <u>not</u> feel competent in recognizing/diagnosing?

_____
_____
_____
_____
_____

19. How qualified do you feel you are to provide psychological services compared to a psychologist?

1	2	3	4
Not Qualified	Partially Qualified	Moderately Qualified	Very Qualified

20. How well do you feel your education prepared you for diagnosis and treatment of psychological disorders?

1	2	3	4
Not Well	Somewhat Well	Moderately Well	Very Well

21. How well do you feel your education prepared you for referral and collaboration with psychologists?

1	2	3	4
Not Well	Somewhat Well	Moderately Well	Very Well

22. Do you feel that there needs to be an increase in the amount of education and training that physicians receive regarding the identification/diagnosis of psychological problems in patients?
- Yes/No

23. Do you feel that there needs to be an increase in the amount if education and training that physicians receive for treating psychological issues?
- Yes/No

24. Describe for me how you make the referral?

25. To whom do you make the referral?

26. How do you decide when to refer?

27. How do you know where to refer?

28. How effective would you rate your current referrals to psychologists?

1	2	3	4
Not Effective	Partially Effective	Moderately Effective	Very Effective

29. What do you see as being the biggest barriers to effective referrals between physicians and psychologists?

30. Does your decision of whether or not to refer depend on the level of collaboration you have with the psychologist?
a) yes/no

b) explain.

31. Does your decision of whether or not to refer depend on whether or not you have referred to the psychologist before?
a) yes/no

b) explain.

32. Does your decision of whether or not to refer depend on your previous experience with referrals to the psychologist (i.e. whether you have had positive or negative experiences in the past)?
a) yes/no

b) explain.

33. Does your decision of whether or not to refer depend on the specialty of psychologist?
a) yes/no

b) explain.

34. Please rate the amount of responsibility that a psychologist assumes for ongoing care once they get a referral?

a)

1	2	3	4
Too Little	Barely Enough	Appropriate Amount	Too Much

b) explain

35. Does the possibility of the patient becoming upset by the referral to a psychologist influence your decision of whether or not to refer?

a) yes/no

b) explain

36. Do you feel that there is a shortage of available psychological services for psychological referral or consultation?

a) yes/no

b) Does this influence whether or not you refer?
yes/no

c) explain

37. Do you feel that psychotropic medication is more cost effective in treating psychological problems than psychotherapy?
a) yes/no

b) Does this influence whether or not you refer?
yes/no

c) explain

38. Does the patients' age influence whether or not you refer them for psychological services?
a) yes/no

b) explain.

39. Does the patients' gender influence whether or not you refer them for psychological services?
a) yes/no

b) explain.

40. Does the social economic status of the patient influence whether or not you refer them for psychological services?
a) yes/no

b) explain.

41. Does the patients employment status influence whether or not you refer them for psychological services?
a) yes/no

b) explain.

42. Does the patients employment status influence where you refer them for psychological services?
a) yes/no

b) explain.

43. Does the number of times the patient has brought the problem to your attention influence whether or not you refer them for psychological services?:
a) yes/no

b) explain.

44. Does your belief/knowledge of whether or not the patient's insurance will reimburse for psychological treatment affect your decision to refer?
a) yes/no

b) explain

45. How much of an influence does the patients level of coverage have on whether or not you refer?

a)

1	2	3	4
Not Influential	Partially Influential	Moderately Influential	Very Influential

b) explain

_____
_____
_____
_____
_____

46. How difficult is it for you to find mental health treatment for patients who are not covered for psychological services?

1	2	3	4
Not Difficult	Somewhat Difficult	Moderately Difficult	Very Difficult

47. How do you ascertain what coverage each patient has?

_____
_____
_____
_____
_____

48. Did you know that the city of Lethbridge has a subsidy program that covers psychological services?
- Yes/No

49. Did you know that if people are covered for prescriptions they are most likely covered for psychological services?
- Yes/No

50. Did you know that all employee, full or part-time, and their family members of the following have 100% coverage for psychological services:
a) any school in Southern Alberta? - Yes/No
b) Lethbridge Community College - Yes/No
c) Costco - Yes/No
d) London Drugs - Yes/No
e) Overwaite Foods - Yes/No
f) Alberta Treasury Branch - Yes/No
g) any Bank - Yes/No
h) Safeway - Yes/No
i) RCMP - Yes/No
j) City Police - Yes/No
k) all city of Lethbridge employees - Yes/No

51. Did you know that Worker's Compensation will cover 100% of the cost of psychological services?
- Yes/No

52. Did you know that professionals and business owners can write off psychological services as consulting fees or medical expenses?
- Yes/No

53. Describe for me, from beginning to end, a referral that you would consider effective.

54. What could be done to improve your referrals:
a) by psychologists:

b) by you:

55. Could it benefit you to refer out patients with psychological issues?
a) Yes/No

b) if no, why not?

c) If yes, in what ways?

56. Describe any clinical experiences that may have affected your willingness to refer to psychologists.

57. What deeper issues may prevent you from referring to psychologists?

58. Of the patients that you do refer to psychologists, what percentage follow through with getting counselling?

Part III: Collaboration

1. How would you define effective collaboration between physicians and psychologists?

2. What do you see as being the biggest barriers to effective collaboration between physicians and psychologists?

3. How would you rate your current level of collaboration with:

a) psychologists in general?

1	2	3	4
Not Effective	Somewhat Effective	Moderately Effective	Very Effective

b)explain

c) with the psychologists that you currently refer to:

1	2	3	4
Not Effective	Somewhat Effective	Moderately Effective	Very Effective

d) explain

4. How much collaboration would you like to see between physicians and psychologists?

5. Would you want there to be a signed consent from the patient so that you and the psychologist could:

a) speak verbally - Yes/No
b) speak via voice mail - Yes/No
c) have reports go back and forth - Yes/No

6. What kind of information would you like to see in that communication/collaboration?

7. Would you want to receive information regarding:

a) patient diagnosis - Yes/No
b) patient status - Yes/No
c) treatment plan - Yes/No
d) prognosis - Yes/No
e) expected length of treatment - Yes/No
f) answers to your specific questions - Yes/No
g) recommendations - Yes/No
h) test data - Yes/No

8. What could be done to make your current level of collaboration with psychologists more effective?

a) by psychologists:

b) by you:

9. Do you have any additional ideas or comments that we have not touched on that you think would be important in improving the effectiveness of referral and collaboration between physicians and psychologists?

Below is a list of patient problems and psychological services for which you may request the services of a psychologist.
a) Please indicate all the ones you would refer for.

b) Then, using the following scale, rate every item in terms of its overall importance for you to seek a psychological referral.

1	2	3	4
Not Important	Partially Important	Moderately Important	Very Important Important

PATIENT PROBLEM		REFER	DON'T REFER	RATING
1. Adult Abuse	i) emotional			
	ii) physical			
	iii) sexual			
2. Child Abuse	i) emotional			
	ii) neglect			
	iii) physical			
	iv) sexual			
3. Offenders	i) sexual			
	ii) violent			
4. Adoption				
5. Affective Disorders				
6. Aging/Psychogeriatrics				
7. Anxiety				
8.Attention/Deficit/Hyperactivity				
9. Autism				
10. Biofeedback				
11. Brian Injuries				
12. Burnout				
13. Career/Vocational Planning				

PATIENT PROBLEM	REFER	DON'T REFER	RATING
14. Child management			
15. Conduct disorders			
16. Consultation			
17. Custody/Access			
18. Crisis management			
19. Critical incident stress debriefing			
20. Dementia			
21. Depression			
22. Developmental disorders			
23. Diagnosis			
24. Disability i)Assessment			
ii) Treatment			
25. Dissociative disorders			
26. Divorce/Separation			
27. Dual diagnosis			
28. Eating disorders			
29. Education/Workshops			
30. Family issues			
31. Forensic Services			
32. Gay/Lesbian issues			
33. Grief/Bereavement			
34. Health promotion			
35. Hypnosis			

36. Illiteracy

PATIENT PROBLEM	REFER	DON'T REFER	RATING
40. Mental retardation			
41. Neuropsychology			
42. Obsessive compulsive disorders			
43. Pain management			
44. Palliative care			
45. Perinatal			
46. Personality disorders			
47. Phobias			
48. Physical health problems i)autoimmune disorders			
ii) Cancer			
iii)Cardiovascular disorders			
iv) degenerative disorders			
v) gastrointestinal disorders			
vi) HIV/AIDS			
vii) metabolic			
viii) renal disorders			
ix) respiratory disorders			
x) somatoform disorders			
49. Posttraumatic stress disorder			
50. Program development/Program evaluation/Quality management			

PATIENT PROBLEM	REFER	DON'T REFER	RATING
51. Psychological Assessment i) adolescence			
ii) adults			
iii) children			
52. Psychoses			
53. Psychotherapy relationship i) couple/marital			
ii) family			
iii)group			
iv) individual: adolescent			
v) individual: adult			
vi) individual: child			
vii) play therapy			
54. Rehabilitation			
55. Relapse prevention/Treatment adherence			
56. Relaxation training			
57. School readiness			
58. Sexual dysfunction			
59. Sexual identity			
60. Sleep disorders			
61. Smoking			
62. Stress			
63. Substance abuse			
64. Supervision/Professional training			
65. Victims of crime			
66. Weight loss			
67. Women=s issues			
68. Workplace issues			

Appendix B
Consent for Research Participation

I hereby consent to participate as a subject in the research project entitled "Partnerships in Mental Health: Effective Referral and Collaboration between Family Physicians and Psychologists" conducted by Kim Witko under the supervision of Dr. Kerry Bernes of the Faculty of Education at the University of Lethbridge. I understand that the study will involve an interview to discuss my perspective on the referral and collaboration processes between family physicians and psychologists. The research project is expected to help identify the strengths and weaknesses of the current referral and collaboration processes between family physicians and psychologists in Lethbridge.

I understand that my participation is completely voluntary and that I am free to withdraw from the study at any time I choose, without penalty.

The general plan of this study has been outlined to me, including any possible known risks. I understand that this project is not expected to involve any risk or harm. I also understand that it is not possible to identify all potential risks in any procedure but that all reasonable safeguards have been taken to minimize the potential risks.

I understand that the interview will be recorded for the purpose of transcription and that the tape will be destroyed after it is transcribed.

I understand that the results of this project will be coded in such a way that neither my identity nor the identity of my clinic or organization will be physically attached to the final data that are produced. The key listing my identity will be kept separate from data in a file accessible only to Dr. Kerry Bernes and Kim Witko, and it will be physically destroyed at the conclusion of thesis defense.

I understand that the results of this research may be published or reported to scientific groups, but neither my name nor my clinic name will be associated in anyway with any published results.

I understand that if I have any questions, I can contact Kim Witko at (403) 328-1335, her supervisor, Dr. Kerry Bernes at (403) 329-2447 or the chair of the Human Subject Research Committee, Dr. Keith Roscoe at (403) 329-2446.

_____ _____

Date Signature

_____

Participant's Name (printed)

Appendix C
Initial Telephone Contact Script

Hello, my name is Kim Witko. I am a graduate student in the counselling psychology program at the University of Lethbridge. I am conducting research on the referral and collaboration processes between physicians and psychologists.

I am calling to ask if you would be willing to participate in a short interview with regards to your perspective on referral and collaboration practices with psychologists.

If the answer is "yes," the interviewer will schedule a time and location that is convenient for the physician.

If the answer is "no," the physician will be asked if there is a better time to contact him/her or if he/she is simply unable to participate in the project. If the physician states he/she is unable to participate, the interviewer will thank him/her for their time and move on to the next telephone contact. If the physician states that another time would be better to contact them, a future time will be scheduled at the convenience of the physician.

Although the results of my research may be published or reported to scientific groups, neither your name nor your clinic name will be associated in any way with any published results.

If you have any further questions, you may contact me at (403) xxx-xxxx or my supervisor, Dr. Kerry Bernes at (403) xxx-xxxx.

Thank you for your participation.

Appendix D
Letter for Validity Check

Date__, 2002

Dear :
Thank you for your participation in the research project entitled "Partnerships in Mental Health: Effective Referral and Collaboration between Family Physicians and Psychologists." In order to increase the validity of my methods, I have randomly selected 20% of the respondents for a validity check. As your name was randomly selected, I have faxed you a copy of the information obtained in our interview which was held on __*Date*__
.

Since this study is intended to describe your perceptions of the referral and collaboration processes between physicians and psychologists I am most interested in ensuring that I have accurately reordered the responses you gave on the date of our meeting. Therefore, it would be most beneficial if you alerted me to any inaccuracies in what was recorded on *Date*__.
Please make any changes on the document and fax it back to me at xxx-xxxx. If I have not received an update fax from you by __*Date*__, I will contact you again in order to determine the accuracy of the data collected.

Thanks again for your cooperation.
Sincerely,

Kim Witko