INTERPROFESSIONAL HEALTH CARE SERVICES IN PRIMARY CARE SETTINGS: IMPLICATIONS FOR THE EDUCATION AND TRAINING OF PSYCHOLOGISTS

June, 1998

Final report submitted by the Education Directorate, American Psychological Association
for Work Order Requisition Number 97M220464
Substance Abuse and Mental Health Services Administration (SAMHSA)/
Health Resources and Services Administration (HRSA)
U.S. Department of Health and Human Services
Project on Managed Behavioral Health Care and Primary Care

AUTHORSHIP AND ACKNOWLEDGEMENTS

Jean Spruill, Ph.D., University of Alabama served as the principal consultant on this project as well as senior author of this report. Assisting Dr. Spruill on the bibliographical research and other project activities were Ms. Cheryl Barksdale and Mrs. Dana Bush, undergraduate and graduate student assistants, respectively.

The work of this project was facilitated significantly by a panel of psychologists with experiences related to the issues of the project who served as advisors to Dr. Spruill. They were Cynthia Belar, Ph.D., Martin Harris, Ph.D., Susan McDaniel, Ph.D., Karl Moe, Ph.D., Susan Scheidt, Psy.D. and Antonette Zeiss, Ph.D. Also advising Dr. Spruill were selected staff of the American Psychological Association with experiences also related to one or more aspects of the project. They were: John Anderson, Ph.D., James "Gil" Hill, and Randy Phelps, Ph.D. Appreciation is expressed also for editorial review and suggestions offered by James Bray, Ph.D. and Robert Frank, Ph.D., both serving during the period of this contract on t the APA Board of Educational Affairs and both being national leaders in health psychology and primary care.

Paul D. Nelson, Ph.D., Deputy Executive Director for Education, American Psychological Association, served as Project Officer, providing administrative support and editorial assistance for the project. Assisting him in that regard was Ms. Laura Wilson, APA Education Directorate, whose support was substantial throughout the project, ensuring timely communications and progress reports, planning the advisory panel meeting, and ultimately in formatting, integrating, and editing the final report.

In addition, the patient and thoughtful leadership provided throughout this project by SAMHSA Project Director, Frances Cotter, MPH, contributed significantly to the work accomplished throughout this contract, including the development of this report.

The opinions and recommendations expressed in this report are those of the authors and advisory panel, based in large part on their analysis of the published literature cited herein and by their experience as behavioral health service providers in psychology. Consequently, except as indicated otherwise, the opinions and recommendations should not be interpreted as necessarily reflecting the official policy or as having the formal endorsement of the American Psychological Association as an organization.

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Introduction

In FY 1997, the Senate Appropriations Committee addressed the importance of mental health and substance abuse services as essential elements of primary care. The Committee expressed concern about the impact of managed care on access to behavioral health services and indicated its support of the training of behavioral health professionals in managed care settings, particularly in rural and underserved communities. The Committee specifically recommended that the Secretary of Health and Human Services develop standards and guidelines for the delivery of mental health services in managed care entities, including guidelines for cultural competencies, work force diversity and collaboration with primary care disciplines. The Committee also expressed support for projects to design curricula and training models that prepare behavioral health professionals to work in managed care systems and interdisciplinary primary health care settings.

Responsive to these Congressional recommendations, the Substance Abuse and Mental Health Services Administration (SAMHSA) in partnership with the Health Resources and Services Administration (HRSA) contracted work with the American Psychological Association to develop a bibliography and appropriate education and training guidelines related to the participation of psychologists in interprofessional health care services, inclusive of substance abuse and mental health services, within a managed care system in primary care settings. The report that follows resulted from that contract.

While the bibliographical citations are relevant to the education, training, and practice of psychologists under these parameters, they are not limited in their relevance in all instances to the profession of psychology. Nor are the education and training principles and guidelines so restricted in their entirety. The focus of the report text, of course, is on the role of psychology and psychologists in primary care, including a summary of key issues and barriers for the profession in that context. Recommendations advanced in this report likewise are intended for psychology, though they may be relevant to other health profession disciplines as well.

One theme that clearly emerges from the bibliography, principles, guidelines, and recommendations is that considerations about professional education, training, and practice in primary care roles and settings must be framed by a collaborative interprofessional model of service. Funding must also be provided for training, towards that end.

The Need for Collaborative, Interprofessional Training

Integrated primary care services require collaborative, interprofessional functioning between providers of different professional disciplines. Managed care systems favor the use of multidisciplinary teams or collaboration between physicians and other health care providers (Bachrach, 1996). An extensive body of literature arguing for interdisciplinary treatment of disorders and interdisciplinary training among various health care professions has been reviewed. There is consensus that training various professionals together early in their careers is important for effective collaboration later (Clark, 1994; Hinshaw, & DeLeon, 1995; Ivey, Brown, Teske, & Silverman, 1988; Lesse, 1989). There is also evidence to suggest that collaborative, interprofessional treatment is more effective and cost-efficient (Addleton, Tratnack, & Donat, 1991; Bachrach, 1996; Jackson, Gater, Goldberg, Tantam, Loftus, & Taylor, 1993; Morris, 1997). Given the nature of problems presented in primary care, psychologists need to be an essential part of that interprofessional primary health care team. They need training, however, specific to primary care settings and services, including the interprofessional training component, in addition to the breadth of scientific and clinical training they receive in their doctoral preparation. Psychology, however, is not alone is this regard. The December 1995 Pew Health Professions Commission Report "Critical Challenges:

Revitalizing the Health Professions for the Twenty-First Century" (Pew Health Professions Commission, 1995) makes the point that the health professions in general need to reevaluate and revise their education and training programs to prepare professional practitioners for the new roles and health care service systems that are evolving as we enter the next century. This needs occurs at all levels—from preservice, doctoral training to internship training, to postdoctoral, continuing education training of professionals in practice.

In response to this need, as well as the need to provide psychological services to underserved populations in our nation, the American Psychological Association (APA), in cooperation with American Nurses Association (ANA) and the National Association of Social Workers (NASW), developed in-service interprofessional training guidelines for psychologists, nurses, and social workers to provide primary health care services in rural areas (American Psychological Association, 1995). Support for this project came from a contract from the Health Resources and Services Administration (HRSA). Recently, with its own resources, the APA is developing a textbook based on that project and, in a separate initiative, sponsored a task force to define the nature of psychologists' roles and functions in primary care services (American Psychological Association, Committee for the Advancement of Professional Psychology Primary Care Task Force, 1996). Over the past two years, in addition, the APA conducted a needs analysis and developed principles and guidelines related to training psychologists to function in organized or managed care systems (American Psychological Association, 1997), an effort supported by contract with the Substance Abuse and Mental Health Services Administration (SAMHSA) Center for Mental Health Services (CMHS). Although the need for interdisciplinary or interprofessional training is discussed extensively in the health care literature, in practice such training is infrequent. Where it has occurred, it is primarily in settings that focus on the care of persons with disabilities (e.g., DeGraw, Fagan, Parrott, & Miller, 1996) or the geriatric population (e.g., Clark, 1994). More emphasis on interprofessional training in all areas of health care is needed.

Project Objectives and Outcomes

Building on these initiatives and the need for greater emphasis on interprofessional education and training, the present project had as an objective the development of education and training principles and guidelines to prepare psychologists for primary health care services, based on an extensive bibliographical review of the literature. That bibliography is presented alphabetically by author in Appendix A, with an annotated bibliography of selected publications by topic in Appendix B. The bibliography was developed by multiple searches on key words of significance to this project across multiple libraries. From the bibliography, education and training principles and guidelines were developed to prepare psychologists (and other health professionals) to function in primary health care settings and roles. These are presented in Appendix C.

The principles and guidelines are organized in relation to psychologist's roles in clinical services (assessment, intervention, and consultation), teaching, research, and administration as members of a primary care interprofessional team. There is also a preamble category of “general” principles for primary care. The APA advisory panel was mindful that these principles and guidelines may be neither unique to psychology nor to primary care services in all instances. They are intended to frame perspectives about different aspects of professional education and training relevant to primary care settings and functions, allowing the differentiation of how psychologists (or other primary care providers) might function as members of primary care service teams from the ways in which they would provide services as secondary or tertiary care providers upon referral. They represent parameters of professional knowledge and skill. Preceding the principles and guidelines for the development of knowledge and skills essential for psychologists to function as members of primary health care teams is a summary of

professional attitudes and assumptions that are equally essential to effective primary care service. They reflect characteristics of primary care settings and functions that require collaborative, interdisciplinary teamwork under constraints of time and other resources, and where brief, focused, directive or "prescriptive-like" interventions are the rule rather than the exception.

A final part of the project consisted of ascertaining the extent to which primary care training is present currently in doctoral and internship training in professional health-related areas of psychology. According to the most recent directory of graduate programs in psychology, there are 43 doctoral programs providing education and training in clinical health psychology at the doctoral level. However, only a few emphasize primary care. Among (more than 500) internship training programs for psychologists, about 36% presently offer training in behavioral medicine, while only 2% offer a major rotation in primary care. Thus, there is clearly a need at pre-service and in-service levels for greater emphasis in preparing psychologists to function in primary care settings and roles, including interprofessional training. Demonstrating that this can be done is a summary in Appendix D of this report of exploratory and operational programs in which psychologists are being trained at doctoral (pre-service) or postdoctoral (in-service) levels. Although there was insufficient time during the course of this project to survey these and other training programs for more detailed information about their curriculum, setting, and other programs characteristics, a survey questionnaire was developed for possible use in the future. It is presented in Appendix E.

Throughout this project, the Project Evaluation Consultant and APA Staff Project Officer received significant consultation from an advisory panel of psychologists appointed for purposes of the project, as well as from selected APA staff, all of whom have professional experience in one or more areas of education, training, practice, or research related to this project. They are listed with institutional affiliation, as well as selected materials from the panel meeting, in Appendix F. The panelists represent expertise in primary health care roles and services for psychologists, the treatment of alcohol and substance abuse, behavioral and mental health services, and multicultural psychological services. They also represent leadership at doctoral (pre-service) and postdoctoral (in-service) levels of professional education and training in psychology, with expertise in the training and evaluation of collaborative, interprofessional health care teams. One of the panelists, Dr. Susan McDaniel, was the first psychologist selected for the HRSA Primary Care Fellow Program.

The Role of Psychology in Primary Health Care

Although the clinical practice of psychology traditionally has been associated largely with mental health, and continues to be in the public's image of the field, it has become a broader health profession (American Psychological Association, 1996; Cummings, 1995; Hersch, 1995; Johnstone et al., 1995; McDaniel, 1995; Newman & Reed, 1996). This is not an entirely new development. Psychologists have worked in general medical settings for many years in a variety of roles, including teaching physicians and other health professionals about behavioral aspects of medical problems and health maintenance; conducting research related to behavioral medicine and health; providing psychological or behavioral interventions in the prevention and treatment of non-psychiatric medical problems and physical rehabiliation; and providing neuropsychological and mental health services (Frank & Ross, 1995; Matarazzo, 1980; Mensch, 1953; Miller, 1983; Schofield, 1969). Kaplan (1990), moreover, advances the argument that behavior is the central outcome of health care in terms of human life quality and daily function. Psychologists trained in the science and measurement of human behavior thus can make a major contribution in the assessment of health care outcomes.

A milestone in the recognition of this evolutionary development in the science and practice of psychology was the founding of the American Psychological Association Division of Health Psychology in 1978. Since that time, health psychology has become one of the most popular areas for research in psychology. In addition, there are an increasing number of doctoral and postdoctoral training programs in the general clinical practice of psychology with an emphasis in health psychology (Sayette & Mayne, 1990). These programs have a focus on the application of psychology to health promotion and disease prevention as well as the development of psychological interventions that are efficacious and cost-effective for treatment of the behavioral components of various medical problems. Concomitantly, employment of psychologists in medical centers and other general health care settings has increased (Belar, 1980 and 1989; Ludwigsen & Albright, 1994). As a result, psychologists provide services in collaboration with virtually all of the major specialties of medicine. An increasing number of psychologists, in particular, are in collaborative practice with two of the medical primary care specialties, Family Medicine and Pediatrics (Bray, 1996; Bray & Rogers, 1995; Drotar, 1983; Glen, Atkins, & Singer, 1984; Kriesel & Rosenthal, 1986; McDaniel, 1995; Schroeder, 1996).

This development in the clinical practice of psychology reflects in part the observation by Newman and Reed (1996) that the evolution of health care services in our nation has been increasingly in the direction of integrated services with correspondingly increased emphasis on primary care. This shift in emphasis from highly differentiated and specialized tertiary care services to primary care integrated services has been shaped by the costs of health care in our nation and the evolution of organized or managed health care, within which system primary care is the predominant gatekeeper. Accordingly, in recent years, postgraduate medical residencies have increased proportionately in the medical primary care specialties of Family Medicine, Internal Medicine, Pediatrics, and Obstetrics/Gynecology. Although the profession of psychology has not defined itself as a specialist in primary, secondary, or tertiary levels of care, the recent Institute of Medicine report (1997) stated that psychologists are an integral part of team-based medical care, filling a need in health care as it moves to more integrated approaches to care. Thus psychology's vital role in our nation's new health care system was affirmed.

Primary care is committed to preventing illness and injury, the early detection and treatment of health problems, and ensuring coordinated, comprehensive care in a family or community systems environment (Belar, 1995a; Diekstra & Jansen, 1988; Newman & Rozensky, 1995). The three components of primary care that need to be considered in delivering health care services in a primary care setting are: (a) the patient or client; (b) the primary care provider team (of which the psychologist is a member); and (c) other "stakeholders" (i.e., the broader health care system, the family, the community). The primary care provider as a gatekeeper must have a broad understanding of all three of these components, the limitations of resources, and the competence to plan the most effective course of care needed relative to resources available. Based on the breadth of their education and training, which integrates science and practice, psychologists have the foundational preparation to provide innovative and integrative behavioral services in primary care; to design and evaluate the outcomes of prevention and treatment programs; to improve primary care team functioning; and to treat, educate, and consult about the emotional and behavioral aspects of problems presented in primary care. That psychologists have a valid role in primary care practice is documented also by the nature of problems presented in such settings.

The Relation of Primary Care to Behavioral and Psychological Problems

Unhealthy behaviors such as smoking, over-eating, alcohol and other drug use, violence, accidental and intentional injuries, sedentary lifestyles, and unsafe sexual practices are significant contributors to physical illnesses. Stress, behavior, and life-style have been found to be significant contributors in five of the seven leading causes of death in the United States (Higgins, 1994). Furthermore, many medical

disorders (e.g., hypertension, ulcers, headaches, chronic pain, etc.) have been shown to have a strong psychological component (e.g., Belar, 1995a, 1995b). In a recent large scale study of over 1,000 patients in an internal medicine clinic (Kroenke & Mangelsdorff, 1989), less than 16% of the most commonly presented complaints had a clear physiological basis, 10% had a clear psychiatric diagnosis, and the remainder of the symptoms were unknown in origin. Significant psychological distress was present in over 80% of the presenting complaints. The most common complaints were pain, dizziness, insomnia, fatigue, impotence, weight loss/gain, etc. It has been estimated that as much as 60% of physical disorders are somatized psychological problems (Cummings, 1996). Thus, it is well documented that many patients in primary care settings have clinically significant psychological problems (Von Korff, & Simon, 1996). A related conclusion from the research literature is that the psychological aspects of a patient's problems often are not detected or treated appropriately by the primary care physician (Docherty, 1997; Eisenberg, 1992; Horn, 1997; Higgins, 1994, Saltz, 1985; Von Korff & Simon, 1996; Wells, 1997).

In addition to the types of problems just summarized, it is estimated that 50-60% of patients seen in primary care settings receive some mental health services. Depression and anxiety are the two disorders most often mentioned in the literature as underdiagnosed and undertreated in those settings. Longitudinal research has shown that the psychological problems of patients treated or seen in primary care settings, although not necessarily acute, often are recurrent and chronic and are not treated appropriately when they are treated in these settings (Von Korff & Simon, 1996). Even when primary care physicians make referrals for mental health treatment, it is estimated that up to 50% fail to follow through on such referrals (Callahan, Hendrie, Dittus, Brater, Hui, & Tierney, 1994). Reasons given for failure to follow through are the inconvenience of making separate appointments, the stigma associated with mental disorders, and the patient hearing a message of "it's all in your head, your problems are not real" (Haley et al., 1998). However, when behavioral health care services are located in the same site as the primary care medical services, and are seen as an integral part of overall services in that setting, referrals for mental health care are more successful (Bray & Rogers, 1995; McDaniel, Hepworth, & Doherty, 1992). Other studies have shown that a collaborative (interprofessional) model of care, when compared to a "physician-only" model of care, produces improved adherence to treatment, improved outcomes, and improved patient satisfaction (Katon et al., 1997; Von Korff & Simon, 1996).

Co-location and integration of services is responsive also to the increasing demand for what has been called "one-stop shopping" in health care services. By using integrated delivery systems, a seamless, coordinated continuum of care can be offered to patients. One of the keys to this integrated delivery system is to integrate behavioral and mental health care into the primary care system. Integrating the two systems will facilitate more effective psychological and behavioral interventions in the early treatment of many disorders related to stress, life-style, and behavior as well as in disorders such cancer, heart disease, diabetes, etc. (Barlow, 1994; Blanchard, 1994). Psychologists are prepared as well to work with other primary care providers in addressing issues of family distress and family adjustment problems that interfere significantly with adherence to medical treatment regimens or the management of chronic pain, illnesses, etc. Domestic violence, conduct disordered children, and attention deficit hyperactivity disorders are yet other examples of behavioral problems that are commonly seen in primary care for which psychologists are well prepared to treat. All of these problems, moreover, are amenable to a family systems approach in treatment that is recognized as an important area for training primary health care providers (Bray & Rogers, 1995; McDaniel, 1995; and McDaniel, Campbell & Seaburn, 1990).

Key Issues for Psychology Related to Managed Care/Primary Care

The three key issues for psychology with respect to managed care and primary care are recognition of psychology as a health profession; a partner in primary care and the need for training in the area of primary care.

- **Psychology as a Health Profession**

A key issue for psychology is the public recognition of psychology as a health profession, not exclusively a mental health profession, and the role of psychologists in that context as health service providers. Traditionally, the field of health care has been defined by echelons of care i.e., primary, secondary, and tertiary, with service providers ranging from generalists to specialists, correspondingly. Over the past 50 years, medicine and other health professions became increasingly specialized, with major emphasis on tertiary care service settings. Psychologists followed much the same pattern, historically, providing specialized mental health services, in conjunction with psychiatrists and social workers, as well as in consultation with other medical specialties and health professions. The impact of managed care, with the common practice of carving-out mental health services from general health care services, has continued to emphasize the role of psychologists and other mental health professionals in the delivery of mental health care. However, mental health is a subset of the expertise of clinically trained psychologists, not the defining characteristic. On the basis of advancements in the science and practice of psychology, and their training, psychologists' roles are much broader today.

- **Psychology as a Partner in Primary Care**

Another key issue is the need for psychologists to be partners in collaborative, interprofessional primary health care teams. While psychologists have been collaborating with many specialties of medicine and other health professions for some time, providing services in behavioral medicine and health psychology, as well as in mental health, these services have been provided predominantly through secondary or tertiary care settings and roles, by referrals and interprofessional consultation. As managed health care is becoming more integrated, and the past emphasis on specialty care is being replaced with an emphasis in primary care and integrated services, psychological services need to be an integral part of primary health care for the most cost-effective outcomes. The problems presented in primary care settings have significant behavioral and psychological components or implications, and there is substantial evidence on the effectiveness of behavioral interventions in the treatment of a wide range of mental disorders, physical disorders, and psychosocial problems commonly encountered in a primary care setting.

- **Need for Primary Care Training**

A third key issue is the need for psychologists to receive formal training in primary care settings and roles as members of interprofessional teams. This training should occur at all levels--graduate programs, internship, postdoctoral residency and continuing professional education. Unfortunately, education and training of psychologists (as that for other health care professionals) often lags behind changes in the health care system. According to the most recent directory of graduate programs in psychology, there are 43 doctoral programs providing education and training in clinical health psychology at the doctoral level. However, only a few emphasize primary care. Among (more than 500) internship training programs for psychologists, about 36% presently offer training in behavioral medicine, while only 2% offer a major rotation in primary care. Thus there is a critical need for more training in relation to primary care services for psychologists. In another section, this report presents representative examples of programs that have such training.

Major Barriers Encountered in Adapting to Managed Care/Primary Care

- **Reimbursement**

Perhaps the major barrier for psychologists participating fully within a primary care or managed care setting is the current reimbursement system for such care. Under the current system, physicians are reimbursed for procedures whereas psychologists are reimbursed for time. Thus, psychologists can get paid for "therapy" services but not as readily paid for such services as consultation to primary care physicians, or briefly seeing a patient conjointly with the primary care physician, etc. One way psychologists are working in primary care settings at the present time is employment as a staff member of the HMO, hospital, or clinic. This is not a satisfactory solution. The reimbursement issue, combined with the lack of access to the general health care system, has made it very difficult to develop programs for integrating psychology into primary health care.

- **Mind-body dualism**

Another major barrier to the creation of integrated health systems and the integration of psychology into health care versus mental health care is the mind-body dualism of our current health policy. For example, the carving-out of behavioral health care (or mental health care) poses obstacles to the integration of psychology into the health care system. Carve-outs also make it difficult to apply psychological knowledge and principles to health promotion and treatment—both of which are very important in the delivery of integrated, comprehensive health care services. Psychology needs to work toward the elimination of such dualism, not only in the administrative structures of the health care delivery system, but also in legislation, insurance, health-plan benefits, etc.

- **Training and Role Models**

Too few of the current educational programs for training psychologists provide training for the needed skills to work within the field of primary health care, especially within the context of managed care. One factor hindering the development of training programs and/or practicum sites in primary care is the lack of sufficient role models. There are simply not enough psychologists with the appropriate training and experience to serve as faculty in such programs, either at the doctoral or internship level. An associated barrier is the lack of training stipends for support of students in the primary health care field. Graduate students in psychology most often receive their "practicum" training in community agencies that also pay them for service provision. The psychology students typically are working 20 hours/week in a "practicum" setting and also have courses and research to complete. They cannot add additional practicum hours for 10-20 hours per week in a primary care setting without that also being their source of financial support. As managed care becomes even more dominant, the fact that graduate students (who are not licensed as professionals) cannot be reimbursed for their services is cutting into the number of opportunities for practicum placement—with or without financial support. Currently, primary care settings are even more problematic with respect to reimbursement for professionals, much less graduate students.

- **Other barriers**

Other barriers often cited in the literature are things such as different theoretical orientations (biomedical vs. psychosocial), lack of a common language (medical vs. psychological jargon), different practice styles, differences in time management, differences in expectation of assessment, intervention and consultations, hierarchical issues (i.e., turf, power struggles), availability, etc. With training and education on the part of psychologists and primary care physicians, these barriers can be overcome.

Recommendations of the Project Advisory Panel

1. Psychology should be recognized as a health care profession inclusive of but not limited to mental health services. With appropriate education and training psychologists can and should function in primary health care settings as well as at the secondary and tertiary levels of health care.

2. Psychology must be involved in the development of practice guidelines for all the major problems treated in primary care. This is immediately obvious in terms of the traditional mental health problems seen in primary care: depression, anxiety, stress, etc. However, the relevance of behavioral sciences/interventions across the board should be recognized, in guidelines for hypertension cardiovascular disease, cancer, diabetes, pain, and life style change as examples of frequently seen health problems where our services are integrated to comprehensive care.

3. In order to have an impact on the development and implementation of such guidelines and health care policy, psychology must support and participate actively in coalitions bringing together representatives from multiple health profession organizations, the health care industry, and consumers of health care services.

4. Psychology should work to ensure legislative and/or policy changes to obtain financial incentives for organizations (e.g., hospitals, clinics, HMOs, etc.) to provide interprofessional care within the primary care setting. Barriers to interdisciplinary care (e.g. licensure laws, restrictions on interdisciplinary groups, etc.) need to be removed.

5. Psychology should develop public educational efforts for various stakeholders (health provider organizations, patient groups, third party payer, businesses/corporations which contract for health care, faculty of training institutions, mental health providers) on behavioral health care in the primary care system. Advocacy materials and public messages should highlight the role of psychology in the prevention and treatment (behavior change) of problems, both psychological and physiological.

6. Psychology should develop model curriculum/syllabus for training at graduate, internship, and postdoctoral levels which develops the appropriate skills for a primary care practice.

7. Education and training programs in psychology must have access to grants specifically linked to training in primary care.

APPENDIX A

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APPENDIX B

SELECTED ANNOTATED BIBLIOGRAPHY BY TOPIC

SELECTED ANNOTATED BIBLIOGRAPHY BY TOPIC

A. Models of Collaborative Care

1. Team building/teams/interdisciplinary teams. The articles listed below focus primarily on issues involved in team building, case studies of teams, or examples of the development of interdisciplinary teams in various settings.

Barker, S. B., & Barker, R. T. (1994). Managing change in an interdisciplinary inpatient unit: An action research approach. The Journal of Mental Health Administration, (21)1, 80-91.

The authors describe the application of the action research model to managing change in an interdisciplinary inpatient unit by means of a case study approach. The interdisciplinary team consisted of physicians, psychiatry, nursing, social workers, substance abuse counseling, as well as psychology, occupational therapy, and the hospital chaplain in inpatient units. Their results suggested that the use of the model coupled with participation by the client group promoted positive staff morale, open communication, lower staff turnover, team problem solving, and improved goal attainment. This article is relevant for those who are contending with difficulties that arise in interdisciplinary team interactions or for promoting/facilitating the incorporation of independent individuals into an interdisciplinary team as well. They recommend that programs involve all staff members in the change efforts by forming multidisciplinary committees to develop interventions to address major programmatic needs. Problems can be avoided if key players within any cliques are identified and involved early in the action research process. This facilitates staff morale and communication, both between and within disciplines, lowers staff turnover, and diminishes territoriality and increases team building.

Benierakis, C. E. (1995). The function of the multidisciplinary team in child psychiatry: Clinical and educational aspects. Canadian Journal of Psychiatry, 40(6), 348-353.

Presented information about experiences with teams in a university hospital and various community settings that promote the learning of collaboration among different professionals. Discusses a renewed interest in all medical specialties to adopt the biopsychosocial approach to meet the needs of patients.

Brill, N. I. (1976). Teamwork: Working together in the human services. Philadelphia: J. B. Lippincott Company.

An excellent resource book in spite of the date of publication. The book thoroughly discusses the development of teams as well as the use of consultation, collaboration, and referral. The last chapter discusses the education necessary for preparation for teamwork.

Burns, C. (1994). Innovative team building: Synergistic human resource development. Administration and Policy in Mental Health, 22(1), 39-48.

The author describes the development of synergistic teams within mental health treatment settings to reach the goals of effective utilization of human resources and improving quality of services. He also examined the issues of leadership, disciplines, interdisciplinary work, functioning and process, and empowerment. Skills managing limited time and resources in the provision of needed services are important to acquire.

Carty, A. E. S., & Day, S. S. (1993). Interdisciplinary care: Effect in acute hospital setting. Journal of Gerontological Nursing, 22-32.

The authors described a program whereby interdisciplinary teams conducted patient assessments and had "care" planning conferences directed by nurse coordinator. Each team member did assessments and contributed to the data base at the conference. There were interdisciplinary recommendations, estimated length of hospital stay and time frame for accomplishing recommendations as well as additional conferences for modifications if needed. Interdisciplinary team members attended classes on functional assessment, aging process, medication, nutrition, and mobility concerns in the elderly. They learned case presentation formats and in general got to know other team members and their professional roles. The result was an increased level of comfort in discussing their assessments with other members of the team; increase in refinement of assessment skills, increased ability to individualize care plans. Nursing staff began to consult with each other and other team members. Result was more holistic plan of care for the patient, increased knowledge and respect for other team member's area of expertise. Interdisciplinary collaboration led to increased comfort with multidisciplinary treatment plans, knowledge of and respect for other disciplines and better treatment for the patients. This program could be applicable to all mental health disciplines.

Christensen, C., Larson, J. R. (1993). Collaborative medical decision making. Medical Decision Making, 13, 339-346.

This article examines the existing literature on group decision making, explores its relevance for the domain of medicine, and identifies potential sources of strength and weakness in team-based clinical decision making. It is included here because of the useful information on group decision making.

Cooley, E. (1994). Training an interdisciplinary team in communication and decision-making skills. Small Group Research, 25(1), 5-25.

Discusses the complications that arise from team collaboration across different disciplines, and describes three barriers that often stand in the way of effective team interactions: disorganization, misunderstandings, and problem-solving difficulties. The authors argue for the need to develop interventions that can successfully improve team communication and decision making. They describe the implementation and evaluation of an intervention addressing the barriers described above. Results indicate that the intervention had some success and team members found the training to be both useful and enjoyable. The authors discuss the implications for future research.

Czirr, R., & Rappaport, M. (1984). Toolkit for teams: Annotated bibliography on interdisciplinary health teams. Clinical Gerontologist, 2(3), 47-54.

An excellent reference for readings on a number of topics, including general information on teams, team-building techniques, effective use of time and problem-solving, and references on systems theory and some specific to interdisciplinary health teams. Also provides addresses for ordering some items listed and leads for locating other materials. Although the article is 15 years old, bear in mind the statements made by the authors in their abstract: "People beginning to work with interdisciplinary team training have a tendency to 'reinvent the wheel.' The most useful articles and books on teamwork are scattered over many literatures, so that professionals often locate some within their own discipline but overlook other valuable material."

Drinka, T. J. K. (1994). Interdisciplinary geriatric teams: Approaches to conflict as indicators of potential to model teamwork. Educational Gerontology, 20, 87-103.

Interdisciplinary health care teams are essential for the delivery of health care to frail elderly persons. Teaching professionals how to function in health care teams is difficult. The article discusses ways to make interdisciplinary teams more effective. Skills in conflict management, problem solving, and assumption of functional leadership are necessary for team members who assume the leadership role of teaching teamwork. In addition, evidence of constructive confrontation may be a good indicator of an interdisciplinary health care team's readiness to model teamwork.

Drinka, T. J. K., & Streim, J. E. (1994). Case studies from purgatory: Maladaptive behavior within geriatrics health care teams. The Gerontologist, 34(4), 541-547.

Behavior of team members exists on a functional continuum, from adaptive to maladaptive. Health professionals readily identify maladaptive behaviors in patients, but may ignore or avoid such behavior in colleagues. Ignoring these behaviors precludes influencing the affected team member to seek help, and can cause members to leave the team. Team members with maladaptive behavior, and persons colluding with this behavior, can negatively influence care. Using case vignettes, this article categorizes common maladaptive behavior patterns within teams and suggests intervention strategies from an individual, team, and organizational perspective.

Dunn, M., Sommer, N., & Gambina, H. (1992). A practical guide to team functioning in spinal cord injury rehabilitation. In C. Zejdlik (Ed.), Management of spinal cord injury (pp. 229-239). New York: Jones and Bartlett.

Describes the challenges of working as a member of a spinal cord injury (SCI) team. Attempts to identify the strengths of the team in SCI rehabilitation (a number of which would apply to other health care disciplines) both for patient care and individual staff satisfaction, and suggests concrete ways that team members can strengthen and maintain team functioning.

Edmunds, M., Canterbury, II, R. J., Connors, H., & Schoener, E. P. (1994). Multidisciplinary approaches to research, teaching, and clinical services. Association for Medical Education and Research in Substance Abuse, 15(1), 17-19.

Discusses the advantages of multidisciplinary teams over conventional approaches to research, teaching, and clinical services. Describes multidisciplinary team strategies and approaches used within the authors' university-based medical settings. Presents essential components of effective teams, with an emphasis on factors including team building and maintenance, cross-training, and leadership and governance.

Garner, H. G. (1994). Multidisciplinary versus interdisciplinary teamwork. In. H. G. Garner & F. P. Orelove (Eds.), Teamwork in human services: Models and applications across the life span (pp. 19-36). Newton, MA: Butterworth-Heinemann.

Addresses the question of what is a team, and differentiates multidisciplinary teams (e.g., limited interdependence) and interdisciplinary teams. Also discusses internal processes as they are relevant to team building (or team training), such as having knowledge and understanding of other disciplines. Relevant for health and mental health care teams.

Garner, H. G. (1994). Critical issues in teamwork. In. H. G. Garner & F. P. Orelove (Eds.), Teamwork in human services: Models and applications across the life span (pp. 1-18). Newton, MA: Butterworth-Heinemann.

A good reference for general health and mental health care team issues and tenets. Also discusses impediments to teamwork, stages of team development, and eight characteristics of effectively functioning teams.

Goldstein, M. K. (1989). Physicians and teams. In R. J. Hamm (Ed.), Geriatric medicine annual 1989 (pp. 256-275). New Jersey: Medical Economics Books.

Given that care of a geriatric patient (but also other patient groups) may often rely on the input from multiple disciplines, the article discusses the role and usefulness of teams, and the need for physicians to be involved in team activities (for the benefit of all parties involved). The article discusses team function, structure, leadership, communication, and building, explores potential benefits and problems (including financial issues). Offers practical advice on the development of more teamlike approaches in various settings.

Gosselin, J. Y. (1983). The team approach: For or against the patient? Canada's Mental Health, 31(3), 23.

The team approach may or may not be helpful to the patient. In many instances, the outcome of team work can only be what the participants in the process--including the patient--want it to be. An ongoing attention to the dynamics of the group relationship is essential to the group's good functioning. A problem-solving attitude should be cultivated by each member, and brought to bear on any difficulties within the team, in order to spare the patient from becoming the scapegoat or even the victim of such possible difficulties. The comments in the article are intended to trigger questions among those interested and involved in the multidisciplinary approach to patient care.

Heinemann, G. (1988/89, December/January). Education for interdisciplinary practice in geriatric health care education. AGHExchange: Newsletter of the Association for Gerontology in Higher Education, 12, 1-3.

Discusses strategies for educating health care providers on participation in health care teams. Proposes the use of a team-specific educational program that is "tailor-made" for a specific team, occurring over a considerable period of time, although this is time-consuming and lengthy. Also discusses the use of a workshop. Discusses how to select the appropriate educational format.

Heinemann, G. D., Farrell, M. P., & Schmitt, M. H. (1994). Groupthink theory and research: Implications for decision making in geriatric health care teams. Educational Gerontology, 20, 71-85.

According to the authors, teams do not necessarily function in the most appropriate fashion. The article describes barriers to effective team functioning and ways to prevent groupthink in collaborative or team decision making. The suggestions provided are useful for improving team interactions in interdisciplinary contexts.

Hutchens, G. C. (1994). Differential interdisciplinary practice. Journal of Nursing Administration, 24(6), 52-58.

The intended audience for this article is medical personnel, however, the information about interdisciplinary practice is applicable to mental health professionals as well. The authors recommends that training programs redefine and/or clarify the roles of various professions to remedy duplication and omission of services. This will lead to better care and greater patient satisfaction. Role confusion and ambiguity about division of responsibilities leads to frustration and isolation of team members. The author recommends that the various disciplines develop a consensus in defining care requirements and discuss which discipline would assume accountability for those requirements—this would minimize fragmentation, omission, and duplication of services. Quality of care improved as consensus about client standards and respective accountability for care services was obtained. Practitioners expressed clearer understanding of each other's roles, greater sense of teamwork and job satisfaction.

Jackson, G., Gater, R., Goldberg, D., Tantam, D., Loftus, L., & Taylor, H. (1993). A new community mental health team based in primary care: A description of the service and its effect on service use in the first year. British Journal of Psychiatry, 162, 375-384.

This article describes the formation and effects of a new community multidisciplinary team (e.g., including general practitioners, social workers, occupational therapists, and clinical psychologists), with some recommendations for the creation of successful teams. Provides a higher degree of detail than most articles on the actual teamwork processes involved (e.g., how often meetings were held, who attended, what the hierarchical structure was, what events occurred during meetings, etc.). In spite of the team's efforts to provide information and its willingness to accept hospital referrals, they were at first rarely used as a resource. The availability of specialists to help GPs with neurotic disorders may be more cost effective than treating those disorders in general practice.

Krueger, M., & Drees, M. (1995) Generic teamwork: An alternative approach to residential treatment. Residential Treatment for Children & Youth, 12(3), 57-69.

The article focuses on an example of a social worker, teacher, and five youth care workers and the development of a "transdisciplinary" approach to residential treatment of children called Generic Teamwork. The team members were hired together, trained together and paid the same for the work. The goal was to have team members develop and implement treatment plans—with all members being a "generalist." The approach was effective in developing an interdisciplinary team. Advantages were: 1) the generalists thought it was a more efficient way of working together, 2) a general feeling of mutual respect developed, regardless of professional backgrounds, 3) it created a sense of structure that easily accommodated new clients and staff, 4) generalists were able to offer complete schedule of daily activities, so, for example, more time could be spent in social skills, counseling, group activities, etc. and 5) consumer surveys, self-concept and behavior assessments, and treatment plan evaluations showed gains occurred.

Lary, M. J., Lavigne, S. E., Muma, R. D., Jones, S. E., & Hoeft, H. J. (1997). Breaking down barriers: Multidisciplinary education model. Journal of Allied Health, 26(2), 63-69.

Describes the implementation of a pilot project involving students from three disciplines: dental hygiene, physical therapy, and physician assistant. The purpose was to prepare students to work together in multidiscipline teams utilizing concepts of problem-based learning (PBL) on both simulated and real patients. This model may provide a viable means to prepare interdisciplinary teams to work effectively together.

Lazarus, A. (1994). A proposal for psychiatric collaboration in managed care. American Journal of Psychotherapy, 48(4), 600-609.

Managed care has had a significant impact on the biopsychosocial model as seen through patient-psychiatrist relationships. Nonmedical therapists, primary-care physicians, and third- and fourth-party administrators have played an increasingly visible role in managed-care delivery systems and are now considered part of the treatment team. Several vignettes are presented to illustrate some of the difficulties encountered in this type of expanded arrangement. The needs of each part can best be served through a model that relies on collaboration rather than competition.

LeBaron, S., & Zeltzer, L. (1985). Pediatrics and psychology: A collaboration that works. Journal of Developmental and Behavioral Pediatrics, 6(3), 157-161.

This article describes differences and similarities in training and orientation between psychologists and pediatricians, three different models of collaboration, and the benefits of such collaboration. Many of the points on differences between MDs (pediatricians) and PhDs (psychologists) are relevant for medical-mental health collaboration involving other disciplines or subdisciplines. Both groups need to be aware of the differences in approach, thinking styles, language, use of time, etc., between MDs and PhDs. There is more of a common ground between pediatricians and pediatric psychologists than MD's in general. Pediatricians, as opposed to other specialists, are oriented not only to pathophysiology but also to normal growth and development, health maintenance, and prevention of illness. As with any collaborative relationship, problems resulting from differences between pediatricians and psychologists can usually be resolved or kept to a minimum with: mutual tolerance, flexibility, frequent communication, a willingness to improvise, a sense of humor, and a little luck.

Lichtenberg, P. A., Strzepek, D. M., & Zeiss, A. M. (1990). Bringing psychiatric aides into the treatment Team: An application of the Veterans Administration's ITTG Model. Gerontology and Geriatrics Education, 10(4), 63-73.

Although directly responsible for most of the patient care in long-term care facilities, the psychiatric aides are typically not a part of the service delivery treatment team. To combat the resulting poor morale and delivery of inadequate care delivered by the aides, the Veterans Administration ITTG Model was adopted in this study, during 12 weekly training sessions, in an attempt to increase aide involvement with the team. The aides trained with the ITTG scored significantly higher than a comparison group on a post-training test. Their attendance at team meetings also increased by 60%. The issue of furthering aides involvement in the treatment team, and future research directions are discussed.

Macbeth, G. (1993). Collaboration can be elusive: Virginia's experience in developing an interagency system of care. Administration and Policy in Mental Health, 20(4), 259-282.

States are attempting to improve services for children with mental health needs and their families by using interagency service approaches. This article chronicles two approaches used by Virginia to implement an interagency planned, funded, and managed state-wide system of community care. The conceptual base of each approach is examined and service data is used to illustrate their benefits and weaknesses. Article contains relevant information on getting agencies and various disciplines to work together.

Margolis, R. B., Duckro, P. N., & Merkel, W. T. (1992). Behavioral medicine: St. Louis style. Professional Psychology: Research and Practice, 23(4), 293-299.

Article describes a unique multidisciplinary division in which 8 clinical programs are all administered by psychologists working in a university medical center setting. Discusses issues such as organizational structure and professional roles.

Moulder, P. A., Staal, A. M., & Grant, M. (1988). Making the interdisciplinary team approach work. Rehabilitation Nursing, 13(6), 338-339.

Authors were disillusioned by the lack of communication and coordination in the interdisciplinary team approach and set about changing the approach. They identified the main trouble areas as (1) team leader's role not clearly defined, (2) frequent rotation of staff among teams (3) inadequate planning for patient care (4) ineffective communication and (5) role identification. Team members were individuals from psychiatry, nursing, physical therapy, occupational therapy, speech therapy, neuropsychology, social work, recreational therapy and dieticians. The article describes the methods by which the teams overcame the problems mentioned and became effective as a collaborative group.

Paavola, J. C., Carey, K., Cobb, C., Illback, R. J., & Joseph, Jr., H. M., routh, D. K., & torruella, A. (1996). Interdisciplinary school practice: Implications of the service integration movement for psychologists. Professional Psychology: Research and Practice, 27(1), 34-40.

Interdisciplinary teams are needed to meet and effectively treat the complex problems of families and children. We must work towards that goal. Although oriented towards school psychologists the article is applicable to all mental health professionals. Service integration provides comprehensive, responsive, flexible, coordinated, and collaborative services. The authors contend that increased coordination and collaboration will remove barriers. Clearly the greater the number of involved agencies, the greater the need for continual communication, collaboration, and coordination.

Perkins, A. L., Shaw, R. B., & Sutton, R. I. (1990). Summary: Human Service Teams. In J. R. Hackman (Ed.), Groups that work (and those that don't). Creating conditions for effective teamwork. San Francisco: Jossey Bass.

Authors note that the differences among human service teams discussed in the book are not nearly as striking as the similarities. Specifically, they note three endemic tensions across the teams: (1) struggling for control; (2) providing efficient versus high-quality service; and (3) balancing client needs and team member needs. This summary chapter describes these tensions and derives from them five questions whose answers may be useful in guiding the design and management of human service teams.

Peterson, D. W., & Lane, B. A. (1985). The role of interdisciplinary teams in the promotion of physical and mental health. Health Promotion in the Schools, 1(3), 113-124.

Delineates important issues to be considered in using special services professionals to develop and implement health promotion programs by means of a school-based interdisciplinary team approach. Discusses the current status of interdisciplinary teams and the advocates for the expanded role for such teams in health promotion activities. Reviews specific issues pertaining to interdisciplinary team organization and integration into school systems in the context of health promotion program development.

Qualls, S. H., & Czirr, R. (1988). Geriatric health teams: Classifying models of professional and team functioning. The Gerontologist, 28(3), 372-376.

The authors present arguments that many differences of opinion or behavior which arise in multidisciplinary settings can be understood as rationally arising from differences in models. Models for professional functioning include the four dimensions of logic of assessment, focus of efforts, locus of responsibility, and pace of action whereas models for team functioning include three dimensions of focus of attention, decision-making style, and beliefs about interprofessional dependence. Recognizing the differences in the models is important for working together effectively.

Roberts, K. T., Wright, J. C., Thibault, J. M., Stewart, A. V., & Knapp, K. R. (1994). Geriatrics partnerships in health care: The LIFE SPAN model. Educational Gerontology, 20, 115-128.

Health care professionals are expected to function as partners, but most health care professionals are not trained to work in teams or to develop organizational structures to support a team approach. The authors describe a successful interdisciplinary partnership program in geriatric health care called LIFE SPAN. Nine factors that contributed to its success are analyzed: common goals, right timing, leadership support, expertise, breadth of ideas, compatibility of organizational design, team building, persistence, and sufficient financial resources.

Seaburn, D., Lorenz, A., Gunn, W., Gawinski, B. & Mauksch, L. (1996). Models of collaboration. New York: Basic Books.

An excellent resource book for anyone wanting to know more about different types of collaborative models in the health care field.

Shaw, R. B. (1990). Mental health treatment teams. In J. R. Hackman (Ed.), Groups that work (and those that don't). Creating conditions for effective teamwork. (pp. 330-357). San Francisco: Jossey Bass.

Although based on experiences in mental health teams in a mental hospital, the author's observations and suggestions are relevant for other mental health treatment teams that involve interdisciplinary collaboration and working within institutional constraints. The author notes factors that inhibit effective teaming, how team structure or activities may conflict with the traditions within or between different fields, and sources of tension related to team work.

Solomon, R., & Mellor, M. J. (1992). Interdisciplinary geriatric education: The new kid on the block. Journal of Gerontological Social Work, 18(3-4), 175-186.

This article was written for social workers but is applicable to other mental health professions. Educators face the challenge of helping social workers in the field both to upgrade their gerontological knowledge and skills and to become functioning members of the emerging modality—the interdisciplinary care team. The article discusses the need for interdisciplinary teams and the barriers that must be overcome to develop effective interdisciplinary teams.

Sorrells-Jones, J. (1997). The challenge of making it real: Interdisciplinary practice in a "seamless" organization. Nursing Administration Quarterly, 21(2), 20-30.

The author describes a hospital which was reorganized from unidisciplinary units to interdisciplinary service centers in an effort to reorganize into a "boundaryless" organizational structure with more highly developed interdisciplinary clinical and administrative practice. In the reorganization, the direct care service providers worked in interdisciplinary teams of equals and collaborated by pooling knowledge in

an interdependent manner to develop/evaluate a plan of care for the patient. This model emphasized difference between multidisciplinary (team where members of different disciplines assess/treat patients independently, then share information with each other) and interdisciplinary (deeper level of collaboration; develop and evaluate a plan of care jointly, with professionals in different disciplines pooling knowledge in an interdependent manner. Barriers to collaboration were: 1) fear of downsizing because of the loss of the familiar, unidisciplinary "home" departments; 2) lack of understanding of how to work in teams of equals; 3) lack of knowledge about each other's fields; and, 4) limited ability/willingness to confront and handle conflict. Honest communication about one's lack of knowledge, etc. (above) led to much better team functioning and successes fed enthusiasm and personal investment/effort. However, eradicating unidisciplinary units is not without problems. The major problems can be overcome by electing a "lead person" from each discipline who convenes regular meetings of the staff of that discipline to maintain their own professional identity and practice and to deal with discipline-specific practice issues and standards.

2. Collaboration/Consultation models (as related to medical or primary care practice).

Berlin, R. M., & Wise, T. N. (1986). An introduction to consultation-liaison psychiatry. Family Systems Medicine, 4(1), 43-50.

The purpose of the article is to introduce the concept of consultation-liaison psychiatry and to suggest areas for collaboration between family therapists and consultation-liaison psychiatrists. The functions of consultation include diagnosis, advice on patient management, resolution of conflicts and teaching. Liaison model includes functioning as an integral part of the organizational structure of general hospitals or primary care clinics. C-L psychiatry emphasizes family issues to provide the most effective clinical care.

Biaggio, M. K., & Bittner, E. (1990). Psychology and optometry: Interaction and collaboration. American Psychologist, 45(12), 1313-1315.

Health care professionals have long emphasized the value of interdisciplinary collaboration. A unique collaboration is between psychology and optometry. A number of vision conditions have a psychological component and some psychological conditions may be complicated by vision difficulties. When both disciplines are involved, an integrated treatment approach is most effective. The authors conclude that better organized health care delivery is likely to result from interdisciplinary training and cooperation, as clients are likely to receive more efficient diagnosis, treatment, and management of health problems.

Bloom, J. D. (1996). Psychiatry: Three models in search of a future. Psychiatric Services, 47(4), 874-875.

Author proposes three models for future of psychiatry—public health psychiatry, clinical neuroscience, and primary care psychiatry. Psychiatrists can be effective consultants to primary care physicians and other medical and mental health providers. The last model will require more primary care medical training on the part of psychiatry.

Boccellari, A. (1998). Integrated primary care mental health. Unpublished manuscript.

Describes a proposed model of care (and recommendations for a pilot study) for an integrated Mental Health and Primary Care Consultation Program developed in conjunction with specialty mental health treatment provided by the Psychosocial Medicine Clinic and Community Mental Health Services. The

model is will be tried in San Francisco hospitals starting July, 1998. It consists of three levels of care and the mental health provider will be on-site at the clinics.

Browne, A., Carpenter, C., Cooledge, C., Drover, G., Ericksen, J., Fielding, D., Hill, D., Johnston, J., Segal, S., Silver, J., & Sweeney, V. (1995). Bridging the professions: An integrated and interdisciplinary approach to teaching health care ethics. Academic Medicine, 70(11), 1002-1005.

This article is specifically relevant for an interdisciplinary ethics course, but the authors also discuss the benefits of collaboration between students of different health care professions in a classroom-seminar setting, benefits which can translate to other interdisciplinary training efforts. The course trained students from schools of medicine, nursing, dentistry, dental hygiene, pharmaceutical sciences, rehabilitation sciences, audiology and speech sciences, social work, health care administration, laboratory science, and nutrition science. Apparently psychology and psychiatry were not among those represented. The students formed interdisciplinary groups to discuss ethical dilemmas in health care, posit a solution, and present it to the class at the next meeting. Participants indicated they profited from learning the guidelines of other professional groups.

Castro, R. M., & Julia, M. C. (1994). Interprofessional care and collaborative practice. Pacific Grove, CA: Brooks/Cole Publishers.

This text provides information about the strengths and limitations of collaborative practice. It is oriented towards a variety of professionals (e.g., teachers, clergy, social workers, physicians, nurses, psychologists, counselors, lawyers, and other human service professionals) who wish to become more effective interprofessional practitioners. It provides examples of interprofessional programs and an in-depth coverage of ethical issues viewed from a variety of professional perspectives.

Cowles, L. A. & Lefcowitz, M. J. (1992). Interdisciplinary expectations of the medical social worker in the hospital setting. Health and Social Work, 17(1), 57-65.

Questionnaire responses indicated that physicians and nurses expect social workers to work with families, resolving social –environmental issues whereas social workers have a broader expectation as to their role in a hospital setting. The conclusion is that other groups may not understand or accept the person-in-environment focus of social work. Social workers need to educate others about their roles and to accept a shared rather than dominant responsibility for many tasks.

Cummings, J. W. (1992). Psychologists in the medical-surgical setting: Some reflections. Professional Psychology: Research and Practice, 23(2), 76-79.

Author reflects on his years as a psychologist in a medical setting. He saw two approaches to the provision of psychological services to medical surgical patients—the "visitor" model and the "on site" model; the latter being far more effective than the former. A psychologist functioning on site had much more useful awareness of the situational factors that were contributing to the patient's illness.

Denelsky, G. Y. (1996). Collaborative practice: Psychologists and internists. In R. J. Resnick & R. H. Rozensky (Eds.), Health psychology through the lifespan: Practice and Research opportunities (pp. 101-107). Washington, DC: American Psychological Association.

The author discusses some factors that contribute to smooth, harmonious working relationships between psychologists and internists. Topics discussed include communication, the referral process, the ongoing relationship, and the benefits of collaboration. Collaboration benefits the patient both physically and psychologically.

Drotar, D. (1983). Transacting with physicians: Fact and fiction. Journal of Pediatric Psychology, 8(2), 117-127.

Experiences with physician and psychologist collaboration underscore the necessity to construe interprofessional exchanges in terms of benefits to individual professions as well as to children and families. Changes in the models that govern clinical practice have led to changes in the nature of professional roles. Because of changes in the health care profession (e.g., expanding technology and cost accountability) psychologists will benefit most if they assume leadership roles, particularly in developing systematic outcome studies in pediatric psychosocial problems. Research which furthers the implementation of psychological knowledge in medical settings is important. We must develop realistic models of collaboration with physicians. Problems to over come are the inevitable tensions between the professions arising out of different cultures, backgrounds and values. Advantages of collaboration are seen in the benefits to consumers of services. Although the article is focused towards collaboration in the areas of pediatrics, it is relevant for other medical disciplines as well. The discussion of issues involved in mental health-primary care collaboration (e.g., culture differences) is particularly relevant.

Engel, G. L. (1992). The need for a new medical model: A challenge for biomedicine. Family Systems Medicine, 10, 317-331.

Does not cover interdisciplinary training, but a "classic" article, with good background information (e.g., for other disciplines to read) on the medical model. Describes other models used in psychiatry and general medicine. This article is cited a lot in the primary care and interdisciplinary literature.

Falvey, J. E. (1992). From intake to intervention: Interdisciplinary perspectives on mental health treatment planning. Journal of Mental Health Counseling, 14(4), 471-489.

The article reviews the development of standardized case simulations and treatment planning criteria by two nationwide panels of interdisciplinary mental health experts. These simulations show promise as performance-based assessment of clinical judgment across profession, theoretical orientation, and other therapist variables. The application of these case simulations for training and credentialing of professionals is discussed.

Glen, M. L., Atkins, L., & Singer, R. (1984). Integrating a family therapist into a family medical practice. Family Systems Medicine, 2(2), 137-145.

This paper reports the initial experiences of the authors in integrating a family therapist into a low income family medical practice. Several researchers have shown that illness is a phenomenon which involves the entire family system. Also, many have demonstrated the advantages of integrating psychotherapists into a medical practice. The authors further illustrate this point. In their experience, communication problems were frequent with "different terms or descriptions used by the physician and therapist, different in theoretical models (e.g. biosocial versus systemic family interventions), and differences in expectations. Unless both parties are committed to collaboration, the effort may not be worth it. However, when both are committed to collaboration, have respect for the other, and learn the differences between themselves, the process can be rewarding for the patient and the professionals.

Goldberg, R. J., Tull, R., Sullivan, N., Wallace, S., & Wool, M. (1984). Defining discipline roles in consultation psychiatry: The multidisciplinary team approach to psychosocial oncology. General Hospital Psychiatry, 6, 17-23.

Attempts to define the unique contributions of psychiatry, social work, nursing, and psychology in relation to an oncology consultation program in a general hospital setting. The definitions of each discipline's contributions are proposed as a model that can be generalized to other consultation programs. Knowledge of the unique contributions of each team member and interdisciplinary training is important and barriers to collaboration include confusion about the potential contribution of different professions, lack of clarity about what to expect, lack of role definition and inability to speak the language of the others (especially biomedical and psychological disciplines). Traditional administrative boundaries to collaboration need to be removed.

Gonzales, J. J., & Randel, L. (1996). Consultation-liaison psychiatry in the managed care arena. The Psychiatric Clinics of North America, 19, 449-466.

Although the major focus of the article concerns psychiatry and managed care, the authors describe how shared responsibility and team functioning between primary care MDs and psychiatrists led to better outcomes for patients with major depression. Since psychiatry has a long history of relationships with primary care, the authors suggest pursuing a more formal liaison with primary care clinics as a role for psychiatry.

Hansen-Grant, S., & Riba, M. B. (1995). Contact between psychotherapists and psychiatric residents who provide medication backup. Psychiatric Services, 46, 774-777.

This article is relevant for any multi-disciplinary "team" or people seeing the same patient (e.g., consultations between any group of professionals). The article describes how psychiatric residents frequently prescribe medication for patients who are in psychotherapy with another clinician. The study examined the extent and characteristics of communication between psychiatric residents and psychotherapists who treated patients in a university outpatient clinic. The authors concluded that several steps are necessary to optimize communication between treating clinicians and documentation of such communication. They include initial contact to discuss the treatment contract and clarify each clinician's responsibilities, formal written consent from the patient, regular contact between clinicians to discuss the patient's progress, and collaboration between clinicians on the patient's treatment plan.

Holzman, P. S. (1985). The fences of psychiatry. American Journal of Psychiatry, 142(2), 217-218.

Notes that progress in treatment of mental disorders is facilitated by dismantling the walls and fences that separate the disciplines, barriers which represent a disciplinary chauvinism. Notes that formidable fences still separate psychiatry from the behavioral sciences. Psychiatry needs to recognize the emergence of cognitive psychological science and to provide for innovative institutional structures that will encourage the interaction of these disciplines and psychiatry.

Houghton, M. A. (1995). Economic grand rounds: Psychiatric kibitzing. Psychiatric Services, 46, 764-765.

Discusses psychiatric consultation with attention to both sides—as the consultant, and as the physician receiving the consultation. Limited utility for planning training of health care professionals , but a good utility for educating mental health professionals about consultation with other medical or mental health professionals.

Kahn, Jr., N. B., Davis, A. K., Wartman, S. A., Wilson, M. E. H., & Kahn, R. H. (1995). The interdisciplinary generalist curriculum project: A national medical school demonstration project. Academic Medicine, 70(Suppl 1), 75-80.

Describes interdisciplinary leadership in a project to get medical students into generalist roles instead of specialist. The three generalist roles: family physician, internists, and general pediatricians. Members of these three subdisciplines worked together to organize the project. No psychology-related material.

Katon, W., Von Korff, M., Lin, E., Simon, G., Walker, E., Bush, T., & Ludman, E. (1997). Collaborative management to achieve depression treatment guidelines. Journal of Clinical Psychiatry, 58 (Suppl. 1), 20-23.

The article describes two models that integrate the psychiatrist into treatment of depression in primary care and the evaluation of the models. In the psychiatrist/primary care model, a psychiatrist alternated visits with a primary care physician. In the psychiatrist/psychologist model, the psychiatrists worked with a team of psychologists. When compared to the primary care physician alone model of treatment, both collaborative models were associated with improved adherence to treatment, increased patient satisfaction with care, and an improved outcome. The success of these models indicates that collaboration with primary care physicians in the care of depressed patients is effective.

Kriesel, H. T., & Rosenthal, D. M. (1986).The family therapist and the family physician: A cooperative model. Family Medicine, 18(4), 197-200.

The author discusses the problems involved in collaboration between family therapists and physicians and proposes a model to enable the professions to work cooperatively. A framework to assist the physician and therapist in working with the patient is provided. If both professions share a common belief that the family is the focus of care the cooperative model proposed can be effective in providing care for patients and their families.

LeBaron, S., & Zeltzer, L. (1985). Pediatrics and psychology: A collaboration that works. Journal of Developmental and Behavioral Pediatrics, 6(3), 157-161.

This article describes differences and similarities in training and orientation between psychologists and pediatricians, three different models of collaboration, and the benefits of such collaboration. Many of the points on differences between MDs (pediatricians) and PhDs (psychologists) are relevant for medical-mental health collaboration involving other disciplines or subdisciplines. Professions need awareness of the differences in the approaches, thinking styles, language, use of time, etc., between MDs and PhDs. There is more of a common ground between pediatricians and pediatric PhDs in that these MDs, as opposed to other specialists, are oriented not only to pathophysiology but also to normal growth and development, health maintenance, and prevention of illness. "As with any collaborative relationship, problems resulting from differences between pediatricians and psychologists can usually be resolved or kept to a minimum with: mutual tolerance, flexibility, frequent communication, a willingness to improvise, a sense of humor, and a little luck."

Levy, S., Pollak, J., & Walsh. (1994). Primary care psychology: Current status and future prospects. Annals of Behavioral Science and Medical Education, 1, 43-48.

Psychologists who work in primary care should be generalists, who are able to serve a number of functions. Training should be broadly based and expose the student to a number of different clinical experiences. Unlike others in the field they do not recommend a specialty track at the predoctoral level.

Additional training at the postdoctoral level may be necessary for psychologists working at the level of primary health care. The major emphasis of this article is the generalist training needed by psychologists.

McDaniel, S. H. (1995). Collaboration between psychologists and family physicians: Implementing the biopsychosocial model. Professional Psychology: Research and Practice, 26(2), 117-122.

Although less specific than some other articles on training, this is a good article on issues in collaboration, barriers, and how to overcome them. Would be very useful in training in an interdisciplinary setting for any health care professional. McDaniel's view is that patients need physicians and psychologists to interact with each other. It allows for more comprehensive care and fewer errors in treatment. The skills needed bear some similarity to skills in interpersonal therapy: good communication, understanding of the other's worldview, development of a personal relationship, a common language, shared goals, and a contract to work together. Working with physicians requires that psychologists develop the ability to communicate clearly, succinctly, and effectively about complex patient problems. Psychologists must negotiate the boundaries of confidentiality with the patient to communicate with the team what is necessary for good health care and at the same time protect the patient's right to confidential psychological treatment. This means distinguishing between privacy, to which the patient has every right, and secrecy, which may indicate interpersonal dysfunction as much in need of treatment as any other psychological problem. Differences in training, theoretical paradigms, and working styles, among other factors, can interfere with communication and accessibility, which are the two major problem areas in collaboration (e.g., both physicians and therapists complain that the other is inaccessible and will not communicate). This may be partly due to the differences in working styles mentioned above.

McDaniel, S. H., & Campbell, T. L. (1986). Physicians and family therapists: The risk of collaboration. Family Systems Medicine, 4(1), 4-8.

Presented in the format: "What I hate most about working with (physicians or family therapists) by a physician and family therapist," the authors articulate the differences in communication and accessibility as viewed from the role of a physician and the role of a therapist.

McDaniel, S. H., & Campbell, T. L., Seaburn, D. B. (1990). Family-oriented primary care: A manual for medical providers. New York: Springer-Verlag.

A book oriented toward medical providers that describes family-oriented primary care. The authors use the principles in the book in their training programs for medical residents and psychology interns. The use of other mental health professionals as collaborators is discussed.

McDaniel, S. H., & Campbell, T. L., Seaburn, D. B. (1995). Principles for collaboration between health and mental health providers in primary care. Family Systems Medicine, 13, 283-298.

This article is based on a presentation at the first annual Collaborative Family Health Care Coalition in 1995. A brief background of changes in the health care system is presented and the authors make the case for making primary care primary in the current system. In primary care settings, mental health symptoms usually present in the context of physical symptoms (e.g. depression as fatigue, loss of appetite, etc.) and the patients are often more resistant to "psychological" interpretations and treatment. The authors discuss what they view as the important principles for collaboration.

McDaniel, S. H., Hepworth, J., & Doherty, W. J. (1992). Medical family therapy: A biopsychosocial approach for families with health problems. New York: Basic Books.

An excellent book describing the biopsychosocial approach to treatment of health related problems. Focus is on all aspects of the individual and is oriented towards working with families instead of the individual patient. A good textbook for a variety of health care professionals.

Moffic, H. S., Brochstein, J., Blattstein, A., & Adams, G. L. (1983). Attitudes in the provision of public sector health and mental health care. Social Work in Health Care, 8(4), 17-28.

Describes one often overlooked factor in the development of comprehensive health and mental health services, that of the attitudes of the health care providers. In an attempt to address this and related issues, the Houston Consortium was designed as a prototype training model. As part of that endeavor, the attitudes of mental health trainees toward the poor, interdisciplinary interaction, and community mental health were assessed. While the ethnic identity of the students had some influence, the major findings concerned the discipline of the students. Social work students, in particular, seemed to possess or be able to develop attitudes relevant to a prominent role in primary health care (as compared to psychiatric residents).

Moye, J., & Brown, E. (1995). Postdoctoral training in geropsychology: Guidelines for formal programs and continuing education. Professional Psychology: Research and Practice, 26(6), 591-597.

Only brief discussions noting that a multidisciplinary approach is optimal or necessary in health care for the elderly. Describes some of the goals and skills needed by the clinicians (e.g., broad range of skills within the area of geropsychology).

National Joint Committee on Learning Disabilities. (1987). Learning Disabilities: Issues in the preparation of professional personnel. Journal of Learning Disabilities, 20(4), 229-231.

Suggests that interdisciplinary training is needed because of: (1) diminished financial resources for education and training; (2), variability in pre-professional learning disabilities programs; (3) the heterogeneous nature of learning disabilities; and (4) the different manifestations and consequences of LD. Although some of the recommendations given (e.g., practicum areas) are specific to learning disabilities, the issues presented are relevant to some degree for other pre-professional preparation programs in mental health.

Netting, F. E., & Williams, F. G. (1996). Case manager-physician collaboration: Implications for professional identity, roles, and relationships. Health and Social Work, 21(3), 216-224.

Article reports the results of a study of the professional identities, roles, and relationships of case managers in nine demonstration sites around the United States. Presents implications for health care social workers, educators, and community-based providers and stresses the need for collaboration with primary care physicians.

Nicholas, D. R., Gerstein, L. H., & Keller, K. E. (1988). Behavioral medicine and the mental health counselor: Roles and interdisciplinary collaboration. Journal of Mental Health Counseling, 10(2), 79-94.

The authors discuss roles of various mental health professionals employed in behavioral medicine settings, as well as ethical dilemmas and issues related to interdisciplinary collaboration. The authors

focus on the training of mental health counselors and recommend required coursework, etc. Much of what they recommend is applicable to any mental health discipline.

Nickels, M. W., & McIntyre, J. S. (1996). A model for psychiatric services in primary care settings. Psychiatric Services, 47(5), 522-526.

Authors describe a program that provides mental health care at 12 locations in a network of primary care sites. The goal is of program is to improve the recognition, diagnosis and treatment of mental health problems and to educate the primary care providers about these issues. The integration of mental health care and primary medical care enhances the treatment outcomes and improves the overall cost-effectiveness of care. The authors discuss the advantages and disadvantages of the program and the plans for it's future.

Okasha, A. (1997). The future of medical education and teaching: A psychiatric perspective. American Journal of Psychiatry, 154(6), 77-85.

Notes that medical students need to learn to interact constructively as part of a health care team, where the physician isn't the leader. Community based needs assessment leads to more awareness of needs for multiprofessional teamwork. Team learning enhances professional socialization and more respect for colleagues and the community.

Paradis, C. M., Smith, L., Ackerman, R., Viswanathan, R., & Von Oiste, G. (1997). Integrating behavioral treatment in cardiac care: A case report. The Behavior Therapist, 20, 134-135.

Article focused on the integration of behavioral treatment to facilitate medical treatment (e.g., reduce fear of medical procedures) in a collaborative relationship between physicians, consultation/liaison psychiatrists, health psychologists, and social workers. The team approach in working with patients with fears of medical procedures is important. Cognitive-behavioral-oriented psychotherapists can collaborate with medical staff to facilitate treatment of avoidant patients.

Rodrigue, J. R., Hoffmann, R. G., Rayfield, A., Lescano, C., Kubar, W., Streisand, R., & Banko, C. G. (1995). Evaluating pediatric psychology consultation service in a medical setting: An example. Journal of Clinical Psychology in Medical Settings, 2(1), 89-107.

This article is an evaluation of the types of referrals to pediatric psychology services and the level of satisfaction with the services rendered. Over half of the referrals came from general pediatrics, pediatric neurology, and surgical services, and approximately 70% of the services were rendered on an outpatient basis. Most frequent referrals were for behavior problems and a cognitive (IQ) or neuropsychological evaluation. Evaluations of the services by the medical staff were positive and they indicated a strong likelihood of requesting future psychological services. Implications and limitations of the study were discussed.

Sargent, J. (1985). Physician-family therapist collaboration: children with medical problems. Family Systems Medicine, 3(4), 454-465.

The author presents a model of physician-family therapist collaboration in the context of treating a child and his or her family in cases of chronic illness, physical disability or unexplained physical symptoms in the child. Various approaches to deal with resistant families, distances between the collaborators, etc. are discussed. A useful article for illustrating some of the problems involved in a practice context and possible solutions.

Schroeder, C. S. (1996). Psychologists and pediatricians in collaborative practice. In R. J. Resnick & R. H. Rozensky (Eds.), Health Psychology through the life span: Practice and research opportunities (pp. 109-131). Washington, DC: American Psychological Association.

Pediatricians are likely to be the first professional to encounter a child's behavior problems. Estimates are that about 20% of pediatric patients present with serious behavior problems. Thus there is a need for collaboration between pediatricians and clinical psychologists. The author describes a pediatric practice in Chapel Hill (8 MDs) that involves mental health professionals in their practice. Services are routinely evaluated and the satisfaction rate is high. The collaborative practice is described and recommendations for setting up similar practices are given.

Schubert, D. S. P., Billowitz, A., Gabinet, L., & Friedson, W. (1989). Effect of liaison psychiatry on attitudes toward psychiatry, rate of consultation, and psychosocial documentation. General Hospital Psychiatry, 11, 77-87.

The authors reported on a study comparing the attitudes toward psychiatry on wards that had psychiatric liaisons with wards that did not. Prior research suggested that such liaisons would increase referrals as well as satisfaction with psychiatry. The present study replicated those findings but did not find an increase in psychosocial documentation in the charts. They suggested the psychiatric liaison might be more effective if the senior medical faculty were actively involved and if the interventions [by psychiatrists] were more direct and active.

Schuster, J. M., Kern, E. E., Kane, V., & Nettleman, L. (1994). Changing roles of mental health clinicians in multidisciplinary teams. Hospital and Community Psychiatry, 45(12), 1187-1189.

Describes how psychiatrists must focus on their unique skills and abilities while collaborating with non-physician providers. Has some relevance for both understanding psychiatric viewpoint as well as informing strategies for psychology collaboration in multidisciplinary teams.

Seaburn, D., Lorenz, A., Gunn, W., Gawinski, B. & Mauksch, L. (1996). Models of collaboration. New York: Basic Books.

A useful book for anyone interested in different models of collaboration, particularly in the health care field.

Sheppard, M. (1992). Contact and collaboration with general practitioners: A comparison of social workers and community psychiatric nurses. British Journal of Social Work, 22(4), 419-436.

Although this article is focused on contact and collaboration between health and welfare professionals, their results are informative for the collaboration of other non-medical professionals with MDs and for social workers and community psychiatric nurses (CPNs) working with other health or mental health professionals (e.g., CPNs were far more likely to contact GPs than social workers, although GPs very rarely initiated contact themselves. These and other differences reflected different "philosophies of contact," a factor which training for interprofessional collaboration should not ignore, as well as differences in occupational culture or role expectations.

Sobsey, R. J., & Orelove, F. P. (1983). Conducting transdisciplinary research with severely handicapped individuals. Education and Treatment of Children, 6(3), 311-321.

The article proposes that the field of educating severely handicapped persons can benefit by an increased emphasis in transdisciplinary research. Ten guidelines are presented that relate to the establishment and conduct of a transdisciplinary research team. Emphasis is placed on fostering planning and cooperation among the team members. Specific recommendations are provided for facilitating communication and breaking down disciplinary barriers among research team members. The coordinator's role in enhancing efficient, cooperative efforts is discussed as a critical element in each step from reviewing the literature through the dissemination of findings. The recommendations provided are applicable to mental health disciplines and applicable to clinical services as well as research.

Walsh, P. L., Garbs, C. A., Goodwin, M., & Wolff, E. M. (1995). An impact evaluation of a VA geriatric team development program. Gerontology and Geriatrics Education, 14(3), 19-35.

Describes the results of using a variety of evaluation methods (qualitative and quantitative) to measure the long-term outcomes of a four-year series of workshops designed to teach VA employees of various disciplines the value of teamwork and consultation in caring for geriatric veterans. Presents implications of this impact evaluation that may be useful to education program planners and evaluators.

Wellner, A. M. (1990). Some thoughts on the future of the professional practice of psychology. Professional Psychology: Research and Practice, 21(2), 141-143.

Discusses how societal and marketplace changes, and psychology's unique contribution in bridging science and practice. Although the article does not provide details on interdisciplinary training, it often cited in health-mental health collaboration papers.

B. Education/Training for Collaborative Care

1. Primary care and/or primary care settings

Antonovsky, A. (1992). The behavioral sciences and academic family medicine: An alternative view. Family Systems Medicine, 10, 283-291.

The author reviews the contribution a behavioral scientist can make in patient care. Behavioral scientists in academic family health settings are needed because of immense potential contribution of behavioral science to family physician concerning psychological processes. According to the author, family medicine students emerge from their training sadly unprepared for collaborative relationships with behavioral science. The full integration of behavioral science with family medicine is contingent upon the admission that the biomedical paradigm has failed. Behavioral scientists with a major commitment to clinical medicine have more to offer to academic family medicine than communication skills, compassion, and an understanding of psychopathology. Namely, they offer a full-blown, rich version of the psychosocial components of the biopsychosocial model.

Armstrong, P., Fischetti, L. R., Romano, S. E., Vogel, S. E., & Zoppi, K. (1992). Position paper on the role of behavioral science faculty in family medicine. Family Systems Medicine, 10, 257-263.

This article reviews collaboration between behavioral science practitioners (e.g., psychologists) and physicians in the context of an academic training setting for family physicians. Points made in the article are relevant for collaboration between mental health and medical practitioners in other settings as well. To work effectively with medical colleagues, behavioral science faculty must be able to work as a team member, be flexible, and occasionally promote behavioral science assertively. Most family physicians need additional graduate training in the social and behavioral sciences to assume a leadership role in behavioral science arenas. Barriers to collaboration are differences in perceptions of responsibility between the behavioral scientists and family physicians for behavioral science teaching and care of patients' behavioral/psychosocial needs; the lack of clear guidelines on specific competencies needed for effective functioning in this role for the behavior scientist. These barriers can be overcome by tolerance of differing "cultures" between the disciplines, efforts to avoid personalizing inevitable conflicts, commitment to resolve these problems, and an atmosphere of mutual respect are all essential ingredients!

Belar, C. D. (1989). Opportunities for psychologists in health maintenance organizations: Implications for graduate education and training. Professional Psychology: Research and Practice, 20(6), 390-394.

Belar focuses on the current roles and functions for psychologists in HMOs, particularly in the areas of teaching, research, and clinical service. She discusses the implications of these roles for graduate education and training of psychologists. Current models are discussed with respect to their strengths and weaknesses with respect to program content, role models, and the socialization process.

Belar, C. D. (1998). Graduate education in clinical psychology: "We're not in Kansas anymore". American Psychologist, 53, 456-464.

This article highlights the changes in the medical care system and the implications for psychology, particularly with respect to training. One trend is the focus on accountability in accreditation standards and the new accrediting of post-doctoral training programs. The author discusses changes in technology, the academy, the marketplace and the supply and demand issues for psychology. Dr. Belar concludes that psychology has always been a caring profession and that because we are trained in the use of scientific methods, we too, like Dorothy, can find our way home.

Belar, C. D., & Deardorff, W.W. (1995). Clinical health psychology in medical settings. Washington, DC: American Psychological Association.

The book describes the field of clinical health psychology, the education and training necessary, the personal and professional issues related to the field of health psychology and ethical issues encountered. The authors also describe assessment and intervention strategies, and future issues for psychology in the health care field.

Bergan, J. (1995). Behavioral training and the new mental health: Are we learning what we need to know? The Behavior Therapist, 18, 161-164

The author talks about the changes in the health care profession and the fact that behavioral training programs have been slow to adapt to the changes needed. A careful examination of our curriculum is important—otherwise we may face many gaps between what we are training for and what is needed by the marketplace.

Brantley, P. J., & Applegate, B. W. (1998). Training behavior therapists for primary care. The Behavior Therapist, 21(4), 74-76.

In order for psychologists to function successfully in medical settings in general, and in primary health care settings specifically, they must be equipped with the knowledge and skills necessary to make them a valuable member of the primary care team. The article reviews some of the recommendations for the content of training, but they note that the degree to which psychology can integrate into the primary care market depends on the ability of the training programs to train graduate students with the requisite skills. This article highlights a clinical training program at Louisiana State University designed to train psychologists to work in primary health care settings. The program is described in terms of how it addresses the training needs of graduate students preparing for careers in primary care medical settings.

Bray, J. H., & Rogers, J. C. (1995). Linking psychologists and family physicians for collaborative practice. Professional Psychology: Research and Practice, 26(2), 132-138.

This article describes a training program intended to facilitate collaborative linkages between rural family physicians and psychologists. The goals of the program were to: a) facilitate linkages between rural family physicians and psychologists; b) educate psychologists and family physicians regarding the treatment of alcohol and drug abuse and a model of collaborative practice; c) increase knowledge base of providers on substance abuse (e.g., identification) and d) enhance treatment options for patients with drug or alcohol problems. The training program is described in detail on pages 134-135. Training programs should provide more information about psychologists' training and their approaches to patient evaluation and treatment, and more information about different mental health professionals and what these professionals can and cannot offer. Barriers to collaboration include: 1) differences in theoretical orientation, 2) lack of a common language, 3) different practice styles, 4) lack of accessibility to the different providers, and 5) varying expectations for assessment and treatment. Based on observations of these barriers, the authors recommend that we develop a set of principles or guidelines for training and fostering collaborative relationships—include these in the training sessions, negotiate language barriers, clarify theoretical models, acknowledge the differences about maintaining confidentiality, recognize the different time constraints, and note the possibility of competition for areas of practice.

Brochstein, J. R., Adams, G. L., Tristan, M. P., & Cheney, C. C. (1979). Social work and primary health care: An integrative approach. Social Work in Health Care, 5(1), 71-81.

An interinstitutional, interagency Consortium has been formed in Houston to develop an innovative service model and provide interdisciplinary primary care/mental health training. The Houston Consortium Program integrates mental health professionals and trainees into the primary care framework of a neighborhood center serving a low income, predominantly Mexican-American population…. The social workers' full participation as members of primary care teams builds upon their traditional training to provide them the experience and skills required to function effectively in the expanded coordinative capacity of health/mental health manager…[Abstract]. Authors note even back then that the splitting up of medical care into specialties has caused problems and draws attention to the need to address the problem in primary care medicine, which has been defined as entailing the individual physician or primary care team providing "first contact" care. The program's trainees include graduate social work, psychiatric nursing and clinical psychology students; residents in psychiatry, pediatrics, internal medicine and the prototype primary care; and medical students. It appears that a number of their strategies and comments are still relevant today for the integration of mental health and primary care.

Cone, J. D., Alexander, K., Lichtszajn, J. L., & Mason, R. L. (1996). Reengineering clinical training curricula to meet challenges beyond the year 2000. The Behavior Therapist, 19, 65-70.

The authors believe that health care reform is likely to engender a "paradigm overhaul" in both the structure and content of behavioral training programs. We need to make changes to prepare our graduates for the changes. They provide a model for programs to make needed changes and ways to organize the training activities. This model also can be used for continuing education activities after the degree is obtained.

Drotar, D. (1992). Influences on collaborative activities among psychologists and pediatricians: Implications for practice, training, and research. Journal of Pediatric Psychology, 18(2), 159-172.

This article is included here (and in the interdisciplinary section) because pediatricians often are considered as primary care physicians. The author addresses the need for a comprehensive framework that describes the broad range of professional interactions between psychologists and pediatricians, presents a generic model of influences or collaboration and proposes specific implications for training, practice and research. To enhance collaboration, interventions should promote positive beliefs and expectations among colleagues concerning interdisciplinary work, facilitate specific skills related to cooperative research and management of clinical problems, and develop new practice settings. Author suggests that it requires ingenuity and persistence to overcome the inherent barriers to collaborative work, but the rewards are worth the effort.

Dym, B., & Berman, S. (1986). The primary health care team: Family physician and family therapist in joint practice. Family Systems Medicine, 4(1), 9-21.

The authors provide a good review of several models of MD-PhD collaboration and proposes an experimental model, one which has a high level of joint interaction. The authors acknowledge how this level may be modified as we learn more about how to effectively collaborate. The model provides a focus on training family physicians to be more systems-oriented and training family therapists to be more health-oriented. There is a spectrum of collaborative models, each with its own implicit assumptions, from mind/body dualism to integration of body and mind. Models which are most wedded to the dualistic view focus on biological events first and other data later, and tend to be more wedded to a professional hierarchy of primary physician assisted by auxiliary professionals. Article proposed an experimental model: a primary care partnership—family physician as primary medical care provider and family therapist as primary care therapist. The MD and family therapist working together in the same office. It affords a "stereoscopic view" of the family and invites the practitioners to "think holistically about the symptom and the family dynamics that shape and interpret it" (p. 15-16). For effective collaboration we need flexibility and willingness to challenge many old habits and assumptions. The therapist must learn to (1) work in brief, variable periods of time, (2) be responsible for referring to therapeutic specialists (e.g., for intensive individual or family therapy, or for inpatient treatment for addictions or for parent or support groups), (3) educate patients about these services, and monitor their progress (as a primary care MD does in relation to a cardiologist, orthopedist, etc.) Barriers to collaboration are: 1) hierarchical issues, with MD ascendant; 2) differences in language and working assumptions (e.g., for the MD, disease is the central focus, rather than looking at the symptom/problem along with contextual factors, typically the goal of the Ph.D.; and, 3) economics—physicians are reimbursed for procedures while therapists are reimbursed for professional time-the current economic realities almost preclude the idea of joint practice. These barriers can be overcome through: 1) moving toward mutual problem solving and collaboration (requires open minds and patience); 2) joint practitioners coining their own language, with patience, persistence, and mutual respect; and considering alternate sources of funding to further test this model in order to document its utility (e.g., grants, HMO). The distinct advantages of same-office collaboration are: 1) lowered threshold for psychotherapy; 2) earlier introduction of psychotherapy; 3)

better continuity of care; 4) greater efficiency; 5) better use of time and improved follow-up; 6) decreased resistance to referral; and 7) decreased unnecessary utilization of health care facilities.

Elliott, T. R., & Klapow, J. C. (1997). Training psychologists for a future in evolving health care delivery systems: Building a better Boulder model. Journal of Clinical Psychology in Medical Settings, 4(2), 255-267.

The changes in the demand for and reimbursement of psychological services and expertise in health care delivery systems have radical implications for the preparation of psychologists at the predoctoral, internship, and postdoctoral levels. The authors review some of the limitations and unfortunate consequences of traditional training programs that have confined research and practice to the realm of "mental health," propose that future psychologists be trained from a broader perspective as "behavioral scientists," prepared to operate at the highest levels of health care delivery systems, and discuss specific recommendations for training and education. Specifically, "doctoral students must be prepared to develop, implement, and assess programs applicable to a wide variety of symptoms common to the primary care setting," (p. 261).

Halleck, S. L. (1996). A different kind of education for psychiatric residents. Psychiatric Quarterly, 67(2), 95-110.

Discusses the issues confronting psychiatric residency training programs, including unclear roles/expectations/job opportunities for graduates, cost cutting, and managed care. Discusses some of the proposed changes to psychiatric education and presents his own, somewhat different solution. Discusses some of the basic assumptions of psychiatric training, and delineates the activities of the psychiatric student over the years of training (with the most radical changes occurring in the fourth year curriculum). Some of the ideas sound like they're swinging more towards what psychology graduate trainees are already doing.

Heinemann, G. D., Zeiss, A. M., Waite, M. S., Tsukuda, R. A., & Brown, G. F. (1998) Teamwork in primary care: Education as a crucial element. Unpublished Manuscript.

Discusses the integral role of education for effective teamwork in primary care and outlines the role of the new primary care teams in the VA system. The authors distinguish between multi- and interdisciplinary teams and emphasize the need for education and attention to process goals if a team is to function at the more sophisticated, interdisciplinary level. Presents numerous formats for team development and education as well as the circumstances when each is appropriate for use. Discusses the elements necessary for educational programming to be effective, five domains of curriculum content, and primary care learning objectives for each domain. Recommendations draw heavily on the philosophy of the VA's Interdisciplinary Team Training Program (ITTP), a clinically based educational program for health professionals and student trainees.

Hepworth, J., Gavazzi, S. M., Adlin, M. S. & Miller, W. L. (1988). Training for collaboration: Internships for family-therapy students in a medical setting. Family Systems Medicine, 6(1), 69-79.

The authors describe their involvement in training interns in a family-medicine training program. Advantages and disadvantages of working in such a collaborative arrangement are discussed. Perspectives are presented from the point of view of a psychology intern, a psychologist supervisor, a family-medicine resident, and a physician.

Hess, H. (1985). Social work clinical practice in family medicine centers: The need for a practice model. Journal of Social Work Education, 21(1), 56-65.

Reports the findings of study of social work in family medicine residency training in eight southeastern states. Findings indicate that the practice of social work is firmly entrenched and expanding in this primary health care setting. Discusses problems in meeting the imperatives of social work in family medical settings (service to clients and education of medical residents), and suggests that social work clinical practice in primary health care settings is inadequately conceptualized and needs a preferred practice model. Curriculum changes to prepare social workers for teaching of medical residents and coordinating health care services are needed.

Ludwigsen, K. R., & Albright, D. G. (1994). Training psychologists for hospital practice: A proposal. Professional Psychology: Research and Practice, 25(3), 241-246.

Hospital practice has become increasingly important for psychologists over the past decade, but these opportunities for practice require training for competency. The authors propose developing a comprehensive, systematic, and flexible program of training for hospital practice in psychology including graduate course work, supervised practicum experience, and opportunities for retraining. Includes recommendations for certification in hospital practice, credentialing and privileging, and continuing education.

McDaniel, S. H., & Campbell, T. L. (1997). Editorial: Training health professionals to collaborate. Families, Systems & Health, 15(4), 353-359.

Based on a presentation by S. H. McDaniel about the training believed to be important for Collaborative Family Health care. Very relevant, covers topics such as training needs within one's discipline (e.g., core skills) and across disciplines, as well as conceptual skills, principles of care, and interpersonal skills.

Orley, J. (1997). WHO produces behavioral science modules series for school instruction. Psychology International, 8(1), Winter, 1, 4.

Modules published to date are: Preparing Patients for Invasive Medical and Surgical Procedures; Communicating Bad News; Introducing Parents to their Abnormal Baby; Promoting Nonpharmacologic Interventions to Treat Elevated Blood Pressure; Psychological Interventions for Patients with Chronic Back Pain; Self-Management of Recurrent Headache; Improving Adherence Behavior with Treatment Regimens; Insomnia: Behavioral and Cognitive Interventions. The modules demonstrate how behavior influences health, review evidence that behavior can changed and that healthcare workers can learn skills to influence their patient's health and their health care. To get copies of the modules contact:

John Orley, M.D. , Division of Mental Health and Prevention of Substance Abuse, World Health Organization, 1211Geneva 27, Switzerland. FAX 41 22 7914160; Orleyj@who.ch

The World Health Organization is reported to be using aspects of the model to develop international primary care physician training curricula. The model also is being evaluated at The University of Alabama Medical School in their primary care clinic—they will evaluate the model with an insurance payer case mix (fee-for-service, managed care, Medicare) and will include cost-related outcomes. No report of their results is available at this time.

Oxman, T. E. (1996). Geriatric psychiatry at the interface of consultation-liaison psychiatry and primary care. International Journal of Psychiatry in Medicine, 26(2), 145-153.

This article describes a primary care geriatric psychiatry program which serves clinical, educational, and research functions. Fellows involved in the raining are psychiatry residents and primary care residents. Clinical rotations are in nursing homes, outpatient clinics, and hospital medical service. For successful collaboration you need primary care physicians with an interest in psychiatric illnesses, the delivery of service and training based on the primary care site's needs and a physical presence at the primary care site.

Pace, T. M., Chaney, J. M., Mullins, L. L., & Olson, R. A. (1995). Psychological consultation with primary care physicians: Obstacles and opportunities in the medical setting. Professional Psychology: Research and Practice, 26(2), 123-131.

Describes the training of primary care MDs and the nature of primary care, and how differences in training and orientation contribute to difficulties in collaboration, and provides suggestions on how to enhance physician-psychologist relationships. Also provides good, solid descriptions of models of collaboration. Although the focus of the article is on how MDs are viewed by psychologists, it should be pointed out that psychologists may play a major role in perpetuating these difficulties (described below) by not seeking to learn more about the training, roles, and experiences of physicians. Barriers to collaboration are seen as 1) differences in theoretical perspectives: e.g., psychologists think in terms of methods and processes and physicians seek specific facts and concrete solutions; 2) differences in training (psychological and sociological theories vs. biological assessment, diagnosis, and treatment; 3) traditional physician dominant hierarchy; and 4) differences in language and technical jargon, which cause communication problems. The authors conclude that psychologists and primary care physicians need to learn more about the training, philosophy, and practice of each other. Through interaction and shared responsibility, psychologists and physicians can learn to understand and respect each other. This will result improved health behaviors, better stress management, better compliance with medical treatment, greater family stability, and reduced overall costs of health care through improved health and reduction in excessive use of general medical services.

Pew Health Professions Commission. (1995). Critical challenges: Revitalizing the health professions for the twenty-first Century. San Francisco: UCSF Center for the Health Professions.

A lengthy publication that offers a number of useful elements. Discusses the changes in the US health care system, and discusses the need for changes in provision of services and education and training of those providing such services. Provides recommendations at both the institutional and practitioner levels across a number of disciplines (e.g., pharmacy, medicine, dentistry, and nursing). Provides a number of case examples to illustrate some agencies/sites that have undertaken some of the changes that will be necessary across the entire health care system. Less specific discussion than some on interdisciplinary training, however.

Resnick, R. J., & Kruczek, T. (1996). Pediatric consultation: New concepts in training. Professional Psychology, Research and Practice, 27(2), 194-197.

The authors note that consultation-liaison has become increasingly important to the diversification of psychological practice. With changes in the health care system, especially the national health proposals, it is critical that we be able to service individuals in a variety of settings. The authors describe a comprehensive training program in consultation-liaison psychology, focusing on child and adolescent populations. They encourage the adoption of the training programs in other areas. If our training

programs do not provide practice experiences in a variety of settings, psychologists may not remain viable in an increasingly competitive mental health marketplace.

Sarafino, E. (1993). Directory of doctoral programs in health psychology. Washington, DC: Division 38, American Psychological Association

A listing of the internship and postdoctoral settings that provide training for psychologists in health psychology.

Sheridan, E. P., & Choca, J. P. (1991). Educational preparation and clinical training within a medical setting. In J. J. Sweet, R. H. Rozensky, & S. M. Tovian, (Eds.), Handbook of clinical psychology in medical settings (pp. 45-58). New York: Plenum Press.

The authors focus on the clinical training possibilities that exist in a hospital setting for training clinical psychologists. Training at the preinternship, internship, and postdoctoral levels is discussed. The authors emphasize the importance of providing the students with the necessary skills and attitudes to work in a hospital setting and suggest that initially, a high level of supervision is required. A collaborative arrangement between the hospital and university faculty is necessary for the training program to be effective.

Winder, A. E., Michelson, L. A., & Diamond, D. (1985). Practicum training for pediatric psychologists: A case study. Professional Psychology: Research and Practice, 16(6), 733-740.

This article describes the development of a practicum training program in pediatric psychology. The program represents a collaborative effort of the two areas of clinical and developmental psychology, as well as joint efforts between pediatric residents and pediatric psychology students. The academic component of the training involves shared coursework between psychologists and pediatric residents. The clinical component includes consultation, assessment, and short-term treatment of children with combined medical, developmental, and psychological problems. An evaluation of the training program using several effectiveness indicators is presented. This collaborative training model can greatly facilitate student training and research in the field of pediatric psychology.

Zilberg, N. J., & Carmody, T. P. (1995). New directions for the education of clinical psychologists: The primary care setting, the VA's PRIME program, and the in-depth generalist model. Journal of Clinical Psychology in Medical settings, 2(1), 109-127.

As part of a special issue on psychology in primary care settings, the authors describe the VA's new approach to education for practice in the primary care setting and concurrently address some general issues related to the education of clinical psychologists for practice in this setting. They argue that the primary care psychologist, in parallel with the generalist in medicine, must have a strong generic background in clinical psychology in order to gain the broad range of clinical skills necessary to function effectively as an "in-depth generalist" (IDG) who is capable of addressing the variety of psychological issues that emerge in the primary care setting. The IDG model of professional practice, which the authors believe is best suited for primary care/managed care settings, requires extensive training in generic clinical skills and increased time devoted to its implementation at both the predoctoral and the postdoctoral levels.

Zungolo, E. (1994). Interdisciplinary education in primary care: The challenge. Nursing and Health Care, 15(6), 288-292.

The author describes an interdisciplinary collaborative education project (nursing and medical disciplines) involving clinical experiences in primary care. He discussed several issues that need to be addressed before an interdisciplinary training (or collaborative) program can be effective. Although the article was intended for nursing and health care providers, administrators, & educators, it is relevant for other disciplines (e.g., psychology, physical therapy, nutrition, etc.) working with MDs. Zungolo stated that a barrier to collaboration was the differences in style of the professions: e.g., the medical student zeros in on known/anticipated pathology while nursing students ask clients questions about their lives (often bringing out unanticipated information, getting to know more about the clients, and "touching" the patients in ways the medical students didn't). All interdisciplinary efforts require a cost-benefit analysis of pointing out inequities in operation (e.g., turf-related expectations that may be demeaning to a discipline). On the one hand, inequity and inaccuracy should always be noted, but, there is a danger that the inequity will begin to overshadow the operation (e.g., if correcting the medical faculty member results in negative effects on student learning opportunities). Obstacles to overcome were differences in: (1) professional socialization, (2) types of students in each discipline, (3) education (4) role expectations and "turf" issues, and (5) attitudes towards other professionals.

2. Managed care articles focused on training

Blackwell, B., & Schmidt, G. L. (1992). Economic Grand Rounds: The educational implications of managed mental health care. Hospital and Community Psychiatry, 43, 962-964.

The authors look at the educational implications of the changes in the health care system and the fact that educational programs often lag behind advances in health care delivery. They point out some of the advantages and disadvantages of the managed care systems and ways in which training programs can adapt their curriculum to better meet the needs of the students and the organizations.

Broskowski, A. T. (1995). The evolution of health care: Implications for the training and careers of psychologists. Professional Psychology: Research and Practice, 26(2), 156-162.

This article, while not specifically targeting the primary care health area, is very relevant for preparing mental health practitioners for service provision in the general health care arena (i.e., medical care delivery system). Managed mental health care is becoming increasingly embedded in general health care yet our current training programs (with the exception, perhaps, of health psychology) do not prepare students for the reality of today's and tomorrow's health care. Graduate education and training should begin to organize its curriculum and practica so that students are trained (1) on models of mental health and illness that view anxiety, depression, and many forms of maladaptive behaviors as episodic conditions requiring brief interventions and subsequent repeat interventions on an as-needed basis, much like the current views of the common cold and minor physical ailments; 2) in settings that expose them to other health care professionals; 3) in a wide range of mental health and medical care settings, including large, multispecialty group practices, HMOs, general hospitals, and specialized units for the treatment of specific medical conditions (e.g., cardiac care), even in employer's worksites, etc.

Charous, M. A., & Carter, R. E. (1996). Mental health and managed care: Training for the 21st century. Psychotherapy, 33(4), 628-635.

Traditional pre-doctoral internships fail to adequately prepare psychologists for practice in a managed care setting. Graduate training programs should integrate practicum experiences in a managed care

setting, especially during internship. Utilization of the scientist-practitioner model will more effectively prepare trainees to apply the research methodology of clinical psychology to evaluate clinical efficacy and treatment outcomes, particularly within a managed care environment.

Cummings, N. A. (1995). Impact of managed care on employment and training: A primer for survival. Professional Psychology: Research and Practice, 26(1), 10-15.

Like many other authors, Cummings contends that training programs have not adjusted adequately to the changes in the health care system. He proposes a number of changes in our curricula as well as our (psychologist's) need to reexamine our attitudes and beliefs about the practice of clinical psychology if we are to survive –much less to thrive in the future.

Cummings, N. A. (1995). Behavioral health after managed care: The next golden opportunity for professional psychology. Register Report, 20-21, 1, 30-33.

Health reform will seek market-oriented services and psychology has an opportunity for developing a marketable behavioral health orientation. Cummings briefly presents the history of managed care and industrialization of healthcare. He makes a variety of predictions as to the future of health care delivery in the next century. It will be interesting to see which, if any, of his predictions come true.

Frances, A. (1997). Training the trainees. Administration and Policy in Mental Health, 25(1), 41-45.

Frances, in his discussion of Troy's 1997 article Training the Trainees, states that we might want to focus on training the existing practitioners to function more effectively in the marketplace. Instead, we are training their competitors who will be better equipped and perhaps willing to work for less money. This is a disservice to those in the field and he makes the argument that professional organizations should focus on providing retooling for current professionals instead of focusing on the training needs of "new" professionals. Other topics about managed care also are discussed.

Frank, R. G., & Ross, M. J. (1995). The changing workforce: The role of health psychology. Health Psychology, 14, 519-525.

Psychology has no concerted workforce policy and this hurts the profession with respect to developing as a health care profession. This is particularly true since other professions have gained statutory authority to provide many of the same services as psychologists. The authors argue for a comprehensive model of training in health psychology—health psychology should become a standard component of all training programs. Curriculum changes needed to make this happen are discussed.

Jackson, V. (1997). Training the trainees. Administration and Policy in Mental Health, 25(1), 37-40.

Jackson, in her discussion of Troy's 1997 article on Training the Trainees, cited below, indicates that many of his observations are applicable to social work. However, she talks about the fundamental difference between the preparation of clinical social workers and psychologists is that clinical social workers first are trained as social workers, then as mental health professionals. The social worker's mantra is the concept of "person-in-environment" and their training emphasizes the role of the social worker as a change agent. Thus, the attitude of the social worker may be somewhat different and this may make it easier for them to learn to function in a managed care environment.

Jacobs, S. C., Hoge, M. A., Sledge, W. H., Bunney, B. S. (1997). Managed care, health care reform, and academic psychiatry. Academic Psychiatry, 21(2), 72-85.

The article describes the need for psychiatry to change their training programs. One of the suggestions is to renew a focus on training in the context of primary care settings. Changes in the education and training of psychiatrists are needed because of he changing health care system, particularly managed care.

Troy, W. G. (1997). Training the trainees: The new imperatives. Administration and Policy in Mental Health, 25(1), 27-35.

Troy emphasizes what others have said, namely, that unless our training programs change to accommodate the changes in health care delivery systems, psychology, along with other stakeholders in behavioral health will be damaged. He presents cogent arguments for the need to change and adapt to the realities of the current market and discusses the major problems and issues involved. The primary dilemma seen by Troy is "the prevailing remoteness of training programs and faculty from the real world of managed care."

3. Interdisciplinary training and education.

Abramson, J. S. (1993). Orienting social work employees in interdisciplinary settings: Shaping professional and organizational perspectives. National Association of Social Workers, Inc., 38(2), 152-157.

The article focused on orienting social workers; however, many elements of this article were relevant for interdisciplinary training, and their suggestions could be relevant for preparing trainees from any health care discipline for interdisciplinary work. The author promotes the use of a strategic approach to orientation that anticipates the influence of non-social work agendas and consciously attempts to counter them." (p. 157). "Complex, multidisciplinary organizations pose hurdles for social workers in relation to role definition, professional autonomy, and interdisciplinary collaboration…..A thoughtful orientation program based on an acculturation model will be most effective in addressing these issues." (p. 157). Orientation needs to address issues of differential professional socialization and educating other professionals about the role repertoire of social workers. Place of orientation (e.g., worksite vs. other), attitudes of others, and information overload are discussed as possible barriers and issues to deal with.

American Psychological Association (1995). Final report of the Interdisciplinary team training conferences for rural mental health providers (HRSA Contract 240 – BHP 95 – 007). Washington, DC: Author.

This report describes a series of workshops designed to implement interdisciplinary team training within the context of rural mental health care. The disciplines involved were physicians, nurses, psychologists, and social work. The curriculum used is described and copies of relevant readings are in the report. This report was the basis for a book (listed below) on interdisciplinary training.

American Psychological Association Office of Rural Health (1995). Caring for the rural community: An interdisciplinary curriculum. Washington, DC: American Psychological Association

This book came out of the rural task for mental health providers. It describes, in some detail, the curriculum for training and gives examples of programs that utilized the curriculum. The curriculum addresses both mental health and substance abuse issues and clearly is one of the best examples of an interdisciplinary approach to mental health/substance abuse services.

Bandler, B. (1973). Interprofessional collaboration in training in mental health. American Journal of Orthopsychiatry, 43(1), 97-107.

The author recommends experimenting with teaching students from different disciplines together in small groups, rather than in jurisdictional settings, suggesting that it would enrich teaching and enhance learning, and can lead to better appreciation of the specific contributions of other disciplines and reduction in interdisciplinary prejudice and misconceptions.

Barry, P. P. (1997). Geriatric education: A team approach. The Beverly Lecture on Gerontology and Geriatrics Education, No. 12. Washington, DC: Association for Gerontology in Education.

A broad review of a number of issues in interdisciplinary team work in patient care, including definitions of relevant terms, descriptions of other programs (e.g., VA system programs), issues in interdisciplinary education, and barriers to and opportunities in interdisciplinary education. Relevant across mental health/medical disciplines and patient groups.

Bassoff, B. Z. (1976-77). Interdisciplinary education for health professionals: Issues and directions. Social Work in Health Care, 2(2), 219-229.

Although this article was published in the 1970s, its points are relevant today, and aren't all necessarily being addressed by more contemporary sources. The author describes several issues to be considered in planning or carrying out interdisciplinary training, as well as providing recommendations and models for framing this training. Bassoff believes that the difficulties that arise from collaborative efforts are generally felt to be an outgrowth of the separate education of, and status strivings between, the various health professionals who experience little opportunity to understand and appreciate each other's skills until they are in work situations. According to Bassoff, the "objective of interprofessional behavior is to (1) act together, not think alike; (2) Communicate effectively and comfortably with other professions, (3) share specialized knowledge and (4) assume responsibility for the necessary actions resulting from shared problem solving." (p. 222). However, a lack of trust in the competency of others (professions), 2) inequality, 3) sexism, 4) institutional racism, and, 5) lack of shared responsibility are significant barriers to interdisciplinary education and/or teams.

Beigel, A., & Santiago, J. M. (1995). Redefining the general psychiatrist: Values, reforms, and issues for psychiatric residency education. Psychiatric Services, 46, 769-774.

This article reviews how changes in service provision necessitate changes in the education of psychiatric residents, and follows with a description of proposed curricular reform. Many of these suggestions would also be relevant for other health care professions, including psychology. It is relevant for preparation of students to work in multidisciplinary health care settings. The authors propose that future general psychiatrists will need the following: to be prepared to work in multidisciplinary health care settings; to recognize their unique professional contributions (e.g., complex cases involving both physical and psychological components); re-examination of the role of psychotherapy; consideration of the patient as an active participant in treatment planning; and integration of clinical and financial decision making into daily practice. Psychiatry should prepare its students for a variety of roles and levels of authority (e.g., in a multidisciplinary team of other physicians and nonmedical personnel, the psychiatrist may or may not be a "team leader." In addition, the curriculum should also incorporate didactic training in areas such as group dynamics and organizational behavior)

Betz, C. L., & Turman, J., Jr. (1997). A process of developing terminal competencies for an interdisciplinary training program. Journal of Allied Health, 26(3), 113-118.

Describes the process used in developing trainee competencies in an interdisciplinary training program for students representing 13 disciplines. Although explained in terms of its use in this specialized program, it can be applied to other training programs that are interdisciplinary in their focus. Article details the development of interdisciplinary competencies.

Clark, P. G. (1991). Toward a conceptual framework for developing interdisciplinary teams in gerontology: Cognitive and ethical dimensions Gerontology & Geriatrics Education, 12(1), 79-95.

Clark outlines a framework for the development of interdisciplinary educational programs. A fundamental form of experiential learning is the interdisciplinary team which is somewhat different from most academic learning situations. In teams, learning is a process, not the mastery of come "book knowledge." He describes the process by which teams learn to function together and discusses the role of values in the interdisciplinary team experience. He then presents mechanisms to promote cognitive and ethical development of teams. Clark's focus is on the conceptual process of team development and he cogently outlines the reasons for differences in approach to education of teams.

Clark, P. G. (1994). Social, professional, and educational values on the interdisciplinary team: Implications for gerontological and geriatric education. Educational Gerontology, 20(1), 35-51.

Early training together of professionals is important for later collaboration among members of interdisciplinary teams. Each team member must focus on professional-client relationships, professional-professional relationships, and team values, i.e. being a successful team player requires reorientation to the central value of group interdependence. Professionals must have a professional identity but also must put team identity first. The traditional university training fosters professional identity but does not encourage team development. We must restructure our training to encompass other professions and value interdisciplinary, collaborative work.

Clark, P. G. (1997). Values in health care professional socialization: Implications for geriatric education in interdisciplinary teamwork. The Gerontologist, 37(4), 441-451.

Clark presents a model for understanding the socialization process of physicians, nurses, and social workers as the development of professional meaning based on the acquisition of value orientations or themes intrinsic to their education and training. Discusses the implications of these patterns for the abilities of different professions to work together collaboratively in the care of older persons as a framework for developing new interdisciplinary curricular models in gerontological and geriatric education.

Clarkin, J. F., Pilkonis, P. A., & Magruder, K. M. (1996). Psychotherapy of depression: Implications for reform of the health care system. Archives of General Psychiatry, 53, 717-723.

This article primarily focuses on interdisciplinary collaboration between general medical and mental health professionals, with limited details on the preparation of those involved for such collaboration. Although the authors provide limited concrete strategies for interdisciplinary collaboration, they do provide some useful comments about the impact of values on the success on interdisciplinary teams and training programs. Until participants on an interprofessional team learn the cognitive maps of other members (so the can modify their contributions to the team effort in light of the other perspectives), they won't be a truly interdisciplinary team. The traditional university departmental approach to structuring its

research, education, and service makes it difficult to develop interdisciplinary programs that model a different approach to learning and discovering knowledge.

Couchman, W. (1995). Joint education for mental health teams. Nursing Standard, 10(7), 32-34.

As health and social problems become more complex, the imperative for interdisciplinary professional education increases. Yet the clash of perspectives between professions has hindered the development of a common approach and lead to real power differentials. The challenge for higher education is to work with services to find models of education and training that translate into truly interdisciplinary clinical and community settings. Joint training initiatives need to become part of the mainstream of professional education.

Davis, L. L. (1997). What comes around doesn't necessarily go around: A commentary on "building community." Families, Systems & Health, 15(4), 401-404.

Discusses the NLN (National League for Nursing) paper in the context of other calls to action for interdisciplinary training/education. Observes that despite numerous position papers such as this one, as well as positive reports from various committees and blue-ribbon study panels, interdisciplinary teams largely remain the unattained "Holy Grail" in most health science education and practice settings. This article discusses how their paper, like many others before it, fails to acknowledge the real and pervasive disincentives that discourage these education and practice endeavors (e.g., finding transdisciplinarians, creating curricula).

DeGraw, C., Fagan, M., Parrott, M. & Miller, S. (1996). Interdisciplinary education and training of professionals caring for persons with disabilities: current approaches and implications for a changing health care system. Article retrieved from the internet: http://aspe.os.dhhs.gov/daltcp/mangcare/intdises.htm

The article describes a project conducted to examine the type and extent of interdisciplinary education and training programs for professionals serving people with disabilities. They identified programs and described their training and education approaches. Although the article focuses on interdisciplinary training for professionals dealing with clients with disabilities, it is useful for examples of interdisciplinary training programs and easily generalizable to other types of programs.

DePoy, E., Wood, C., & Miller, M. (1997). Educating rural allied health professionals: An interdisciplinary effort. Journal of Allied Health, Summer, 127-132.

The article is about need for interdisciplinary collaboration and how to accomplish this collaboration with a focus on rural health care. It is oriented toward any rural health care provider, including psychology, speech communications, social work, human development nursing, physical therapy and occupational therapy. The authors describe courses taught by interdisciplinary faculty. The course content consists of professional socialization theory, explore roles/functions of multitude of health professionals, nature of rurality/rural health practice, and introduction to conflict management as an essential team skill. Also, exploration of attitudes towards rurality, professional boundaries and group function as a basis for promoting favorable attitudinal shifts. Students taking the course felt that through the course they evolved as a "team" or group. The program was not very effective in changing attitudes related to conflict resolution; authors recommend that future interdisciplinary educators may need to focus more time and didactic activity on conflict resolution strategies. The faculty may also function as models through clearly illustrating their own conflict resolution skills.

Diller, L. (1990). Fostering the interdisciplinary team, fostering research in a society in transition. Archives of Physical Medical Rehabilitation, 71, 275-278.

The key to rehabilitation is the interdisciplinary team. However, the definition of the team, including its composition and size, is evolving. The author proposes that we have not developed an adequate theory of teams and the logic under which they operate. Most have been introduced to the team approach by circumstance rather than by formal training. The tendency is, therefore, to learn entirely by experience, rather than profiting from accumulated knowledge or principle. A more sophisticated approach would involve a formal curriculum including academic and experimental components. The development of a curriculum for educating individuals in the task demands of the team approach is being actively pursued by ACRM (American Congress of Rehabilitation Medicine).

Drotar, D. (1992). Influences on collaborative activities among psychologists and pediatricians: Implications for practice, training, and research. Journal of Pediatric Psychology, 18(2), 159-172.

The author addresses the need for a comprehensive framework that describes the broad range of professional interactions between psychologists and pediatricians, presents a generic model of influences or collaboration and proposes specific implications for training, practice and research. To enhance collaboration, interventions should promote positive beliefs and expectations among colleagues concerning interdisciplinary work, facilitate specific skills related to cooperative research and management of clinical problems, and develop new practice settings. Author suggests that it requires ingenuity and persistence to overcome the inherent barriers to collaborative work, but the rewards are worth the effort.

Gitlin, L. N., Lyons, K. J., & Kolodner, E. (1994). A model to build collaborative research or educational teams of health professionals in gerontology. Educational Gerontology, 20(1), 15-34.

This model describes mechanisms to link academic faculty and health practitioners to explore aging issues from distinct but complementary perspectives. The process model would also be relevant for planning for interdisciplinary training. The intended audience is researchers, clinicians, and administrators in gerontological health care and the goal is to have academic faculty and clinicians, both within and across disciplines, collaborating in team building. Collaboration requires flexibility in thinking and work style, ability to relinquish or take control in group processes, and an openness to the ideas of others. Barriers to collaboration include limited time and money for services, a shortage of doctoral level prepared faculty in the health professions, and lack of a mechanism to promote interaction across settings and disciplines. The authors suggest that the process model can help to overcome these factors.

Goldberg, R. J., Tull, R., Sullivan, N., Wallace, S., & Wool, M. (1984). Defining discipline roles in consultation psychiatry: The multidisciplinary team approach to psychosocial oncology. General Hospital Psychiatry, 6, 17-23.

Attempts to define the unique contributions of psychiatry, social work, nursing, and psychology in relation to an oncology consultation program in a general hospital setting. The definitions of each discipline's contributions are proposed as a model that can be generalized to other consultation programs. Knowledge of the unique contributions of each team member and interdisciplinary training is important and barriers to collaboration include confusion about the potential contribution of different professions, lack of clarity about what to expect, lack of role definition and inability to speak the language of the others (especially biomedical and psychological disciplines). Traditional administrative boundaries to collaboration need to be removed.

Hanson, M. J., Hanline, M. F., & Petersen, S. (1987). Addressing state and local needs: A model for interdisciplinary preservice training in early childhood special education. Topics in Early Childhood Special Education, 7(3), 36-47.

Describes an interdisciplinary preservice training program for early childhood special education professionals that was designed to also attract professionals from related fields such as psychology and nursing. The training program included issues in preparing graduate students for work in a variety of settings, including interdisciplinary settings. The authors state we need this type of training because many skills and varied, comprehensive services are required to meet the needs of young children (birth to 5 years). Such a training program would give professionals in the field of early childhood special education the diverse skills and training needed to provide adequate service to young children and their families.

Heinemann, G. D., Zeiss, A. M., Waite, M. S., Tsukuda, R. A., & Brown, G. F. (1998) Teamwork in primary care: Education as a crucial element. Manuscript submitted for publication.

Discusses the integral role of education for effective teamwork in primary care and outlines the role of the new primary care teams in the VA system. The authors distinguish between multi- and interdisciplinary teams and emphasize the need for education and attention to process goals if a team is to function at the more sophisticated, interdisciplinary level. Presents numerous formats for team development and education as well as the circumstances when each is appropriate for use. Discusses the elements necessary for educational programming to be effective, five domains of curriculum content, and primary care learning objectives for each domain. Recommendations draw heavily on the philosophy of the VA's Interdisciplinary Team Training Program (ITTP), a clinically based educational program for health professionals and student trainees.

Hinshaw, A. S., & DeLeon, P. H. (1995). Toward achieving multidisciplinary professional collaboration. Professional Psychology: Research and Practice, 26(2), 115-116.

The article is oriented towards psychologists, physicians, advanced practice nurses. The authors discuss the integration of mental health care with other health care disciplines, describing issues to consider, and training for interdisciplinary (they call it multidisciplinary) collaboration. They also describe three model programs. The authors define inter-, intra-, and multi-disciplinary, with multidisciplinary collaboration involving experts from different disciplines working together (e.g., psychologists and physicians). Joint training provides early learning that shapes future thinking and molds practice styles in a manner that is not acquired later in one's training. Joint training encourages the development of respect and appreciation for other health care disciplines, valuing working together in teams and consulting with colleagues of other health professions.

Holland, B. E., Roberts, K. T., Stewart, A. V., & Wright, II, J. C. (1994). Life span geriatric interdisciplinary curriculum for preparing future health care professionals. Educational Gerontology, 20, 231-239.

Geriatric interdisciplinary teams are needed to provide holistic health care planning for older adults. However, few professional schools prepare health care practitioners to work as effective members of such teams. Thus, the LIFE SPAN geriatric interdisciplinary team curriculum was developed to give students faculty-guided theoretical and experiential educational experience in team practice – introducing the student to team dynamics, assessment, problem solving, and patient care planning from the perspective of multiple disciplines. (Abstract). The article describes the curriculum and the reaction of students to the curriculum.

Ivey, S. L., Brown, K. S., Teske, Y., & Silverman, D. (1988). A model for teaching about interdisciplinary practice in health care settings. Journal of Allied Health, August, 17(3),189-195.

Interdisciplinary training achieved by teaching students of various disciplines together. Greatest efficacy in treatment occurs with interdisciplinary treatment. Their model had interdisciplinary faculty teaching students from dietetics, nursing, occupational therapy, and social work but it is applicable to any discipline. The teaching model had students move from looking at themselves and their own discipline's practice to examining how other disciplines function in teams serving a variety of health care clients. According to the authors, forms of interdisciplinary practice lie along a continuum of professional autonomy: Parallel practice→collaboration→coordination→multidisciplinary practice→interdisciplinary health care team. The later represents the greatest efficacy with chronic/complex patients or those who have difficulty dealing with health care system, e.g., low income individuals. Only when groups of professional meet regularly in each other's presence, around specific goals, does a true interdisciplinary team emerge. Common goals, cooperative relationships and coordinated activities will maximize shared expertise and minimize professional autonomy. Improper balance between collaborative sharing and professional autonomy can impair team functioning. Respect for expertise of other team members along with a commitment to values and ethics of one's own profession and those of other professions is important.

Koff, N. A., DeFriese, A. M., & Witzke, D. B. (1994). Loosely coupled systems as a conceptual framework for interdisciplinary training. Educational Gerontology, 20, 1-13.

Provides a summary of loosely coupled system as a conceptual framework and how it applies to interdisciplinary training. The article is useful for suggestions on developing effective interdisciplinary teams (IDTT), particularly when there is conflict between training programs and/or divergent training goals among various disciplines. The authors described training oriented towards nursing, social work, pharmacy, physical therapy, occupational therapy, speech and audiology, clinical psychology, medicine, and "others." Loosely coupled systems theory facilitates an understanding of interdisciplinary training as a system in which (a) some elements of the training program conflict; (b) the learning activities may be disjointed or confusing; and (c) the learning goals of the various participants, both trainees and instructors, may diverge. Loosely coupled systems theory explains why these are the circumstances of IDTT and reassures that such systems manage to survive and be successful not only in spite of their loosely coupled nature, but because of it. The article is useful for suggestions on developing effective interdisciplinary teams.

Lesse, S. (1989). Editorial: Early joint training for doctoral candidates in the health-care professions. American Journal of Psychotherapy, 43(2), 155-157.

Author proposes that all persons, including medical students, planning to enter the health care professions at the doctoral level should be trained together in their initial academic year. The implications of this proposal for dentistry, psychology, nursing, and social work are discussed. The shared coursework should include anatomy, physiology, and biochemistry, the interrelationships between biodynamics, psychodynamics, and sociodynamics, the effects of macrosociologic factors (e.g., economics & political systems) on health & illness, etc. Professionals need to work toward a system that interrelates the organizational systems of health care professionals. However, the varied backgrounds of trainees and the typical resistance to any transition from our current system to a new system are seen as barriers. "Outdated, entrenched systems are not readily modifiable, let alone replaceable, no matter how inappropriate they become in relation to the rapidly changing cultural and technical scene." (p. 157). This article also is very relevant for primary care.

Libb, J. W., & Eklund, E. (1987). Leadership training in UAFs supported by the Division of Maternal and Child Health. Research in Developmental Disabilities, 8(1), 153-160.

Reviews the role of UAFs (University Affiliated Facilities) in the interdisciplinary (and leadership) training of individuals who will (or do) provide leadership in their professions. Discusses both interdisciplinary training and collaboration. The intended audience is: researchers, clinicians, faculty and administrators involved with developmental disabilities. UAFs were developed and funded to increase the interdisciplinary training of professionals who would become leaders in the development of a coordinated continuum of care for the mentally retarded child. UAFs are located in universities or teaching hospitals to facilitate communication with both the research community and university faculties who provide the basic disciplinary education and for UAFs to operate model service programs and to improve coordination of services. This article also is very relevant for primary care.

Madsen, M. K., Gresch, A. M., Petterson, B. J., & Taugher, M. P. (1988). An interdisciplinary clinic for neurogenically impaired adults: A pilot project for educating students. Journal of Allied Health, May, 135-141.

The authors describe a pilot project for educating students in interdisciplinary team work. The project was designed for students in Occupational therapy, speech pathology, audiology, medical record administrations, and social work, but is applicable to all mental health disciplines. The authors describe a class/clinical experience for students to grow accustomed to working in interdisciplinary groups. The students jointly identify problems and determine an interdisciplinary plan; write daily progress notes, jointly counsel patients and families regarding progress and recommendations, etc.

McDaniel, S. H., & Campbell, T. L. (1997). Editorial: Training health professionals to collaborate. Families, Systems & Health, 15(4), 353-359.

Based on a presentation by S. H. McDaniel about the training believed to be important for Collaborative Family Health care. Very relevant, covers topics such as training needs within one's discipline (e.g., core skills) and across disciplines, as well as conceptual skills, principles of care, and interpersonal skills. This article also is very relevant for primary care.

McEwen, M. (1994). Promoting interdisciplinary collaboration. Nursing and Health Care, 15(6), 304-307.

Describes a course "Collaboration in Health Care" designed to improve collaboration between nursing and other health care providers in order to improve patient health care. The description of their course may be useful in curriculum planning for other disciplines as well. The program is oriented towards nursing educators, nursing students, and professionals in all types of health care roles, direct and indirect. The elective course described the education, licensure, and certification requirements for a wide variety of health care providers; analyzed interrelationships between nursing, medicine, allied health, and other ancillary employees at health care facilities; determined specific strategies for improving collaboration between nursing and other health care providers; integrated knowledge of other health care disciplines to develop a comprehensive plan of care to address human needs for clients and their families; and, evaluated the impact of interdisciplinary collaboration on the quality of health care. The authors contend that excessive specialization in health care has led to fragmentation and inability to look at problems holistically, therefore, our training programs need to incorporate changes in the education of health care providers. If providers better understand the variety of roles and practices in health care, they can better work together to delivery higher quality care within a true "system" (i.e., a group interacting to form a whole).

Mellor, M. J., & Solomon, R. (1992). The interdisciplinary geriatric/gerontological team in the academic setting: Hot air or energizer? Journal of Gerontological Social Work, 18(3-4), 203-215.

Geriatric health care requires the services of an interdisciplinary health care team to assess, treat and order the social service needs of the older person, and this concept needs to be included in geriatric social work education. But while the necessity of interdisciplinary team care is recognized, little focus has been placed on the actual process of developing a functional team. The issues that arise—disparate terminology, organizational and administrative differentials, turf—and the steps needed for a team to become viable are described, using an interdisciplinary team based in academia as a case model.

Miller, T., & Swartz, L. (1990). Clinical psychology in general hospital settings: Issues in interprofessional relationships. Professional Psychology: Research and Practice, 21(1), 48-53.

Suggests that the involvement of clinical psychologists in health care teams may not necessarily improve health care. Examines the position of clinical psychology with regard to medical theory and practice, as well as issues arising from multidisciplinary teamwork (especially consultation-liaison work), and conclude that issues related to professional power structures in hospital settings need to be addressed before health care can benefit from the expertise of clinical psychologists. Although the article does not directly address training and education issues, it is pertinent to those issues.

Moffic, H. S., Blattstein, A., Rosenberg, S., Adams, G. L., & Chacko, R. C. (1983). Attitudes in the development of public sector clinicians. Community Mental Health Journal, 19(3), 211-218.

Article is about students' and residents' attitudes about interdisciplinary team work. While a lot of reference to interdisciplinary team work is in the article, it often is vague (e.g., discusses the attitudes held by students according to group and year of training). It may be of use to those designing interdisciplinary training programs with respect to countering some of the attitudes within and between the different professions. As a rule, social work students were found to be consistently the most enthusiastic towards interdisciplinary training; first-year students of all other disciplines consistently had less positive attitudes about interdisciplinary cooperation, practice and/or training.

Morris, J. A. (Ed.) (1997). Practicing psychology in rural settings: Hospital privileges and collaborative care. Washington, DC: American Psychological Association.

Rural practitioners have been pioneers in gaining hospital privileges for psychologists. However on a small number of states have passed laws allowing psychologists to practice in hospital settings. When psychologists are made part of the interdisciplinary team caring for patients in hospital settings, greater quality of care is achieved. This model benefits both the patient and hospital. It is especially important for those wishing to collaborate with other professionals.

Nicholas, D. R., Gerstein, L. H., & Keller, K. E. (1988). Behavioral medicine and the mental health counselor: Roles and interdisciplinary collaboration. Journal of Mental Health Counseling, 10(2), 79-94.

The authors discuss roles of various mental health professionals employed in behavioral medicine settings, as well as ethical dilemmas and issues related to interdisciplinary collaboration. The authors focus on the training of mental health counselors and recommend required coursework, etc. Much of what they recommend is applicable to any mental health discipline.

Orgren, R. A., Weiler, P. G., & Higby, H. R. (1989). Multidisciplinary training in geriatric health care for preclinical students. Gerontology and Geriatrics Education, 10(1), 13-21.

Reports on the development, implementation and evaluation of a multidisciplinary clinical preceptorship in geriatric health for preclinical students. Involved the collaboration of two postsecondary schools, students and faculty from four health care disciplines. Students attended didactic presentations, reviewed cases, and, in multidisciplinary teams of three and four, rotated through 13 clinical and community based sites which represented a broad array of services to the aged. Discusses the issues faced in developing and presenting multidisciplinary training of this nature.

Panel on Interdisciplinary/Transdisciplinary Education. (1997). Building community: Developing skills for interprofessional health professions education and relationship-centered care. Families, Systems & Health, 15(4), 393-400.

"In 1995 The National League for Nursing commissioned a Panel on Interdisciplinary or Transdisciplinary education." The focus of the Panel was to "examine issues related to interdisciplinary education and to make recommendations for future implementation." The authors are seeking feedback from colleagues in education and practice. In addition, key manuscript components are being placed on the Web Site of the Academic Health Centers and the National Academies of Practice [http://www.ahcnet.org or http://www.nmaa.org/member/nap].

Parrish, J. M., Iwata, B. A., & Johnston, R. B. (1985). Training professionals to record proceedings of interdisciplinary team conferences. Applied Research in Mental Retardation, 6, 247-262.

This article is relevant to those individuals or programs who want to establish effective multidisciplinary treatment teams. Describes two experiments conducted to assess the effectiveness of an instructional program in preparing staff and trainees at a university affiliated facility (UAF) to record proceedings of interdisciplinary team conferences. Also describes the instructional program/training.

Pinkerton, R. S., Moorman, J. C., & Rockwell, W. J. K. (1987). Multidisciplinary training in the college mental health service. Hospital and Community Psychiatry, 38(6), 656-661.

When the core mental health disciplines (psychiatry, clinical social work, mental health nursing, and psychology) participate and "work collectively toward common goals" they can "produce a more positive output than can a group of individual practitioners." Interdisciplinary training, by providing a common body of knowledge and appreciation of the role/expertise of other disciplines, promotes collaboration and mutual support among disciplines. According to the authors, the senior staff must teach positive multidisciplinary practice by modeling sound multidisciplinary functioning and working together in a coordinated and cohesive manner. This takes significant effort, flexibility and sensitivity on everyone's part. Some problems noted are: (1) the multidisciplinary system may be eroding clinical care and undermining the authority of the M.D; (2) patients may have to wait in even longer for services; (3) if members lack a common core of knowledge, then interdisciplinary functioning seems uncoordinated and awkward; (4) values and role expectations may differ among disciplines, and (5) varying administrative support. Interdisciplinary training program can be expensive and may increase managerial problems, especially at the beginning. Different levels of training may cause problems with the various team members; this can be overcome. Multi- or inter-disciplinary training will work if the permanent senior staff and administration are committed to it. This is an excellent resource article for multidisciplinary training, particularly the reference section. Reviews the pro's and some pitfalls of multidisciplinary training as reported from their references. One minor weakness—they could have provided more detail on how they taught multidisciplinary interaction.

Roth, L. (1994). University-based treatment program for the psychiatric elderly--How effective? Educational Gerontology, 20(3), 241-249.

A psychosocial rehabilitation model coupled with more traditional individual and group psychotherapy services is used by a university-based treatment program in Florida in treating the psychiatric elderly patients. The education and training programs for psychologists in the area of clinical gerontology include one-to-one supervision; exposure to individual and group psychotherapy techniques; interdisciplinary treatment team planning; and personality, cognitive, and neuropsychological assessment. The article focuses on the advantages of interdisciplinary teams for effective treatment.

Rowan, L. E., McCollum, J. A., & Thorp, E. K. (1984). Collaborative graduate education of future early interventionists. Topics in Language Disorders, 14(1), 72-80.

Within the field of early intervention, the concept of collaboration with families and across disciplines is considered to be best practice. However, personnel often have not been prepared to provide interactive and integrated early intervention services in conjunction with professionals from other disciplines. The authors describe a graduate interdisciplinary Infancy Specialization Program (ISP) developed with the idea of demonstrating to preservice students from different disciplines the best practice with regard to collaboration, transdisciplinary team approaches, and family-centered services, and reviews the challenges encountered in implementing the collaborative graduate ISP and the strategies used to facilitate successful collaboration. The observations on barriers as well as recommendations for successful collaboration (and training in collaboration) that are presented would be relevant for interdisciplinary collaboration for other health and mental health disciplines.

Saltz, C. C. (1992). The interdisciplinary team in geriatric rehabilitation. Journal of Gerontological Social Work, 18(3-4), 133-142.

The expertise of the interdisciplinary team is essential in devising and implementing an optimal rehabilitation plan for the geriatric patient. However, development and maintenance of skills in team functioning are not routinely part of training for practitioners in geriatric rehabilitation, including social work. Multidimensional assessment forms the basis of the team's activities, and the components of this process are outlined. Presents a review of relevant team dynamics, along with a description of the key elements and activities associated with geriatric rehabilitation team practice. Provides practical information on identifying barriers to effective team functioning and ideas for enhancing effectiveness. Article would be useful in training issues for any mental health discipline.

Sapir, S. G. (1986). Training the helpers. Journal of Learning Disabilities, 19(8), 473-476.

This article does not provide a lot of information but it does describe benefits of including persons from different disciplines together in a multidisciplinary training program. It is oriented toward professionals working in the area of learning disability. Involving multidisciplinary professionals in training programs makes all practitioners more aware of the plight of the child and family and trains people from many disciplines to work collaboratively in a multidisciplinary environment, and at the same time, establishes a bond between the many institutions from which other professionals come.

Satin, D. G. (1987). The difficulties of interdisciplinary education: Lessons from three failures and a success. Educational Gerontology, 13, 53-69.

Four real education programs illustrate the vicissitudes of interdisciplinary education. Five essential factors are (1) interdisciplinary education must be a primary program goal consistent with other major goals; (2) controlling educational authorities must be committed to it; (3) it may have to exist outside the

main academic structure because of its inherent conflict with that structure; (4) honesty, trust, and respect are essential to the interdisciplinary endeavor; and (5) resources must be sufficient for interdisciplinary as well as traditional education. Unfortunately, these factors are often not present, requiring interdisciplinary education to occur in research and demonstration programs, which requires independence, academic support, self-direction, and adequate and stable resources.

Satin, D. G. (1994). A conceptual framework for working relationships among disciplines and the place of interdisciplinary education and practice: Clarifying muddy waters. Gerontology and Geriatrics Education, 14(3), 3-24.

The "interdisciplinary" concept is unclear and unstudied. This article proposes a conceptual framework for models of working relationships among disciplines and contrasts the interdisciplinary model with others. (Defines unidisciplinary, paradisciplinary, multidisciplinary, etc.) Interdisciplinary work recognizes that competencies overlap, and interrelates disciplines to meet multifactorial needs. Interdisciplinary collaboration requires knowledge of other disciplines, role flexibility, evolution of practice and identity, and disciplinary interchange. Interdisciplinary benefits are broad resources, creativity, collaboration, and professional enrichment; costs are time, energy, resources, and changing methods, institutions, and self. The interdisciplinary model should be applied appropriately.

Sheppard, M. (1992). Contact and collaboration with general practitioners: A comparison of social workers and community psychiatric nurses. British Journal of Social Work, 22(4), 419-436.

Although this article is focused on contact and collaboration between health and welfare professionals, their results are informative for the collaboration of other non-medical professionals with MDs and for social workers and community psychiatric nurses (CPNs) working with other health or mental health professionals (e.g., CPNs were far more likely to contact GPs than social workers, although GPs very rarely initiated contact themselves. These and other differences reflected different "philosophies of contact," a factor which training for interprofessional collaboration should not ignore, as well as differences in occupational culture or role expectations.

Stark, R., Yeo, G., Fordyce, M., Grudzen, M., Hopkins, J., McGann, L., & Shepard, K. (1984). An interdisciplinary teaching program in geriatrics for physician's assistants. Journal of Allied Health, (November), 280-287.

Describes a course in clinical geriatrics for medical students and student physician's assistants, physical therapists, and nurse practitioners. Faculty team modeled the interdisciplinary approach, and included MD, physician's assistant, a nurse, social worker, gerontologist, and health educator. The classes were geared toward understanding aging, improving attitudes toward the elderly, work with dying patients and their families, communication with the elderly, identification of community resources for the elderly, and recognizing the value of the team approach to health care for the elderly. The goal was to educate other health professionals about physician assistants' role in health care team. The instructor used seating assignments that encouraged interactions between students of various disciplines. Faculty from various disciplines modeled their respective roles in patient care through simulated patient conferences, case presentations, and videotaped interactions. Interdisciplinary training can provide a cost-effective avenue for stimulating student interest, providing clinical education, and educating other health care practitioners to the role of the physician's assistant on the health care team

Toner, J. A. (1994). Interdisciplinary treatment team training in geriatric psychiatry: A model of university-state-public hospital collaboration. Gerontology and Geriatrics Education, 14(3), 25-38.

This article describes the adaptation and implementation of an interdisciplinary treatment team training model to the training of geriatric psychiatrists. The Program for Organizing Interdisciplinary Self-Education (POISE) was designed as a durable, cost-effective approach to teaching interdisciplinary treatment team members methods of self-education, which serve as ongoing tools for planning treatment for patients. Although the program focuses on training psychiatrists, it is applicable to other mental health disciplines.

Toner, J. A., Miller, P., & Gurland, B. J. (1994). Conceptual, theoretical, and practical approaches to the development of interdisciplinary teams: A transactional model. Educational Gerontology, 20, 53-69.

This article describes the conceptual, theoretical, and practical approaches involved in the development and implementation of the Program for Organizing Interdisciplinary Self-Education (POISE), an interdisciplinary team education program. The conceptual framework is based on the idea that team members can be taught to develop group self-education skills; the theoretical framework of POISE is rooted in self-education, adult education, and group dynamics theory. POISE demonstrates that conceptual and theoretical approaches can be linked and applied successfully to practical approaches to staff education. POISE includes methods that interdisciplinary teams almost anywhere can use to assess and improve their interdisciplinary collaboration. POISE includes training in methods of defining and negotiating team members' roles, case study approaches to prioritizing treatment goals, group simulations, and methods of problem solving. One of the concrete products of POISE is the development of a practical Treatment Decision Guide, which is designed by the interdisciplinary team members specifically for patient management in their particular institution.

U.S. Department of Veterans Affairs, Division of Health Affairs. Washington, DC

Although the specific training available may vary from site to site, in general, the Department of Veterans Affairs (VA) internship programs provide clinical and counseling psychology interns the opportunity to obtain a wide range of experiences in working with a variety of psychiatric, medical, and surgical patients (both inpatient and outpatient) and to work with other health care professionals and their students. Rotations are offered in many different areas, e.g. continuous care teams, post-traumatic stress disorder clinics, substance abuse programs, inpatient and outpatient programs, etc. Two relatively new initiatives in training are available within the VA system. The Geropsychology/Interdisciplinary Team Training Program (ITTP) and the Primary Health Care (PRIME) program. The ITTP offers weekly meetings aimed at maximizing healthcare team function across disciplines. The PRIME program is designed to educate medical and pharmacy residents, psychology interns, nurse practitioners, occupational and physical therapists and social work students to function as members of coordinated, interdisciplinary teams in primary care. PRIME trainees are expected to become effective members of the primary healthcare group to which they are assigned and participate in the provision of healthcare that consists of: (1) health promotion/disease prevention; comprehensive management of acute and chronic medical and mental conditions and patient education. Trainees will learn collaborative skills of team care and gain an understanding of primary/manage care. This is accomplished through didactic training (seminars, readings), shadowing of specified health professionals/primary care providers), home visits, etc.

Waite, M. S., Harker, J. O., & Messerman, L. I. (1994). Interdisciplinary team training and diversity: Problems, concepts and strategies. Gerontology and Geriatrics Education, 15(1), 65-82.

Interdisciplinary health care teams have become a critical part of patient care in geriatric medicine. Team members have diverse ethnic/cultural backgrounds, professional disciplines, and positions in the hospital, which contribute to conflict and miscommunication. Diversity training programs have been developed to address these problems, but have been recently criticized. This article discusses three areas of need for diversity training, outlines a theoretical framework for diversity in health care teams, and suggests ways to improve training effectiveness.

Walsh, S. F. (1985). The psychiatric emergency service as a setting for social work training. Social Work in Health Care, 11(1), 21-31.

Psychiatric emergency service is a collaborative work environment, so social workers have an opportunity to develop facilitating attitudes and communication skills and respect/responsiveness to perspectives/interests/concerns of colleagues (e.g., medicine, psychiatry, nursing and/or psychology). Also, joint interviewing and informal case collaboration with professionals and trainees from allied disciplines let social work students learn from others. Learning is optimal when interdisciplinary seminars focus on areas where disciplines overlap rather than on traditionally "belonging" to a single discipline.

Wieland, D., Kramer, B. J., Waite, M. S., & Rubenstein, L. Z. (1996). The interdisciplinary team in geriatric care. American Behavioral Scientist, 39(6), 655-664.

Clinical geriatrics and interdisciplinary team care approaches have co-evolved during the past 30 years. It has become an article of faith in geriatrics that the goal of multidimensional health for frail elderly patients is most effectively pursued by the interdisciplinary health care team. Geriatrics team models have recently become increasingly differentiated, following secular changes in the health care system that promote community-based care and research findings supporting the efficacy of team-based geriatric services. This article describes a number of these diverse models and evidence of their efficacy and offers some thoughts on the position of geriatric teams within the more general emergence of primary, managed care models of health services delivery. It is a useful reference for training programs.

Zeiss, A. M., & Steffen, A. M. (1996). Interdisciplinary health care teams: The basic unit of geriatric care. In L. L. Carstensen, B. A. Edelstein, & L. Dornbrand (Eds.), The practical handbook of clinical gerontology (pp. 423-450). London: Sage Publications.

Very relevant and useful article for interdisciplinary teams in health care and mental health care, not just gerontological teams. Reviews and contrasts some of the different types of teams (e.g., transdisciplinary vs. multidisciplinary). Discusses the advantages of interdisciplinary teams, as well as the disadvantages of interdisciplinary teams and ways to deal with them. Describes the processes of team development (and functioning). Discusses some of the dilemmas in team work and issues such as role definition, treatment planning. Provides a case example of team work in action, and reviews some of the available resources and training materials. Therefore, a very good reference as well.

Zungolo, E. (1994). Interdisciplinary education in primary care: The challenge. Nursing and Health Care, 15(6), 288-292.

The author describes an interdisciplinary collaborative education project (nursing and medical disciplines) involving clinical experiences in primary care. He discussed several issues that need to be addressed before an interdisciplinary training (or collaborative) program can be effective. Although the article was intended for nursing and health care providers, administrators, & educators, it is relevant for other

disciplines (e.g., psychology, physical therapy, nutrition, etc.) working with MDs. Zungolo stated that a barrier to collaboration was the differences in style of the professions: e.g., the medical student zeros in on known/anticipated pathology while nursing students ask clients questions about their lives (often bringing out unanticipated information, getting to know more about the clients, and "touching" the patients in ways the medical students didn't). All interdisciplinary efforts require a cost-benefit analysis of pointing out inequities in operation (e.g., turf-related expectations that may be demeaning to a discipline). Obstacles to overcome were differences in: (1) professional socialization , (2) types of students in each discipline, (3) education (4) role expectations and "turf" issues, and (5) attitudes towards other professionals.

4. Interdisciplinary teams in managed care or integrated service delivery settings

American Psychological Association Committee for the Advancement of Professional Practice Task Force on Organized Systems of Care. (1996). Final recommendations of the CAPP task force on organized systems of care. Washington, DC: American Psychological Association

This report reviews issues such as education and training and roles for psychologists, particularly with respect to organized systems of care. The article is relevant for summary of managed care issues (which often are occurring in a primary care setting and use interdisciplinary teams). Much of the focus is on issues such as advocacy in addition to education and training for a managed care setting.

Bachrach, L. L. (1996). Managed Care: II. Some "latent functions." Psychiatric Services, 47(3), 243-244.

The author targets managed health care providers in general and describes trends in managed care for the use of multidisciplinary teams or collaboration between physicians and other health care providers. One benefit of the trend in collaboration between physician and non-physician health care providers that it enhances the use of multidisciplinary treatment teams. This is what Bachrach describes as a "latent function." The use of non-physician providers provide lower-cost services and enhances use of multidisciplinary treatment teams.

Chisholm, M., Howard, P. B., Boyd, M. A., Clement, J. A., Hendrix, M. J., & Reiss-Brennan, B. (1997). Quality indicators for primary mental health within managed care: A public health focus. Archives of Psychiatric Nursing, 11(4), 167-181.

The article does not contain much information on interdisciplinary training. However, the authors do recommend that if multidisciplinary teams are included in the design of integrated health care systems, it should be assured that they're properly credentialed and trained.

Gillies, R. R., Shortell, S. M., & Young, G. J. (1997). Best practices in managing organized delivery systems. Hospital and Health Services Administration, 42(3), 299-321.

Believing that organized delivery systems will produce better, more cost-effective care, the VA system is following the lead of the private sector in seeking a more integrated approach to providing patient care. The authors describe the building and managing of an integrated delivery system (for the nations veterans) based on findings from the Health Systems Integration Study. Barriers to organized delivery systems of care include lack of understanding of the new health care environment, lack of understanding of integration of services, continued focus on the "old" operating units of care and consequent lack of commitment to new systems, lack of trained personnel, fear of losing control or failure and subsequent

"turf" issues. The barriers listed (p. 303-305) also apply to "multi- or interdisciplinary training of any type."

Illback, R. J., Cobb, C. T., & Joseph, H. M. (Eds.) (1997). Integrated services for children and families: Opportunities for psychological practice. Washington, DC: American Psychological Association.

An edited book which explores the need for integrated services when working with children and families. The book is organized around the themes of defining integrated care, integrating care within community settings such as schools and clinics and the implications of this approach for the practice of psychology. However, the book would be of interest to any mental health professional working in schools, primary health care, mental health and social service settings.

Olsen, D. P., Rickles, J., & Travlik, K. (1995). A treatment-team model of managed mental health care. Psychiatric Services, 46(3), 252-256.

The authors describe their treatment model, with its relevance for collaboration in decision making and treatment, including collaboration of primary care MDs and mental health professionals. One intended audience was managed care providers/administrators. For best treatment, the authors recommend collaboration among the primary care physician, psychiatrist, psychologist/therapist, and managed care agent (a clinician). They recommend a treatment team model using primary care physician and mental health professional when the patient indicates need for more intense mental health care (than a primary care physician can provide). The patient is seen by a mental health professional who acts as a managed care agent: he/she works with the patient to plan treatment, becomes a part of the patient's treatment team; final decisions are made in consultation with hospital psychiatrist, while keeping in touch with primary therapist. Agent is fully accountable for level-of-care decision, clarifying confusion over accountability. This model can provide more immediate accessibility to services and a broader range of services. The efficiency and quality of care provided by clinician as managed care agent are immeasurably enhanced if he/she is a member of the treatment team. However, leadership can be diffused because managed care agent/clinician isn't a team leader, but has final authority in some decisions. Since the clinician serving as managed care agent has accountability and liability for l treatment decisions, it is in the agent's best interest to have expertise and to work closely with the patient's other care providers. With communication and coordinated efforts at collaboration, the clinician/agent can make responsible, expert, and clinically sound decisions about changes in intensity of care and crisis management in the best way possible as part of a team.

C. Articles of General Relevance to Primary Health Care

Alto, W. A. (1995). Prevention in practice. Primary Care, 22(4), 543-554.

The article focuses on the need for primary care providers to become effective health promoters and to focus on prevention of illnesses. Alto talks about the need to forge relationships with the community and to empower the patient to accept responsibility for their health. He does not talk specifically about integration of mental and physical health care although much of what he does say is toward that aim.

Belar, C. D. (1991). Professionalism in medical settings. In J. J. Sweet, R. H. Rozensky, & S. M. Tovian, (Eds.), Handbook of clinical psychology in medical settings (pp. 81-92). New York: Plenum Press.

This chapter highlights the roles and functions of psychologists in medical settings and issues in interdisciplinary functioning. Clinical psychologists working in medical settings must have knowledge of psychology but also of the sociopolitical processes in medical settings. Interdisciplinary focus also is important. Managed care plans (also called accountable health plans) will be looking for cost-effective providers of behavioral health services and are likely to form their own internal base of mental health programs provided by its own employees within the context of primary medical care. This will provide better integration of services, which can improve outcome and decrease cost.

Corney, R. (1995). The researcher's perspective. In J. Keithley & G. Marsh (Eds.), Counselling in primary health care (pp. 286-295). New York: Oxford University Press.

The article is focused on problems seen by primary care physicians and services available to them. The author points out the need for research to document what patients, with what types of problems, need to be referred to trained counsellors and which ones could benefit from a "befriender" or a listening service, i.e. which clients could benefit from less skillful training. This research could benefit primary care physicians in their decision making about referrals.

DeLeon, P. H., Wedding, D., Wakefield, M. K., & VandenBos, G. R. (1992). Medicaid policy: Psychology's overlooked agenda. Professional Psychology: Research and Practice, 23(2), 96-107.

The authors talk about the necessity for psychology to gain formal recognition under the various state Medicaid plant by way of state by state authorization or by federal mandates.

Engel, G. L. (1992). The need for a new medical model: A challenge for biomedicine. Family Systems Medicine, 10, 317-331.

Does not cover interdisciplinary training, but a "classic" article, with good background information (e.g., for other disciplines to read) on the medical model. Describes other models used in psychiatry and general medicine. This article is cited a lot in the primary care and interdisciplinary literature.

Folen, R. A., Kellar, M. A., James, L. C., Porter, R. I., Peterson, D. R. (1998). Expanding the scope of clinical practice: The physical examination. Professional Psychology: Research and Practice, 29(4), 155-159.

This article describes a program whereby five clinical health psychologists at a major medical center (unnamed in the article) completed a 36 hour graduate level nurse practitioner course in advanced health assessment. The psychologists were trained to conduct physical examinations and evaluate medical histories. The psychologists reported high levels of comfort and satisfaction with their ability to conduct physical exams, describe their findings and provisionally identify medical problems and make referrals. The reason given for such training was the heavy case load of the family medicine physicians and the fact that as health psychologists they are directly involved in the recognition and regulation of pathophysiological mechanisms and psychophysiological syndromes. It is the view of the authors that changes in the provision of health care "are placing more demands on psychologists to integrate within a general health care system" (p. 158). With the knowledge of how to conduct physical exams, the authors believe that psychologists are "in a position to now only integrate into multidisciplinary teams, but serve as primary care managers as well" (p. 158).

Frank, R.G., & Ross, M.J. (1995). The changing workforce: The role of health psychology. Health Psychology, 14, 519-525.

Psychology has no concerted workforce policy, and this hurts the profession with respect to developing as a health care profession. This is particularly true since other professions have gained statutory authority to provide many of the same services as psychologists. The authors argue for a comprehensive model of training in health psychology--health psychology should become a standard component of all training programs. Curriculum changes needed to make this happen are discussed. A very useful article for anyone waiting to develop a training program focusing on the field of health psychology.

O'Byrne, K. K., Peterson, L., & Saldana, L. (1997). Survey of pediatric hospitals' preparation programs: Evidence of the impact of health psychology research. Health Psychology, 16(2), 147-154. Retrieved April 6, 1998 from the World Wide Web: http://members.apa.org/ftdocs/hea/1997/march/hea162147.html

The authors emphasize the importance of linking science and practice in health psychology. They present the results of research in pediatric hospitals in the US and their use of prehospital preparation techniques for brief acute medical procedures (e.g. surgery, blood tests, etc) when children were hospitalized. The article is relevant for pointing out the clinical practice needs to be driven by research findings—a fact which sometimes is forgotten in actual practice. The need to disseminate findings is discussed. This has some relevance for psychologists practicing in primary care settings in that care should be taken in how the research information is presented and integrated.

Ransom, D. C. (1992). Yes, there is a future for behavioral scientists in academic family medicine. Family Systems Medicine, 10, 305-315.

Limited interdisciplinary training information: states that there hasn't been enough. States that family medicine has gained more from behavioral science than the other way around.

Shore, M. F., & Beigel, A. (1996). The challenges posed by managed behavioral health care. New England Journal of Medicine, 334(2), 116-118.

With the goal of reducing costs, managed care in general and managed behavioral health care is a challenge to the traditional allocation of professional resources. There is intensified competition among mental health providers; typically psychologists and social workers receive less fee for the same services as psychiatry. Case managers make decisions about patients and providers that they do not know—not a good situation as they (case managers) often have less training, education, and experience than the providers. Confidentiality is a serious concern. The author concludes that managed behavioral health care is unlikely to continue in its present form. The challenge is for mental health professionals to strike a balance between individual professional responsibility and corporate accountability.

Stein, H. F. (1992). "The eye of the outsider": Behavioral science, family medicine, and other human systems. Family Systems Medicine, 10, 293-304.

The author states that a "permanent outsider's view can help primary care physicians to know their own professional culture and its effect on residency training and patient care. There is a better fit between behavioral scientists (e.g. psychologists) and family medicine than between family medicine and other medical specialties, e.g., surgery.

U.S. Department of Commerce (1998). Telemedicine report to congress. Http://www.ntia.doc.gov/reports/telemed/cover.htm.

Buried within this document is a reference that in the future, savings in health care (e.g. treatment, hospitalization, etc) could be found by timely referrals to the patient's primary care physician via the internet or telemedicine. By extrapolation—referrals to other primary care health professionals (e.g. nursing, psychology, psychiatry, social work, etc) could be done via this mechanism. Only the future will tell!

VandenBos, G. R., DeLeon, P. H., & Belar, C. D. (1991). How many psychological practitioners are needed? It's too early to know! Professional Psychology: Research and Practice, 22(6), 441-448.

The authors discuss the human resource needs for the future changing health care market and conclude that we do not know how many psychologists will be needed. There are many new applications of clinical psychological services—those that cover all bases of health care and beyond. They comment on issues related to changes in health care system and note some of the changes that will be needed in the training programs of psychologists.

West, M. A., & Poulton, B. C. (1997). A failure of function: Teamwork in primary health care. Journal of Interprofessional Care, 11(2), 205-216. Abstract retrieved May 5, 1998 from the World Wide Web: http://www.city.ac.uk/barts/jipc/jipc1b.htm. For ordering information, e-mail: sales@carfax.co.uk.

The objective of this research was to explore the extent of teamworking in primary health care in the UK. Primary health care teams were compared with other multidisciplinary health care teams. With respect to team functioning, primary health care teams scored lower than other teams on all team functioning factors except task orientation. The authors concluded that a restructuring of primary health care is needed for them to facilitate the coordinated approach to delivery of care.

D. Articles Specific to Managed/Health Health Care Services

1. Mental health care vs. behavioral health care providers

American Psychological Association (1994). Psychology as a health care profession. Washington, DC: Author.

A book sponsored by the Board of Educational Affairs that provides information about the role of psychology in health care as opposed to mental health care (which is viewed as an overly restrictive role for psychology). It does not deal specifically with primary health care—but with the health care field in general.

American Psychological Association Committee for the Advancement of Professional Psychology (CAPP) Primary Care Task Force. (1996). Primary care task force final report. Washington, DC: American Psychological Association.

A report of the task force which was charged to develop CAPP's agenda to maximize psychology's role as a health care professional generally, and as a primary care profession specifically. Historically there have been two dominant paradigms in the provision of psychological services in health care settings: One approach emphasizes the contributions of systems theory and family theories, and has been applied

widely in primary care, most often in family medicine settings. The other approach is used most often in disease-specific tertiary care settings, e.g., pediatrics, etc. Both approaches have more similarities than differences sand are viewed as complementary to one another. The report has good ideas and wonderful recommendations (e.g., on training and education, advocacy, research, comments on dominant paradigms and role functions, etc.). Intended to provide advice to CAPP with respect to direction and actions towards promoting the practice of psychology in primary health care. It is unfortunate that nothing ever came of the report. However, some members of the committee authored a paper on practical "nuts and bolts" aspects of practicing in primary care settings (see Haley, et. al)

Belar, C. D. (1996). A proposal for an expanded view of health and psychology: The integration of behavior and health. In R. J. Resnick & R. H. Rozensky (Eds.) Health psychology through the life span: Practice and research opportunities (pp. 77-81). Washington, DC: American Psychological Association.

This chapter serves as an introduction to other chapters in the section of the book and thus is not as informative as other articles by Dr. Belar or other authors in the book. In this article, Dr. Belar asserts "that 100% of all medical visits are psychological and that Cartesian mind-body dualism simply does not belong in any conceptualization or implementation of the health care system" (p. 78). The body of psychological knowledge has mushroomed over the past two decades. The applications of this knowledge to health psychology has correspondingly increased. Research literature supports the belief that brief psychological interventions are consistently associated with shorter hospital stays, fewer surgical complications and lower costs. The basis of her contention that 100% of medical visits are psychological in nature is the fact that behavior and health are inextricably intertwined.

Belar, C. D. (1997). Clinical health psychology: A specialty for the 21st century. Health Psychology, 16(5), 411-416.

Consistent with other writings, Belar again says that clinical health psychology is the specialty for the professional practice of psychology in health care. However, there are numerous challenges to be met if the specialty is to achieve its potential during the next century. This article represents an overview of the author's health promotion effort for the specialty of clinical health psychology. She discusses the scientific bases of practice, dissemination of knowledge, utilization of knowledge (especially in advocacy and clinical practice), and education and training related to the field of clinical health psychology.

Belar, C. & Deardorff, W. W. (1995). Clinical health psychology in medical settings: A practitioner's guidebook. Washington, DC: American Psychological Association.

This book is relevant for suggestions in integrating psychology (and psychology training) in a primary care setting as well as a general medical setting.

Bray, J. H. (1996). Psychologists as primary care practitioners. In R. J. Resnick & R. H. Rozensky (Eds.), Health Psychology through the life span: Practice and research opportunities (pp. 89-99). Washington, DC: American Psychological Association.

The author talks about the expanding roles for psychology in the delivery of behavioral health services in a variety of health care settings. He reviews the definitions of primary care and the role of psychologists and outlines the components of a training model designed to teach psychologists and physicians how to work in collaborative practice. A good overview for anyone contemplating changes in educational programs or in developing an interdisciplinary practice with physicians.

Brown, H. N. & Zinberg, N. E. (1982). Difficulties in the integration of psychological and medical practices. American Journal of Psychiatry, 139(12), 1576-1580.

The authors discuss five principle sources of difficulty in the practical application of an integrative or collaborative practice between psychology and medicine. The primary sources of conflict are differences in values and cultures; differences in training; differences in dealing with emotions, conflicting patient expectations, and differences in ability to tolerate intimate professional relationships. These factors should be taken into consideration in the training of professionals.

Clayson, D., & Mensh, I. N. (1987). Psychologists in medical schools: The trials of emerging political activism. American Psychologist, 42, 859-862.

Psychology in medical education has a history of about 75 years and the number of psychologists on medical school faculties is increasing. Psychology 's role has shifted from research to clinical practice, to teaching, and then to administration within medical schools, following the historical course of other medical school faculty disciplines. "The effective delivery of modern health care depends upon an integration of the social, behavioral, biological and physical sciences into clinical practice" (p. 861).

Dammers, J., & Wiener, J. (1995). The theory and practice of counselling in the primary health care team. In J. Keithley & G. Marsh (Eds.), Counselling in primary health care (pp. 27-56). New York: Oxford University Press.

The authors, a British counsellor and a primary care physician discuss the variety of activities that go on in "primary care" that may be considered as a "type of counselling." They describe a training program developed by Michael and Enid Balint (subsequently referred to in other articles as Balint groups or Balint type groups) which trains counsellors and physicians to work together in seeing patients. The idea is that the more difficult patients would be jointly seen and then seen by the counsellor whereas the patients with minor problems could be handled by the physician alone. Funding of counsellors was addressed as a significant problem as was communication problems and the difficulty of finding a common language.

Diekstra, R. F., & Jansen, M. A. (1988). Psychology's role in the new health care systems: The importance of psychological interventions in primary health care. Psychotherapy, 25(3), 344-351.

This article focuses on the new [sic] health policies of the World Health Organization. The new policies are particularly concerned with prevention, health-enhancing lifestyles, and therefore the role of psychology in primary health care. In the author's view, psychology must establish itself as a discipline within the health sector rather than a "specialist or mental health care provider. They emphasize that simply relabeling an old product (specialized care) instead of changing the product to meet the changing needs of people and the new health care system is harmful to the field. Psychology needs to develop short-term and simple methods of assessment, treatment, and prevention at the primary care level. But, psychology also needs to design and market varied specialized services for a wide variety of patients.

Dörken, H. (1993). The hospital private practice of psychology: CHAMPUS 1981-1991. Professional Psychology: Research and Practice, 24(4), 409-417.

Author reviews and analyzes CHAMPUS inpatient data for 10 years. The article documents the gradual growth of the private practice of psychology in hospital settings over the 10 year period of 1981-1991.

The growth of licensed psychologists has increased dramatically and hospital practice is seen as an important foothold for the growth of psychology.

Enright, M. F., Resnick, R. J., Ludwigsen, K. R., & DeLeon, P. H. (1993). Hospital practice: Psychology's call to action. Professional Psychology: Research and Practice, 24(2), 135-141.

The general public has begun to demand continuity of care from outpatient settings to inpatient settings. Many hospitals have opened the doors to the independent practice of psychology in hospitals, rehabilitation settings, nursing homes, day-treatment centers, etc. The authors describe the background for hospital privileges by psychologists and the implications for continuity of health care, particularly inpatient mental health care. The authors also discuss the political agenda of obtaining hospital privileges in a higher percentage of hospitals than currently exists.

Frank, R. G., Gluck, J. P. & Buckelew, S. P. (1990). Rehabilitation: Psychology's greatest opportunity? American Psychologist, 45(6), 757-761.

Rehabilitation is one of the fastest growing areas in the health care field. Medicare, the major federal health insurance provider has included psychology as one of the providers of health care services. The article focuses on the need for psychology to become involved in health care at the policy level. However, it also discusses various ways in which psychology can become involved in primary health care.

Haley, W. E., McDaniel, S. H., Bray, J. H., Frank, R. G., Heldring, M., Johnson, S. B., Go Lu, E., Reed, G. M., & Wiggins, J. G. (1998). Psychological practice in primary care settings: Practical tips for clinicians. Professional Psychology: Research and Practice, 29(3), 237-244.

Opportunities for practice in primary care settings also challenge many aspects of traditional practice, and require adaptation and innovation. Psychologists must consider changes in their site of practice, treatment duration, type of intervention, and role as part of a health care team. The article describes the culture of primary care medicine and offers ten practical tips for the adaptation of psychological practice to primary care. The article is very relevant for interdisciplinary training for psychologists planning to work in a primary care setting.

Holden, E. W. & Schuman, W. B. (1995). The detection and management of mental health disorders in pediatric primary care. Journal of Clinical Psychology in Medical Settings, 2(1), 71-87.

A literature review about the detection and management of mental health disorders in a pediatric primary health care setting. More recently trained pediatricians are more effective in detection of mental health problems. Suggestions are made for more direct involvement of pediatric psychologists in the primary care setting.

Holland, J. (1996). Psychiatry and primary care: Closing the gap. International Journal of Psychiatry in Medicine, 26(2), 109-111.

This article provides a review of themes for closing the gap between psychiatry and primary care from articles on model programs on collaborative care and joint training. Some of the suggestions are relevant for other mental health professions as well. In the author's view, psychiatry has become separated from the medical establishment (following the trend to set up solo private practice offices) and thus, primary care training programs looked elsewhere for teachers of psychological and behavioral aspects of care. He recommends that we follow the model of consultation-liaison psychiatry—they have maintained the closest ties with primary care. Also, we need to identify those programs that have been the most

successful in closing the gap between primary care and psychiatry and identify themes/patterns that may be used by other programs.

Holloway, R. L. (1995). Building a primary care discipline: Notes from a psychologist in family medicine. Journal of Clinical Psychology in Medical Settings, 2(1), 7-19.

The author describes a number of contributions by psychologists to the growth of family medicine, particularly in the areas of family systems and education. Some of the most promising improvements in patient care have come from the discipline of family medicine. A number of family systems fellowship programs have been developed for training physicians and psychologists to work together. The author sees family medicine as being at a cross-roads and not sure that the collaboration with psychology will continue. Reasons for this were discussed and the author makes a strong argument for the continuation of "family" care by both professions.

Integrating primary and behavioral health care. (1997, November). Medical Benefits, November, 5-7.

"The concept of close cooperation between primary care and mental health as a cost-saving tool is becoming increasingly accepted among payers and managed care." For example, Health Partners has been encouraging close cooperation between its primary care and behavioral health providers (Managed Health care, April 1997). Patients treated under the integrated model had a 27% reduction in hospital admissions and reductions in bed days, physician office visits, and referrals to hospice programs. Cites Strosahl and others involved in integrating primary care and mental health-gives a number of sites and programs that are implementing models along these lines.

Jellinek, M. S. (1997). DSM-PC: Bridging pediatric primary care and mental health services. Journal of Developmental and Behavioral Pediatrics, 18(3), 173-174.

The DSM-PC referred to is the Diagnostic and Statistical Manual for Primary Pare Child and Adolescent Version. Author notes that the timing and context of the DSM-PC is ironic: At a time when we know more than ever about the recognition and treatment of psychosocial disorders, the reimbursement system has moved to restrict what pediatricians, psychologists, and child/adolescent psychiatrists are able to provide. But, "If the only priority driving the care of children were short-term economics, then "no care" is the lowest cost option to a managed care company. If we value children and if medical care has a role in meeting the psychosocial needs of children, the DSM-PC, the first and future revisions, is a fundamental step. The DSM-PC symbolizes collaboration, concern, and a clinical priority to meeting the psychosocial needs of children and their families." And classification is important for recognition and treatment of the psychosocial disorders.

Johnstone, B., Frank, R. G., Belar, C., Berk, S., Bieliauskas, L. A., Bigler, E. D., Caplan, B., Elliott, T. R., Glueckauf, R. L., Kaplan, R. M., Kreutzer, J. S., Mateer, C. A., Patterson, D., Puente, A. E., Richards, J. S., Rosenthal, M., Sherer, M., Shewchuk, R., Siegel, L. J., & Sweet, J. J. (1995). Psychology in health care: Future directions. Professional Psychology: Research and Practice, 26(4), 341-365.

Long article with the views of 20 experts from this evolving area of practice and research on matters of public policy, training, and the future of psychology in health care settings. Includes discussions of, among other things, skills needed by psychologists in this area, and training competencies.

Kaplan, R. M. (1990). Behavior as the central outcome in health care. American Psychologist, 45(11), 1211-1220.

A predominant justification for health psychology and behavioral medicine is that behavior or environmental conditions affect a biological process. Thus, many investigators focus attention on the effects of behavior on pathology and blood chemistry. Kaplan argues that behavioral outcomes are the most important consequences in studies of health care and medicine.

Keithley, J. & Marsh, G. (1995). Conclusions. In J. Keithley & G. Marsh (Eds.), Counselling in primary health care (pp. 296-302). New York: Oxford University Press.

In England, counselling is firmly a part of the services offered within primary health care and the growth of counselling services is not confined to these settings. The cost-effectiveness of counselling is difficult to determine because of the complexity of the task. The authors talk about the need to demonstrate cost-effectiveness and quality of care issues with the latter seen as more important.

Klapow, J. C., Pruitt, S. D., Epping-Jordan, J. E. (1997). Rehabilitation psychology in primary care: Preparing for a changing health care environment. Rehabilitation Psychology, 42(4), 1-11.

The changing health care market has begun to emphasize primary medical care instead of specialty referrals. Thus, new models of training are needed for mental health professionals to transition into this environment. Authors describe the Med-Plus model of clinical care which is a collaborative model of primary care physicians and psychologists. They focus on the application of the Med-Plus model in rehabilitation psychology.

Koenig, T. W., & Clark, M. R. (1996). Advances in comprehensive pain management. The Psychiatric Clinics of North America, 19, 590-611.

Authors describe the difficulties in managing patients with chronic pain. They conclude that chronic pain is a significant public health problem, and that psychiatrists have the capability of taking an active role in the management of chronic pain. Many patients with chronic pain have psychiatric disorders as well—psychiatrists need to participate in an integrated delivery of medical care to these patients.

Lazarus, A. (1995). The role of primary care physicians in managed mental health care. Psychiatric Services, 46(4), 343-345.

This article is useful in consideration of collaborative linkages between primary care MDs and mental health practitioners (both psychologists and psychiatrists). Although it does not discuss interdisciplinary training, its review of issues and goals for such interdisciplinary collaboration is quite relevant. Since the interplay between primary care MDs, psychiatrists, and psychologists is crucial in determining the quality of mental health services provided by HMOs, meetings between disciplines will build reciprocity and let each discipline learn about the other. Frequent collaboration between the primary care MD and other mental health professionals will minimize tension, increase appropriate psychiatric consultation, and decrease therapeutic defensiveness. Patients jointly managed by both psychotherapist and physician often have a closer relationship with the former, so the psychotherapist can better contribute personal and family history to the primary care MD that may have a more immediate impact on treatment. Primary care MDs should receive feedback about the patient's course in therapy and noncompliant patients should be brought to the attention of the primary care MD and HMO. Optimal practice requires cooperation and collaboration among all providers. Integrating primary health care with mental health services offers the best hope of improving the delivery of behavioral health care in managed care plans.

Margolis, R. B., Duckro, P. N., & Merkel, W. T. (1992). Behavioral medicine: St. Louis style. Professional Psychology: Research and Practice, 23(4), 293-299.

Article describes a unique multidisciplinary division in which 8 clinical programs are all administered by psychologists working in a university medical center setting. Discusses issues such as organizational structure and professional roles.

McDaniel, S. H. (1992). Implementing the biopsychosocial model. The future for psychosocia specialists. Family Systems Medicine, 10(3), 277-281.

Describes potential roles for (family practice) psychologists (other mental health disciplines could also fit) in health care, with an emphasis on their role in academic medical settings. Author presents information about barriers to collaboration with medical care providers and says we need to train psychosocial specialists properly so as to enable them to participate in a biopsychosocial approach to medical care. The folklore among therapists is that physicians are not interested in and poorly trained for collaboration…but many physicians now are better trained for their roles than are therapists. We need more internships and fellowships to train mental health professionals on-site in primary care contexts. We need to work on the "physician phobias" characteristic of so many therapists, and work to prevent the physician bashing so common at therapy meetings (p. 280). Primary care needs multiple perspectives, given the complex interweaving of biological, psychological, interpersonal, and social processes seen each day in MDs offices. "Turf issues" can be a source of discomfort for both sides. Central to a functional collaboration is an egalitarian relationship based on mutual respect.

Meyer, E. C., DeMaso, D. R., & Koocher, G. P. (1996). Mental health consultation in the pediatric intensive care unit. Professional Psychology: Research and Practice, 27(2), 130-136.

Mental health professionals often are not trained to provide integrated psychosocial services on an intensive care unit. However, the need for such services is high. The authors discuss how medical crisis counseling can be used as a conceptual framework to develop the skills needed to effectively intervene in crisis situations and/or intensive care units (which often have a 'crisis' atmosphere. The pediatric intensive care unit (PICU) is extremely demanding and stressful and takes a toll on the consultants. The authors describe the process of medical crisis consultation in the PICU setting, suggest survival strategies for the mental health consultant to the PICU, and provide illustrative case examples. Topics such as patient issues (e.g., intubation prevents speaking), consultant issues (effects of an emotionally demanding setting), and other staff issues (e.g., providing support) are addressed.

Newman, R., & Reed, G. M. (1996). Psychology as a health care profession: Its evolution and future directions. In R. J. Resnick & R. H. Rozensky (Eds.), Health Psychology through the life span: Practice and research opportunities (pp. 11-26). Washington, DC: American Psychological Association.

The authors examine changes in the health care system and health care policy in the US. They discuss the evolving role of psychology into a health care profession and consider the implications for the future. Professional psychology is faced with both a great opportunity and a great risk. The opportunity is for psychology to evolve into a health care profession—not primarily a mental health care profession. The risk is that if we do not resolve our "internal struggles and anxiety related to this professional role transition" (p.24) we may lose the opportunity to demonstrate we are competent to provide care other than the traditional mental health care—which can be provided by less well trained, and perhaps cheaper mental health providers.

Newman, R., & Rozensky, R. (1995). Psychology and primary care: Evolving traditions. Journal of Clinical Psychology in Medical Settings, 2(1), 3-6.

In their introduction to a series of journal articles, the authors point out that psychology's place as a primary health care discipline is fairly recent. The American Psychological Association has been sponsoring a number of projects to foster the collaboration between primary care medicine and psychology. They see many opportunities psychological practice in primary care settings.

Paulsen, R. H. (1996). Psychiatry and primary care as neighbors: From the promethean primary care physician to multidisciplinary clinic. International Journal of Psychiatry in Medicine, 26(2), 113-125.

Describes the development of a training program in primary care psychiatry and a co-practice model for psychiatry in primary care practice. Describes hypotheses as to why the program succeeded, and general elements that could be applied in efforts to develop similar practices in different settings. Relevant for integration of primary care and mental health practitioners in general, not just psychiatry. The HCA primary care faculty joined in co-teaching the multidisciplinary seminar taken together by the disciplines. Adaptations for psychiatrists (or other mental health professional in general) may need to make in order to successfully integrate into a primary care setting. Clarity of communication is important as is understanding the differences between the traditional "50 minute hour" and the primary care setting (e.g. clinician may have to learn to handle interruptions, wear a pager, work within the computer-based records system, and make calls to managed care, etc.). Discussion and planning of treatment (e.g., who does what) is vital. Since the medical staff may vary in their desire to engage in this type of activity, it is important to discuss this with the PCP to assess their preferred level of counseling and support this while delineating what will be referred on, and to whom. Remember, isolated practices are not conducive to collaboration but making mental health services accessible at the front line of primary care enhances delivery of care and does not detract from any service. In fact, patients are more likely to be willing to seek mental health services in this context than in the private office context.

Pruitt, S. D., Klapow, J. C., Epping-Jordan, J. E., Dresselhaus, T. (1998). Moving behavioral medicine to the "front line": A model for the integration of behavioral and medical sciences in primary care. Professional Psychology: Research and Practice, 29(3), 230-236.

Discusses the unprecedented opportunity that psychologists with behavioral medicine expertise have to impact primary health care. Somatic symptoms, chronic conditions, and health threatening behaviors are prevalent and most of the problems cannot be addressed from an exclusively biomedical model of care. Primary care physicians lack the time and/or skills to address the behavioral issues underlying chronic conditions and somatic complaints. The authors describe a model (Med-Plus) that has been developed to incorporate behavioral medicine into existing primary care practice with the purpose of delivering integrated, comprehensive, and efficient health care. The role of the psychologist is to bridge the gap between the primary care physician's training and the patient's presenting problems. Thus the psychologist can move away from isolated tertiary care to the "front line" of medical care where health outcomes and costs of primary medical care potentially can be improved.

Robinson, P. (1995). New territory for the behavior therapist…Hello, depressed patients in primary care. The Behavior Therapist, 18, 149-153.

According to Robinson, the primary care setting is or will become prominent in the health care delivery system and behavior therapists have a great deal to offer in this setting. In particular, the behavior therapist orientation towards brief, directive, focused interventions is applicable in this setting. The

author offers many concrete suggestions for anyone wishing to develop a practice in collaboration with primary care physicians.

Sartorius, N. (1997). Psychiatry in the framework of primary health care: A threat or boost to psychiatry. American Journal of Psychiatry, 154(6), 67-72.

Examines the relationship between psychiatry, mental health programs, and primary health care, and historical issues in the development of primary health care and what it was intended to be. Discusses the inclusion of mental health care in primary care within this context. Discussions conclusions from this review, one of which was: The argument about the best person or persons to provide treatment for mental illness is a relatively minor issue in the conundrum of decisions about the way in which the knowledge of psychiatry can be made to bear on new primary health care strategy and consequently on the development of medicine and national health programs.

Schurman, R. A., Kramer, P. D., & Mitchell, J. B. (1985). The hidden mental health network: Treatment of mental illness by nonpsychiatrist physicians. Archives of General Psychiatry, 42, 89-94.

The authors report data indicating that almost 50% of all office visits to physicians that result in a mental disorder diagnosis are likely to have been given by a primary care physician instead of a psychiatrist. The majority of these patients are less seriously ill than patients of psychiatrists, and are elderly, nonwhite females. Based on their research, the authors conclude that the primary care physicians are providing a different product than the psychiatrists, treating disorders less acute and more frequently associated with physical symptoms. They see the patients for briefer periods of time, are less likely to provide psychotherapy and more likely to provide medicine and perform diagnostic procedures and evaluations. They conclude that the role of nonpsychiatrist physicians as providers of mental health care is greater than originally thought. Unfortunately, there is no indication of the quality of the care and efficient use of medical resources available from the data in the present study.

Shapiro, J., & Talbot, Y. (1992). Is there a future for behavioral scientists in academic family medicine? Family Systems Medicine, 10, 247-256.

Examines the issue of whether nonphysician teachers of behavioral science have a long-term future in academic family medicine. While the answer is yes, several sources of threat to the special relationship between family medicine and behavioral scientists are investigated. Various formulations of this working relationship are considered, and a trilateral clinical model is proposed, which emphasizes collaboration regarding multiproblem patients; the establishment of interdisciplinary research endeavors; and the integration of the role of therapist/consultant to the system, which will provide a counterpoint perspective to the traditional medical world view through ongoing commentary and dialogue. The article concludes with a recommendation that opportunities for participation and influence be available to behavioral scientists within the system of academic family medicine.

Steinberg, M. D., Cole, S. A., & Saravay, S. M. (1996). Consultation-liaison psychiatry fellowship in primary care. International Journal of Psychiatry in Medicine, 26(2), 135-143.

Article describes a fellowship for psychiatrists in primary care. The program adapted the knowledge and skills objectives from a traditional consultation-liaison fellowship. They concluded that selecting a psychologically minded primary care practitioner was crucial. The training is best is a primary care setting rather than other location. Traditional consultation-liaison skills were easily transferred to the primary care setting.

Strathdee, G. (1987). Primary care-psychiatry interaction: A British perspective. General Hospital Psychiatry, 9, 102-110.

The author presents three models of interaction between primary care and psychiatry in the British National Health Service system. The first model, the 'replacement' model is similar to the US mental health clinic model where the psychiatrist replaces the general physician and the point of first contact for mental health needs. This model is not really appropriate for the British health care system as 70% of people are in regular contact with their primary care physician. The second model, the "increased input" model, expands the secondary care tier of mental health service. This is done through psychiatric outpatient referrals and did not work effectively. Problems were criteria for referral to an outpatient clinic and patients expressed dissatisfaction with the referral process and the clinical outcome. In the third model, the liaison-attachment service, psychiatrists were "attached" to primary care service settings. These psychiatrists and primary care physicians were studied and the research findings indicated an increased satisfaction in the referral process and clinical outcomes. This was true for patients and the professionals.

Strosahl, K. (1996). Confessions of a behavior therapist in primary care: The odyssey and the ecstasy. Cognitive and Behavioral Practice, 3, 1-28.

Excellent resource article. Strosahl summarizes the key learning experiences from a 5-year primary care integration project, organized by three behaviorally trained psychologists. He examines the major principles underpinning effective health and behavioral health integration and highlights main sources of organizational and disciplinary resistance, as well as some "tried and true" strategies for countering that resistance. He introduces the concept of primary mental health care as a distinctive form of behavioral health service that shares many of the philosophies of primary medical care. The changes in the structure of clinical practice are discussed as well as the more viable model of consultation. The defining characteristics of a consultant (vs. therapist) model are stated along with the core clinical services that are most valued in primary care settings. Psychologists must adjust their practice style to accommodate the demands of the primary care setting.

Sweet, J. J., Rozensky, R. H., & Tovian, S. M. (1991). Clinical psychology in medical settings: Past and present. In J. J. Sweet, R. H. Rozensky, & S. M. Tovian, (Eds.), Handbook of clinical psychology in medical settings (pp. 3-9). New York: Plenum Press.

Authors briefly discuss the history of clinical psychology and document the rapid rise of clinical psychologists employed in medical settings. Then they discuss the financial problems of health care and note that many of the techniques used by clinical psychologists (e.g. behavioral health interventions) can reduce the cost and consumption of health care through programs that reduce behavioral risk factors, increase compliance with medical treatments, etc. A major roadblock is the physician's lack of knowledge about the availability of psychological services. Other chapters in the book focus on ways in which to increase the physician's knowledge of and use of psychological services.

Teitelbaum, M. L. (1985). Obstacles to integration of medical and psychiatric care. Integrative Psychiatry, 3(2), 89-90.

The authors talk of the difficulty faced by the psychiatrist learning to cope with patients who are both physically and mentally ill while under the scrutiny of one's nonpsychiatric colleagues. However, such experiences are deemed necessary for the psychiatrist to learn to effectively collaborate with nonpsychiatric MDs in comprehensive care of the mentally disordered medically ill. Although both groups have much training and socialization in common, barriers to such learning (collaboration) are: 1) differences in basic approach to clinical problems that may interact with personality variables (e.g.,

psychiatry is process-oriented where other physicians are goal oriented); 2) oversimplification of illness (by either side); 3) for psychiatrists—negative emotional responses and distaste for working with physically ill patients; 4) deficiencies in knowledge among psychiatric trainees in important areas, including organic brain syndromes; and 5) training for psychiatry tends to be limited to work with psychiatric patients, providing little opportunity to collaborate with nonpsychiatric MDs.

Thompson, R. J. Jr. (1991). Psychology and the health care system: Characteristics and transactions. In J. J. Sweet, R. H. Rozensky, & S. M. Tovian, (Eds.), Handbook of clinical psychology in medical settings (pp. 11-25). New York: Plenum Press.

In this chapter, Thompson focuses on the challenges and opportunities confronting psychology in medical settings. A brief historical overview of psychology in medical settings in provided as a context for discussing the changing health care system. Four problems are identified and discussed: the increasing number of health care providers, corporatization and bureaucratization, administrative waste; and the crisis in medical education. Thompson concludes by saying that psychology has much to offer and to gain by fostering the continued development of psychology as a health care science and profession.

Tovian, S. M. (1991). Integration of clinical psychology into adult and pediatric oncology programs. In J. J. Sweet, R. H. Rozensky, & S. M. Tovian, (Eds.), Handbook of clinical psychology in medical settings (pp. 331-352). New York: Plenum Press.

Cancer has numerous secondary psychosocial problems associated with it and thus oncology programs in medical settings are important areas for clinical practice. The author focuses on the integration of psychology into oncology services. He provides a biopsychosocial model for understanding the patient. A variety of methods of psychological assessment and intervention are provided in the chapter, all focusing on applications to cancer patients. A very useful chapter for anyone wishing to work with cancer patients in a treatment and/or research capacity.

Wickramasekera, I., Davies, T. E., & Davies, S. M. (1996). Applied pychophysiology: A bridge between the biomedical model and the biopsychosocial model in family medicine. Professional Psychology: Research and Practice, 27(3), 221-233.

Over half of all patient visits to primary care physicians are related to psychosocial problems that are presented as common somatic complaints. Physicians often miss the psychological aspects of the illness; however, psychophysiological diagnostic and therapeutic methods can directly, objectively, and quantitatively reveal this missing mind-body connection. Psychophysiological treatment methods, including biofeedback, hypnosis, and cognitive behavior therapy, have been shown to be empirically effective with several somatic conditions. Patients are best treated by a psychophysiological approach that can most effectively be conducted in a nonpsychiatric primary care setting.

Wright, L. (1985). Psychology and pediatrics: Prospects for cooperative efforts to promote child health: A discussion with Morris Green. American Psychologist, 40, 949-952.

Presents a discussion with Morris Green, Professor of Pediatrics at Indiana University School of Medicine. This article indicates numerous ways psychology and pediatrics could interact and highlights the need for primary mental health care. It is noteworthy that whereas pediatrics represents true primary health care for children, both psychology and psychiatry have defined their role as secondary or specialty care. There is, therefore, no primary mental health discipline. Because a majority of Americans are seeking mental health care in primary care settings, it stands to reason that our total health care delivery system could benefit considerably from the emergence of primary mental health service providers, namely psychologists who work in primary (e.g., pediatric) settings.

\Wright, L., & Burns, B. J. (1986). Primary mental health care: A "find" for psychology? Professional Psychology: Research and Practice, 17(6), 560-564.

Authors discuss the challenges facing psychology in the field of primary health care as opposed to secondary or tertiary care. They focus on pediatric and family medicine settings. Unfortunately our graduate programs are not oriented towards this particular area. However, they see many opportunities for psychology in the primary care field, as a consultant, service provider, and researcher.

Wright, L., & Friedman, A. G. (1991). Challenge of the future: Psychologists in medical settings. In J. J. Sweet, R. H. Rozensky, & S. M. Tovian, (Eds.), Handbook of clinical psychology in medical settings (pp. 603-614). New York: Plenum Press.

Authors discuss the current challenges (from within and without the field) for psychologists involved in medical settings. Expanding knowledge and understanding of the interrelationship between health and behavior increases the opportunities for psychologists in the behavioral health care field. The authors make the case that scientifically oriented psychologists can develop improved methods for both primary mental health care and physical health care, particularly for medical problems associated with behavioral life styles.

Wulsin, L. R. (1996). An agenda for primary care psychiatry. Psychosomatics, 37(2), 93-99.

Proposes an agenda for developing primary care psychiatry programs in departments of psychiatry. Discusses the rationale for shifting resources toward primary care psychiatry and the goals of primary care psychiatry programs, with examples of existing initiatives. Suggestions are to provide direct teaching to primary care physicians on recognition and treatment of psychiatric illness in primary care populations; revising psychiatry's first year training in medicine to emphasize more "primary care" rotations; providing fellowships in primary care psychiatry for graduates of primary care residencies who want to develop an expertise in psychiatric disorders. The author recommends combined residencies between psychiatry and primary care departments; interdepartmental rotations, and primary care psychiatry clinics (the part-time provision of psychiatric services in the outpatient primary care setting). These changes will minimize the gap that currently sabotages psychiatric referrals and will maximize collaboration between clinicians, increasing chances for teaching primary care physicians about psychiatry and vice versa. A frequently mentioned barrier is the lack of access to timely psychiatric resources. This can be overcome through location psychiatric practice sites within/near key primary care sites, tailoring recommendations to constraints of primary care practice and rapid responses to requests for consultation. All of the above should result in an increased recognition and treatment/referral of mental illness by primary health care providers.

2. Efficacy and cost-effectiveness of psychosocial interventions

Blanchard, E. B. (1994). Behavioral medicine and health psychology. In A. E. Bergin & S. L. Garfield (Eds.) Handbook of psychotherapy and behavior change (4th ed., pp. 701-733). New York: Wiley.

The author reviews 11 areas of medical disorders and diseases (e.g. headaches, inflammatory bowel disease, obesity, etc.) for which psychological treatments have been shown to be useful. Treatments involve behavioral and cognitive techniques and are very brief. While this article does not argue for psychology and psychological treatments in primary care, it provides a lot of evidence documenting the need for and effectiveness of such treatment in medical settings.

Friedman, R., Sobel, D., Myers, P., Caudill, M., & Benson, H. (1995). Behavioral medicine, clinical health psychology, and cost offset. Health Psychology, 14, 509-518.

The authors review six pathways by which behavioral interventions can maximize clinical care and result in economic savings in the cost of health care. They provide many details about the benefits of behavioral health care in terms of actual cost as well as psychological benefits to the patients. The need to distance the "behavioral medical interventions" from traditional psychotherapy is discussed.

Groth-Marnat, G., & Edkins, G. (1996). Professional psychologists in general health care settings: A review of the financial efficacy of direct treatment interventions. Professional Psychology: Research and Practice, 27, 161-174.

Although the authors do not focus on the role of psychology in primary care medicine, they review the literature demonstrations the extent to which psychologists (i.e., mental health care) can reduce medical costs of health problems while still maintaining treatment effectiveness. This is a good article to document the need for mental health treatment in combination with physical health treatment.

Kroenke, k. & Mangelsdorff, A. D. (1980. Common symptoms in ambulatory care: Incidence, evaluation, therapy, and outcome. American Journal of Medicine, 86, 262-266.

Authors report a study of over 1,000 patients in an internal medicine clinic. Of the most common symptoms in primary care settings, less than 16% had a definite physiological basis, 10% had a psychiatric basis, and the remainder of the symptoms were unknown in origin. Many of the patients had clear psychological distress associated with their medical or somatic symptoms.

Smith, G. R., Monson, R. A., & Ray, D. C. (1986). Psychiatric consultation in somatization disorder: A randomized controlled study. The New England Journal of Medicine, 314(22), 1407-1413.

The authors conducted a randomized trial experiment to determine if psychiatric consultation would reduce the medical cots of patients with significant somatization. The results indicated that the treatment group costs were significantly lower than the control group and when the control group was given psychiatric consultation, their overall medical costs declined significantly. Thus psychiatric care for the patients reduced overall health care costs.

Sobel, D. S. (1995). Rethinking medicine: Improving health outcomes with cost-effective psychosocial interventions. Psychosomatic Medicine, 57, 234-244.

Author proposes that integrating psychosocial interventions into health care is complementary to biomedicine and results in healthier patients and potentially lower health care costs. Current treatments typically ignore the mental, emotional, and behavioral dimensions of illness. However, addressing the psychological and educational needs of patients makes economic and health sense.

3. Practice or application in managed care settings

American Psychological Association. (1992). Integrated care. Washington, DC: Author.

A book focusing on the delivery of integrated care within the context of managed care. A good reference for anyone contemplating setting up a practice, joining a group, etc. Emphasizes the necessity of

providing all the services a client needs, not just "mental health" counseling and providing these services in an integrated care setting.

American Psychological Association Practice Directorate. (1995). Building a group practice: Creating a shared vision for success. Washington, DC: American Psychological Association.

Book summarizes the practical steps involved in building a group practice with a focus on doing so in a managed care environment. A necessary resource for anyone contemplating developing a group practice, especially an interdisciplinary group.

American Psychological Association Practice Directorate. (1996). Developing an integrated delivery system: Organizing a seamless system of care. Washington, DC: American Psychological Association.

Book summarizes the development of the concept of integrated delivery systems and discusses how to develop such a system within the context of managed care. A necessary resource for anyone contemplating developing such a system. A good resource in general for managed care.

Barlow, D. H. (1994). Psychological interventions in the era of managed competition. Clinical Psychology: Science and Practice, 1(2), 109-122.

This article is frequently cited in other articles on the changes in training and practice that are needed for psychologists to thrive in the coming marketplace. "The importance of psychological treatments in forthcoming national health care plans has been deemphasized in federally sponsored clinical practice guidelines published to date, and questioned by certain policymakers and consumer groups. Many critics impugn the clinical efficacy and effectiveness of psychological treatment compared to drug treatments. This article reviews evidence suggesting that psychological interventions from a variety of theoretical perspectives have demonstrated effectiveness for a wide range of disorders--either alone or, in some cases, in combination with medications. In most cases these treatments are effective and often longer lasting than credible alternative psychological interventions serving as psychological placebos." (Abstract) Political and public relations issues, as well as problems with dissemination, must be overcome if the public is to benefit fully from powerful and effective psychological interventions in any national health care plan."

Belar, C. D. (1995). Collaboration in capitated care: Challenges for psychology. Professional Psychology: Research and Practice, 26(2), 139-146.

A theme that is recurrent in the literature is the need to integrate physical and psychosocial health care, particularly in an HMO setting. Belar discusses the problems for psychology in this setting and argues that psychology's future in a capitated care setting (e.g. primary care HMO) is dependent upon the psychologists' skills in research, program development and specialty practice areas, e.g. behavioral health not mental health. She makes a strong argument for multidisciplinary collaboration and the elimination of mind-body dualism in health care policy.

Chisholm, M., Howard, P. B., Boyd, M. A., Clement, J. A.., Hendrix, M. J., & Reiss-Brennan, B. (1997). Quality indicators for primary mental health within managed care: A public health focus. Archives of Psychiatric Nursing, 11(4), 167-181.

Primary mental health is an orientation to care that addresses mental health needs of consumers at the point of first contact with a health care provider. The authors provide guidelines for determining quality

care, particularly in a primary care setting. The authors recommend multi-disciplinary teams to provide services.

Crane, D. D. (1986). The family therapist, the primary care physician, and the health maintenance organization: Pitfalls and possibilities. Family Systems Medicine, 4(1), 22-30.

The therapist and physician need to appreciate the differences between the professional contexts in which the family therapist and the primary care physician work. This is particularly important in the era of HMOs or other organized systems of health care delivery. The author provides suggestions for maximizing the primary care physician as treatment resource and avoiding an adversarial relationship with the physician.

Cummings, N. A. (1996). The new structure of health care and a role for psychology. In R. J. Resnick & R. H. Rozensky (Eds.), Health Psychology through the life span: Practice and research opportunities (pp. 27-38). Washington, DC: American Psychological Association.

Like patients in denial, psychologists and educators denied the changes in the health care marketplace and lost the opportunity to take charge of the behavior managed care industry. Once more, we are faced with a new opportunity to make a difference—the question is will we. According to Cummings, carve-outs are out and carve-ins are in and the future is in behavioral health. As early as 1979 Cummings talked about the psychologist as the behavioral primary care physician of the future. He believes that psychologists have the knowledge and skills to participate as owners in the provider groups that are likely to replace the current managed care carve-outs that he sees as having outlived their usefulness. However, an attitude shift is paramount and only those with the 'right' attitude will be among the survivors.

DeLeon, P. H., Sammons, M. T., Frank, R. G., & VandenBos, G. R. (1998). Changing health care environment in the United States: Steadily evolving into the 21st century. Manuscript submitted for publication.

Discusses the changes in the nation's health care system that will have a direct impact upon the future of professional psychology, including: increasing acceptance of managed care, technological advances in computer and communications industries, decreasing numbers of psychologists, and the evolution of psychology into the generic health care arena. The authors argue that psychology is one of the "learned professions" and should prosper if the practitioner and academic communities work collaboratively to address society's pressing needs. Some of the topics discussed that are particularly relevant for this project are: The Office of Rural Health Policy (e.g., an emphasis on multidisciplinary and community-focused care; may be a useful reference for this area alone, as this project may be covering concerns raised but not addressed by them), Graduate Medical Education issues, health care costs (e.g., fragmented care has often been viewed as a sizeable factor in the escalation of cost), the Oxford Health Care Plan (and other programs that may serve as models/blueprints), and opportunities for the future (e.g., individuals with chronic health conditions).

Fischer, L. R., Heinrich, R. L., Davis, T. F., Peek, C. J., & Lucas, S. F. (1997). Mental health and primary care in an HMO. Families, Systems & Health, 15(4), 379-391.

The authors describe the first phase of a multi-year project to integrate (and evaluate) primary care and mental health in a staff-model HMO. Two components of the mental health delivery system were evaluated: 1) the traditional separate system and 2) a health psychology pilot program. Little collaboration occurs in the traditional, separate system because of the communication gap between primary care and mental health often creates an access problem. However, physicians who work on teams with health psychologists describe advantages in terms of communication, access, and

collaboration. Unfortunately, because the health psychology pilot program operated in only a portion of a very large care system, it has thus far had only a minimal effect on the way care is delivered in the overall system. Perhaps changes will continue to occur.

Hersch, L. (1995). Adapting to health care reform and managed care: Three strategies for survival and growth. Professional Psychology: Research and Practice, 26(1), 16-26.

This article focuses on the impact on and reaction to managed care by psychologists. Psychology could "expand its traditional role as a mental health profession to a broader role as a primary health care profession. There are a number of important health care statistics that support this position. It is known that stress, behavior, and lifestyle are significant factors in five of the seven leading causes of death in American. Similarly, 15 of the 20 leading diseases treated by primary care physicians have significant stress-related or behavioral components. Finally, approximately 60% of all visits to primary care physicians are stress-related. In this context, it becomes quite clear that psychologists must be included as core members of an integrated comprehensive primary health care prevention and health promotion system if such health care delivery systems are to become both clinically effective and cost-effective." Article also discusses issues in working with PCPs and discusses some of the advantages of working in a PCP office. Also an excellent article for anyone needing more information about working and surviving in a managed care setting.

Lazarus, A. (1994). A proposal for psychiatric collaboration in managed care. American Journal of Psychotherapy, 48(4), 600-609.

Managed care has had a significant impact on the biopsychosocial model as seen through patient-psychiatrist relationships. Nonmedical therapists, primary-care physicians, and third- and fourth-party administrators have played an increasingly visible role in managed-care delivery systems and are now considered part of the treatment team. Several vignettes are presented to illustrate some of the difficulties encountered in this type of expanded arrangement. The needs of each part can best be served through a model that relies on collaboration rather than competition.

Mauksch, L. B., & Leahy, D. (1993). Collaboration between primary care medicine and mental health in an HMO. Family Systems Medicine, 11(2), 121-135.

The authors describe ways to dissolve the many barriers to collaboration between primary care providers and mental health professionals. The Group Health Cooperative of Puget Sound (GHC) is one of the nation's largest HMOs and the authors describe how GHC developed an integrative system for mental and physical health care within the organization. They describe the evolution of care and emphasize that continuing education (particularly in collaborative care) and continuing emphasis on resolving differences is important for all professionals.

Peek, C. J. & Heinrich, R. L. (1995). Building a collaborative health care organization: From idea to invention to innovation. Family Systems Medicine, 13, 327-342.

The authors discuss how they built a collaborative health care organization—the problems and conflicts that arose and the ways in which they surmounted them. They worked together to build a integrated care system in which physical and mental health care are collaborative rather than separate.

Perrott, L. A. (1998). When will it be coming to the large discount chain stores? Psychotherapy as commodity. Professional Psychology: Research and Practice, 29(2), 168-173.

The author, in contrast to others who argue for psychology pursuing a health care model, argues that psychotherapy is a product purchased by "businesses" or consumers and they want 'bargain basement prices" for this product. He suggests that practitioners should focus on developing specialized techniques for newly defined market segments and not focus on the medical model. Only by developing innovative approaches to the treatment of mental health problems will psychology have a unique and desirable product for consumers or customers.

Richardson, L. M., & Austad, C. S. (1991). Realities of mental health practice in managed-care settings. Professional Psychology: Research and Practice, 22(1), 52-59.

As a current review of managed care plans and how to practice within those plans, this article is probably quite out of date. However, many of the suggestions with respect to clinical practice are still relevant. A good review of information in the late 80's through 1990.

Roulidis, Z. C., & Schulman, K. A. (1994). Physician communication in managed care organizations: Opinions of primary care physicians. Journal of Family Practice, 39(5), 446-451.

A survey about communication between primary care physicians and specialists. Results indicated that communication between primary care physicians and mental health professionals (or even other medical specialists) may be impaired when managed care programs are involved.

Shortell, S. M., Gillies, R. R., & Anderson, D. A. (1994). The new world of managed care: Creating organized delivery systems. Health Affairs, 13, 46-64.

Authors suggest that integrated delivery systems which have psychologists practicing in collaboration with primary care providers are more effective than other systems. Psychologists who work closely with primary care providers as part of an integrated delivery system are most likely to continue to deliver services to a wide variety of patients.

4. Primary care physicians: diagnosis and treatment of mental illness

Callahan, C. M., Hendrie, H. C., & Tierney, W. M. (1996). The recognition and treatment of late-life depression: A view from primary care. International Journal of Psychiatry in Medicine, 26(2), 155-171.

Article discusses the issue of efforts to improve the recognition and treatment of late-life depression by primary care physicians (PCP). PCPs can expect to see about 150-250 patients per year with significant symptoms of depression. PCPs lack information about how best to treat the majority of their patients with depression. More research is needed to assist PCPs in their treatment efforts.

Cohen-Cole, S. A., Bird, J., Freeman, A., Boker, J., Hain, J., & Shugerman, A. (1982). An oral examination of the psychiatric knowledge of medical housestaff: Assessment of needs and evaluation baseline. General Hospital Psychiatry, 4, 103-111.

The authors administered a standardized exam to 26 medical residents of a hospital and discovered that 88% could not differentiate organic from functional psychosis, and could not list three side effects of tricyclic antidepressants. They concluded that there are clear deficits in resident's knowledge of common psychiatric disorders in medical practice. The findings guided their development of a needs-based liaison psychiatry curriculum for residents in primary care internal medicine. (The curriculum is available upon

request from the authors). The curriculum covers the basic elements of diagnosis and treatment of common psychiatric disorders.

Docherty, J. P. (1997). Barriers to the diagnosis of depression in primary care. Journal of Clinical Psychiatry, 58 (Suppl. 1), 5-10.

According to the author, approximately 50% of patients receiving care for depression do so in primary care settings. However, primary care physicians often underdiagnose and undertreat depression. Detection is difficult and complaints of physical symptoms confuse the clinical picture. Also, the physician often is reluctant to inquire about depression. A variety of tools (questionnaires) are available to assist the physician in the recognition and accurate diagnosis of depression.

Eisenberg, L. (1992). Treating depression and anxiety in primary care: Closing the gap between knowledge and practice. New England Journal of Medicine, 326, 1080-1084.

Article summarizes the treatment of depression and anxiety and states that these disorders are underdiagnosed and undertreated in a primary care setting. Recommends are made to address these issues.

Heldring, M. (1995). Primary health care for women: What is it and who provides it? Journal of Clinical Psychology in Medical Settings, 2(1), 39-48.

Women comprise the majority of the population, particularly the elderly. Their needs often are ignored or misdiagnosed by the primary care physician. The author discusses how primary health care services for women can be cost-effective, comprehensive, and effective. Prevention and education are two primary health care services needed, particularly in a collaborative setting where the psychologist and primary care physician work together.

Horn, S. D. (1997). Overcoming obstacles to effective treatment: Use of clinical practice improvement methodology. Journal of Clinical Psychiatry, 58 (Suppl. 1), 15-19.

Author discusses the results of a large scale study examining the effects of cost-containment strategies on patient outcome and utilization of care. A significant finding was that "given the wide use of psychiatric medications without psychiatric diagnoses, there is substantial underdiagnosis of psychiatric illness in the ambulatory patient population…and that the management of such illness is inconsistent and inappropriate" (p. 18). The patients studied were in primary care settings, further pointing out the fact the primary care physicians often underdiagnose and inappropriately treat mental illness.

Kane, F. J. (1996). Need for better psychiatric training for primary care providers. Academic Medicine, 71(6), 574-575.

Comments that primary care physicians are improperly trained to recognize and treat psychiatric problems; they have negative attitudes towards these patients and are unlikely to refer them for mental health care.

Kingsbury, S. J. (1995). Bias in the guidelines or bias in the response? American Psychologist, 50(6), 455-456.

Comments on the response of Munoz, Hollon, McGrath, Rehm, & Vanderbos (January 1994) to the Agency for Health Care Policy and Research Depression in Primary Care guidelines. Among other comments (e.g., suggesting a psychosocial bias), they note, on a more pragmatic level, that primary care

physicians would seem to lack the time, the training, and the interest to provide psychotherapy, even if there were enough physicians to provide this care. Referring depressed patients could hurt these physicians financially without clearly documented advantages for the patient. Others may not share the psychosocial bias, which leads to the preference for using psychotherapy.

Liese, B. S., Shepherd, D. D., Cameron, C. L., & Ojeleye, A. E. (1995). Teaching psychological knowledge and skills to family physicians. Journal of Clinical Psychology in Medical Settings, 2(1), 21-38.

The prevalence of psychological problems in primary care is well documented. Family physicians treat more primary care patients than any other specialty yet they are poorly prepared to treat mental health problems. Thus they would benefit greatly from knowledge of psychological principles and skills. Family practice physicians are required to complete a behavioral science component in their training. The authors describe a program they use for teaching these skills to family practice residents at the University of Kansas Medical Center.

Luber, M. P. (1996). Overcoming barriers to teaching medical housestaff about psychiatric aspects of medical practice. International Journal of Psychiatry in Medicine, 26(2), 127-134.

This article describes a training program in psychiatric aspects of medical practice, including six fundamental elements that contribute to the effectiveness of this program, including teaching collaboration between psychiatric and medical faculty. The author cautions that we should be aware that psychosocial programs are poorly perceived by medical residents who often believe they are "marginal to 'real medicine'" and have little impact on how doctors actually practice medicine. This is a significant barrier in the provision of training in the psychiatric aspects of medical care and can only be overcome through collaboration between psychiatric and medical faculty. The medical students often resistant to learning about psychosocial treatment because it takes too much time, and they believe that if feelings are brought up, everyone can get carried away (p. 128). The solution is to 1) directly address trainees' resistance to psychosocial/psychiatric topics; 2) place an emphasis on practical skills; 3) emphasize active (not passive) learning and attention to process during teaching sessions; 5) have faculty who are not "outsiders", e.g., collaboration between psychiatric/psychological staff and medical housestaff and 6) be sure that teaching is integrated with clinical service and clinical research.

Pilgrim, D., Rogers, A., Clarke, S., & Clark, W. (1997). Entering psychological treatment: Decision making factors for GPs and service users. Journal of Interprofessional Care, 11(3), 313-323. Abstract retrieved May 5, 1998 from the World Wide Web: http://www.city.ac.uk/barts/jipc/jipc1a.htm. For ordering information e-mail: sales@carfax.co.uk.

This article examines patient and referrer decision-making factors surrounding entry to psychological treatment in a primary care setting. Drawing on qualitative data generated by a case study of patients and general practitioners (GPS), the help seeking concerns of patients and frameworks of understanding of their referrers are compared and contrasted. The accounts of patients reveal a complex process of access which operates in a unique biographical context. The latter includes expectations and experience of counseling, the timing of help seeking, triggers to help seeking, lay problem formulation, the perceived adequacy of GPs and self-care strategies. The analysis presented suggests that negotiations for help seeking to ameliorate psychological distress in a primary care setting reflect both objective processes and subjective attributions about these processes from the two parties studied. (Abstract).

Pincus, H. A., Tanielian, T. L., Marcus, S. C., Olfson, M., Zarin, D. A., Thompson, J., & Zito, J. M. (1998). Prescribing trends in psychotropic medications: Primary care, psychiatry, and other medical specialties. JAMA, 279(7), 526-531.

The purpose of this article was to examine changes in the prescribing patterns of psychotropic medications between 1985 and 1994. They examined practices in office-based physician practices in the U.S. Based on their results, they concluded that prescribing practices have changed. The rate of increase of prescriptions for psychotropic medications was from 5.1% to 6.5% and antidepressant medications were now prescribed more frequently than anti-anxiety medications. Although visits for depression doubled for both primary care physicians and psychiatrists, psychiatrists prescribed antidepressants more often than primary care physicians. One interpretation of the data is that it reflects the lack of knowledge of appropriate treatment by primary care physicians.

Rabinowitz, J, Feldman, D., Gross, R., & Boerma, W. (1998). Which primary care physicians treat depression? Psychiatric Services, 49(1), 100-102.

The data reported on in this study was obtained from a national study on the role of primary care physicians in Israel. Twenty-two percent reported that they always treated depression themselves; 37% reported usually treating depression, 28% sometimes and 13% never. Those who reported always or usually treating depression spent more time on continuing education, specializing in family medicine, conducted more home visits, had more frequent contact with social workers and were more "family oriented." The authors conclude that "because of primary care physicians' pivotal role in treating depression and because so many studies have found low rates of recognition and treatment of depression in primary care settings, considerable attention should be focused on improving treatment of depression in primary care settings" (p. 102).

Saltz, C. C. (1985). Recognizing depression in patients receiving medical care. Health and Social Work, 10(1), 15-22.

Depression goes unnoticed and untreated in primary care. Social workers can help physicians recognize the manifestations of depression and determine whether referral is needed. However, they are usually consulted only when (or if) the physician suspects underlying psychological or social problems. Because physicians don't often recognize depression many patients go untreated.

Saltz, C. C., & Magruder-Habib, K. (1985). Recognizing depression in patients receiving medical care. Health & Social Work, 15-22.

Another article which describes the fact that depression is common condition among patients seeking care in a primary care setting and the primary care physicians often do not recognize the disorder. The article explores how "social workers can help improve the identification and management of depression in such settings" (p. 15).

Sartorius, N., Üstün, B., Costa e Silva, J-A, Goldberb, D., Lecrubier, Y., Ormel, J., Von Korff, M., & Wittchen, H-U. (1993). An international study of psychological problems in primary care. Archives of General Psychiatry, 50, 819.

This article describes a large longitudinal collaborative study that took place in several centers. The study investigated the form (symptoms) frequency, course, and outcome of psychological problems that were seen in primary health care settings in 15 different sites around the world. They reported information on

the rates and comorbidity found in the analysis of this database (e.g., most frequent are mood, anxiety, somatoform disorders, and neurasthenia; approximately half of cases were recognized by the health care providers). Preliminary results suggest that the presence of psychological disorder was associated with substantial levels of disability across diverse countries and cultures. A very useful reference for mental health-primary care issues, such as the lack of recognition of mental health problems in primary care and impairments in functioning due to psychological problems.

Strelnick, A. H., & Massad, R. J. (1986). Preventing drug habits by changing physician habits: Obstacles and opportunities. Family Systems Medicine, 4(1), 51-71.

This article is about physicians' prescribing habits, how they may contribute to drug abuse in their patients, and how to treat drug abuse with a family systems approach. The authors note that other "members of the health team" (e.g., family/community health worker, nurse, receptionist, etc.) can bring knowledge of broader social support networks to the primary care physician and assist in appropriate treatment planning. The authors point out the family physicians often are unaware of important factors contributing to the problems and “reach for the prescription pad” as a way of treating the problem. Health care teams who have knowledge about the community and culture of the individual are recommended. This article indirectly supports the data that primary care physicians often prescribe inappropriately in treating their patient’s mental health problems.

Von Korff, M., & Simon, G. (1996). The prevalence and impact of psychological disorders in primary care: HMO research needed to improve care. HMO Practice, 10(4), 150-155.

A prevalence survey of a stratified sample of consecutive primary care patients. Found that depression, anxiety and somatoform disorders were common among primary care patients. They were associated with significant disability, unfavorable health perceptions and increased health care costs. Concludes that psychological disorders are common among primary care patients and have significant societal impacts including work disability and increased health care costs. HMOs with integrated delivery systems and research capabilities have a critical role to play in efforts to reduce the burden of these disorders by evaluating innovations in health care services for psychological disorders.

Wells, K. B. (1997). Caring for depression in primary care: Defining and illustrating the policy context. Journal of Clinical Psychiatry, 58(Suppl. 1), 24-27.

This article reiterates the knowledge that depression is a important mental disorder that frequently is undertreated, especially in the primary care setting. Quality improvements (e.g. improving antidepressant mediations, adding counseling, and limiting minor tranquilizer use) in the treatment of depression in primary care could improve the outcomes and cost effectiveness of treatment with very little increase in direct costs. The authors recommend adding counseling to the treatment of depression in primary care settings.

5. Primary care treatment of substance abuse, domestic violence, and mental illness.

Addleton, R. L., Tratnack, S. A., & Donat, D. C. (1991). Hospital-based multidisciplinary training in the care of seriously mentally ill patients. Hospital and Community Psychiatry, 42(1), 60-61.

Describes a four-week training program for service providers in public psychiatric health care at a state hospital in Virginia. The program familiarized students in medicine, occupational therapy, pharmacy, psychiatric nursing, psychology, and social work with the range of care for chronic mentally ill patients. Discusses the needs for multidisciplinary training and describes their training program (which included a

multidisciplinary training curriculum). Because students and faculty represented the professional groups that form the typical hospital treatment team, students learned and practiced what they learned in true multidisciplinary fashion. Multidisciplinary training decreases professional differences, creates a shared body of knowledge, promotes more harmonious working relationships, and generates a positive attitude toward a team approach to psychiatric treatment. Despite the need for multidisciplinary training, few such programs exist in public mental health settings. Participants in the hospital-based multidisciplinary training program considered it a positive experience.

Addiction Technology Transfer Centers National Curriculum Committee. (1998). Addiction counseling competencies: The knowledge, skills, and attitudes of professional practice. Rockville, MD: U.S. Department of Health and Human Services.

This document is included because it fits within training/working in a primary care setting. This document presents the knowledge, skills, and attitudes that are needed for achieving and practicing the competencies listed in Addiction Counseling Competencies (included as Appendix C). The document is intended to provide guidance for the professional treatment of substance use disorders which has become recognized as a complex multidisciplinary practice supported by a large and rapidly expanding body of theoretical and scientific literature. Both public and private initiatives have repeatedly demonstrated the cost effectiveness of well designed strategies for intervening with people suffering from the adverse consequences of both substance abuse and dependence. Fits well with the framework of interdisciplinary practice in a primary care setting.

Addiction Technology Transfer Center of New England. (Undated). Developing interdisciplinary teams for substance abuse treatment practitioners and agency personnel. Rockville, MD: U.S. Department of Health and Human Services.

A task force of the Addictions Technology Transfer Center of New England has developed a curriculum for training interdisciplinary teams in the substance abuse arena. There are 12 training modules complete with pre and post-tests to measure learning. A very useful curriculum for any profession that wishes to develop interdisciplinary teams in substance abuse. Much of the material could easily be translated into training interdisciplinary teams in other areas such as primary care.

Campbell, T. L. (1997). Research reports: Domestic violence in primary care. Families, Systems & Health, 15, 345-350.

Domestic violence (DV) is the leading cause of injury and death in women—yet it is infrequently identified by the primary care physician. The author reviews a series of research reports and concludes that much more research is needed in the area of domestic violence. Health care researchers can help primary care physicians identify victims of domestic violence. He concludes that the optimal treatment of DV victims involves collaboration between the primary care physician and a family therapist.

Geczy, B., Jr., Sultenfuss, J. F., & Donat, D. C. (1990). Psychologists in state mental hospitals: Problems and recommendations. Professional Psychology: Research and Practice, 21(5), 392-397.

The authors discuss the contribution of psychology as a discipline to the development of new treatment methods for severe behavior problems such as those found in the chronically mentally ill. They examine some of the more common problems that psychologists face in state facilities (that would be relevant to a number of other interdisciplinary settings), with specific focus on organizational, physician-related, and staff-related issues. They provide recommendations for ways to cope with problems in these three areas. The authors suggest that training programs add state hospital experience for graduate students as well as training in coping with administrative/organizational impediments, e.g., organizational inertia, turf battles,

clinically inexperienced administrators, and functioning within a custodial/medical organizational structure. Students need to learn to apply the same principles used in changing patient behaviors to facilitate staff relationships and encourage change in staff behavior. Need to be able to learn the system and work with it cooperatively rather than antagonistically. They also need knowledge about other disciplines and their contribution to patient care. Significant barriers to collaboration include the lack of knowledge by other staff on what psychologists can do and how they can be useful in patient treatment and the fact that some professionals view psychologists "merely as lab technicians to be used for psychological testing." (p. 394). Nurses may see psychologists as a threat to their authority and autonomy in regards to patient care. One solution is to educate educating administration and staff (probably by the psychologist themselves) about what a psychologist can do and what they can contribute to patient care.

Johnson, D. L. (Ed.) (1990). Service needs of the seriously mentally ill: Training implications for psychology. Washington, DC: American Psychological Association.

The book focuses on the needs of the seriously mentally ill, the fact that our current mental health professional training programs do not train a sufficient number of students in this area. Although the title says psychology, the training needs for psychiatry and nursing also are discussed. Only one interdisciplinary training program is discussed—highlighting the need for such programs! The book is useful for any discipline seeking information about training professionals to serve the needs of the seriously mentally ill.

Johnson, J. G., Spitzer, R. L., Williams, J. B. W., Kroenke, K., Linzer, M., Brody, D., deGruy, F., & Hahn, S. (1995). Psychiatric comorbidity, health status, and functional impairment associated with alcohol abuse and dependence in primary care patients: Findings of the PRIME MD-1000 study. Journal of Consulting and Clinical Psychology, 63, 133-140.

Alcohol abuse and dependence are relatively common in primary care settings, and primary care physicians fail to recognize the presence of alcohol abuse and dependence (AAD) in between 33% and 90% of their patients with AAD. The authors report on a study of 1,000 primary care patients with AAD. When the Primary Care Evaluation of Mental Disorders diagnostic system was used, there was a 71% increase in physician recognition of AAD. Many of these patients also had co-occurring psychiatric disorders. The health and functioning of the AAD patients were associated with the presence or absence of psychiatric disorders. However, the diagnostic system may have missed some patients because it is a screening device. More research is needed to compare the screening instruments with more lengthy structured clinical interviews.

Lefley, H. P. (1988). Training professionals to work with families of chronic patients. Community Mental Health Journal 24(4), 338-357.

The article describes a multidisciplinary (psychiatry, psychology, social work) training program which prepares clinicians to work in a collaborative relationship with families of the chronically mentally ill. The training model includes a didactic component on relevant research and theory, incorporating social policy and cross-cultural issues and emphasizing the actual experience of patients and families within a framework of coping and adaptation. Training in patient and family education, problem management, supportive counseling, and resource knowledge is accompanied by practicum experiences involving longitudinal work with chronic patients and families. Special features in psychiatric residency training are highlighted.

Liese, B. S., Vail, B. A., & Seaton, K. A. (1996). Substance use problems in primary care medical settings: Is there a psychologist in the house? In R. J. Resnick & R. H. Rozensky (Eds.), Health Psychology through the life span: Practice and research opportunities (pp. 177-194). Washington, DC: American Psychological Association.

Substance abuse problems are pervasive in the US; they are most frequently treated in a primary care setting; and, most physicians feel unprepared to deal with the psychological and behavioral manifestations of substance abuse. Thus the author argues that health psychologists should be actively involved in the treatment of substance abuse problems in the primary care setting. Much of the article is devoted to descriptions of the physical and psychological effects of various types of substance abuse. Unfortunately, as a general rule, psychologists have not been actively involved in the treatment of substance abuse problems. The authors suggest six areas in which health psychologists could, and should, become involved in working with patients with substance abuse problems. Although they do not make a strong pitch for collaboration with the primary care physician, others writing on this topic have done so.

Magrab, P. R., & Wohlford, P. (Eds.) (1990). Improving psychological services for children and adolescents with severe mental disorders: Clinical training in psychology. Washington, DC: American Psychological Association.

This book contains a selection of articles describing the need for services to the seriously disturbed child or adolescent, the lack of such services, and provides suggestions for training of clinical psychologists to meet his need. The focus is on the training of psychologists, but much of what is said is applicable to training other mental health professionals in this area. Although there is not much said about the primary care arena, there is some discussion of psychologists working in primary care settings such as pediatrics, child and adolescent services, etc.

Magruder-Habib, K., Durand, A. M., & Frey, K. A. (1991). Alcohol abuse and alcoholism in primary health care settings. The Journal of Family Practice, 32(4), 406-413.

Although alcohol problems are common in primary care patients, they often are not detected or treated by the patient's primary care physician. The authors review methods for detecting substance abuse problems (primarily screening instruments) and recommend that some screening instruments, such as the CAGE questionnaire and the Michigan Alcoholism Screening Test be routinely used by primary care physicians. A problem, discussed in the article, is that after diagnosis, the patient must be willing to go for treatment and the treatment must be effective. A problem not discussed is that the primary care physician may not be aware of adequate referral sources for treatment.

Ries, R. (1994). Assessment and treatment of patients with coexisting mental illness and alcohol and other drug abuse: Treatment improvement protocol series. Rockville, MD: U.S. Department of Health & Human Services, Public Health Service, Substance Abuse and Mental Health Services Administration.

This book provides practical information about the treatment of patients with dual disorders, including the treatment of patients with mood and anxiety disorders, personality disorders and psychotic disorders. Pragmatic information about systems and linkage issues relative to mental health and alcohol abuse programs is provided. The book is useful to any health care provider having to treat dually diagnosed patients, especially in a primary care setting.

Ruddy, N. B. & McDaniel, S. H. (1995). Domestic violence in primary care: The psychologist's role. Journal of Clinical Psychology in Medical Settings, 2(1), 49-69.

The article focuses on the prevalence of domestic violence (DV) in a primary care setting and the difficulties faced by primary care physicians in inquiring about DV with their patients. Psychologists on site can help the physician by being knowledgeable about community resources, making referrals, formulating emergency plans, etc. Psychologists can help physicians learn to broach the topic with their patients, deal with denials, resistance, etc. DV illustrates a serious need for collaboration between psychologists trained to deal with DV situations, primary care physicians, and the shelters that provide refuge to the victims. With close collaboration DV may be reduced.

Wohlford, P., Myers, H. F., & Callan, J. E. (Eds.). (1993). Serving the seriously mentally ill: Public academic linkages in services, research, and training. Washington, DC: American Psychological Association.

This book presents articles discussing the efforts to improve clinical training for psychological services to targeted groups such as seriously mentally ill children, adolescents and adults. Models of effective public-academic collaboration are presented. Also presented are articles discussing how to ensure quality and competence in training for mental health service. Although the focus is on the training of clinical psychologists, much of what is said pertains to other mental health disciplines and is relevant to primary care settings, public health clinics, etc.

E. Practice Guidelines: Articles Related to Practice Guidelines and Cultural Competencies

American Psychological Association (1992). Ethical principles of psychologists and code of conduct. American Psychologist, 47(2), 1597-1611.

The latest revision of the ethical principles for psychologists. This reference is included for information purposes.

American Psychological Association Board of Ethnic Minority Affairs Task Force on the Delivery of Services to Ethnic Minority Populations (1990). Guidelines for providers of psychological services to ethnic, linguistic, and culturally diverse populations. Washington, DC: Office of Ethnic Minority Affairs, American Psychological Association.

This reference is included for general information about guidelines and cultural competence to practice.

American Psychological Association Committee on Professional Standards Board of Professional Affairs (1987). General guidelines for providers of psychological services. Washington, DC: American Psychological Association.

This reference is included for general information about practice guidelines that are applicable to any or all settings.

Nathan, P. E. (1998). Practice guidelines: Not yet ideal. American Psychologist, 53(3), 290-299.

The author presents a brief history of the efforts to identify empirically supported treatments—initially the evidence did not support the efficacy of psychotherapies (perhaps because of methodological problems rather than lack of efficacy). With improved methodology, research studies have supported the efficacy of interventions. Nathan compares and contrasts three sets of practice guidelines (Agency for Health Care Policy and Research--AHCPR, the American Psychiatric Association, and the Division of Clinical Psychology of the American Psychological Association). Practice guidelines developed as a way of identifying empirically supported treatments and "although practice guidelines are not yet ideal they have the potential to enhance both the effectiveness and the accountability of interventions" (p.298). The article is included here because of the relevance of practice guidelines to practice in a primary care setting.

Center for Mental Health Services, Substance Abuse and Mental Health Services Administration (1998). Cultural competence standards in managed mental health care for four underserved/underrepresented racial/ethnic groups. Final report from working groups on cultural competence in managed mental health care. Boulder, Colorado: Western Interstate Commission for Higher Education (Purchase Order No. 97M04762401D).

This reference is included here because of the guidelines for cultural competencies in managed mental health care.

APPENDIX C

EDUCATION AND TRAINING GUIDELINES AND PRINCIPLES FOR PSYCHOLOGISTS TO FUNCTION IN PRIMARY HEALTH CARE SETTINGS AND ROLES

ATTITUDES RELEVANT TO PROFESSIONAL PRACTICE IN MANAGED CARE SYSTEMS AND PRIMARY CARE SETTINGS

1. Acceptance of inevitable change and openness to new ideas.

2. Tolerance for uncertainty, and a willingness to take responsibility in the face of it.

3. A strong disciplinary identity while valuing the unique and shared skills of different disciplines.

4. Having and promoting an attitude of respect for the autonomy and expertise of other professions while acknowledging the interdependence of the different professions in the provision of primary health care.

5. Desire to learn from other disciplines and willingness of different professions to respect their priorities and values.

6. A commitment to resolve conflict in turf issues, e.g. differences in status, values, priorities, etc.

7. An attitude conveying that the primary focus is on the patient, not professional turf issues.

8. A respect for the complexity of the human condition as presented in primary care.

9. Willingness to treat (or refer) whatever comes in the door.

10. Having a sensitivity to and respect for diverse patient, family, community, professional, and system cultures within the context of the provision of health care services.

11. Intraprofessional attitudes necessary for working effectively with others in a health care setting, including:

    a. Commitment to life-long learning (within and outside of one's own discipline)

    b. Accountability

    c. Accepting one's own and other's or system's limitations

    d. Respecting one's own expertise and knowing one's strengths and weaknesses

    e. Willingness to share power and a willingness to make explicit the issues of power that are not usually acknowledged and to negotiate ways of working with other professionals

    f. Continuous awareness of and openness to the dynamics of interprofessional relationships and commitment to working out problems.

    g. Respect for business principles in health care organizations

GENERAL OR GUIDING PRINCIPLES FOR PRIMARY HEALTH CARE PROVIDERS

KNOWLEDGE	SKILLS
1. Knowledge about the history, economics, and politics of health care at the national and local level and the role of primary care within the system. Without such knowledge it is difficult to understand the roles and attitudes of the various health care professionals. 2. Knowledge of the different types of professionals that provide care in a primary care setting; their roles and skills, priorities, values, and cultures. 3. Knowledge about the interprofessional approach to team building. 4. Knowledge regarding primary care. a. PC is the point of first call where patients usually bring undifferentiated problems b. Coordination of comprehensive care across the life span (from pediatrics to geriatrics) c. Knowledge of professional, ethical, and legal issues related to primary health care d. Knowledge about hospital practice (e.g., policies, bylaws, rules, documentation requirements, on-call policies and procedures, peer review, billing procedures, etc.) e. Understanding of the importance of time and resource allocation in primary care. f. Knowledge of the biological, social, cultural, cognitive, and affective bases of behavior, health, and disease. 5. Knowledge of general systems theory and an understanding of how the "parts fit together" at the levels of biology, the individual, the family, the treatment team, and health care.	1. Generalist knowledge of professional skills of your discipline. 2. Skills as a systemic generalist regardless of discipline. 3. The ability to understand and communicate across disciplines (learning others' vocabulary, using clear and comprehensible language, active listening, etc.) 4. The ability to integrate different perspectives, the ability to resolve conflict, interprofessional negotiation skills. 5. The ability to develop treatment plans for collaborative care. 6. Ability to practice the principles of triage, referral and/or delegation to another person, agency, or system. 7. Skills to function in different roles depending upon patient need (e.g. team leader, staff member, consultant, case manager, etc.) 8. Professional skills to: a. Use time effectively b. function within the parameters imposed by the system, c. communicate effectively, (e.g., using clear and comprehensible language, active listening)

CLINICAL ROLES

KNOWLEDGE	SKILLS
GENERAL 1. Understanding of settings where health care is provided. 2. Knowledge of clinical services provided by other professions. 3. Knowledge about team provision of health care services. 4. Specific knowledge of behavioral health services in primary care. 5. Application of systems theory for "a client/family."	**GENERAL** 1. Curbside consultation (impromptu, on-the-spot); going to patients in the examining room, nursing home, etc. 2. Using only the time needed, but not more (15 min., 30 min., 45 min., etc.)
ASSESSMENT/DIAGNOSIS 1. Broad based generalist knowledge of assessment methods. 2. Collaboration with other health care professionals. 3. Knowledge of the most common problems seen in primary care settings (e.g., depression, substance abuse, violence, etc.). 4. Understanding cultural context of behavioral/psychological problems presented.	**ASSESSMENT/DIAGNOSIS** 1. Broad based generalist skills in assessment combined with specific skills such as: targeted interviewing, triage skills, concise report writing, use of screening instruments or measures, ability to prioritize, organize, manage time and resources, and the ability to maintain multiple perspectives. 2. Ability to participate effectively in a team, including interprofessional identification of disorders, collaborative diagnosis, negotiating a mutually-agreed upon definition of the problem and treatment plan. 3. Ability to match your assessment to the referral question. a. Do the minimum to adequately answer the referral question. b. Use the appropriate methods or modality (e.g., a screening exam vs. comprehensive battery).

Clinical Roles continued:

INTERVENTION 1. Broad based clinical intervention skills. 2. Knowledge of evidence-based efficacy of treatment strategies for the most common problems seen in primary care. 3. Knowledge of community resources available (specific to your setting).	**INTERVENTION** 1. Broad based intervention plus specific training in skills such as crisis intervention, group treatment, behavior change skills, relapse prevention, adherence to treatment, etc. 2. Evidence-based efficacy of treatment strategies for the common problems. 3. Decision making as to how, when, and where to refer patients (internal and external referrals). 4. Case management skills. 5. Ability to match the intervention to the problem.
CONSULTATION VS. LIAISON 1. Knowledge of the differences between consultation and consultation-liaison models 2. Knowledge of how differences in training and expectations among different professionals may influence the consultation process 3. Know how to determine whether your responsibility is to the consultant or to the patient and how to resolve any potential conflicts of interest.	**CONSULTATION VS. LIAISON** 1. Acquiring skills in consultation/liaison 2. Having the skills to answer the consult question/issue(e.g. appropriate diagnosis, treatment recommendations, etc.)

We see psychologists as performing a variety of clinical roles, including but not limited to assessment, interventions, and consultation. Primary care psychologists need to be broadly trained to handle a variety of problems in a timely and cost effective manner. They need to know when to treat and when and how to refer the client to other mental health professionals.

TEACHING ROLES

KNOWLEDGE	SKILLS
GENERAL 1. Knowledge to teach others about: a. how to access health care; b. the various health care disciplines; c. interdisciplinary (team) collaboration in health care; d. concept of integrated service delivery in primary care settings; e. systems or biopsychosocial systems, especially the interaction between physical health and behavior.	**GENERAL** 1. Ability to use multiple teaching modalities and strategies to do the above 2. Match teaching modality to the task (workshops, seminars, video, retreats, rounds, family meetings) 3. Effective communication skills, i.e. the ability to translate psychological constructs into everyday language. 4. Teaching others, within and external to the primary care system, about health behavior generally, roles of psychologists and psychological services available.
CLINICAL 1. Knowledge of assessment and intervention skills discussed under Clinical Role so that the psychologist can teach them to others in an appropriate manner.	**CLINICAL** 1. Teaching appropriate intervention skills and principles to other health care providers. 2. Teaching others to match interventions to the problems identified 3. Teaching others to use support groups (e.g. AA) as adjuncts to treatment 4. Teaching triage and referral skills 5. Teaching others about the impact of behavior on physical health

We see psychologists as teaching patients, families, health care professionals (including other psychologists) and administrators. For example, psychologists can teach patients to be their own advocates; they can teach other health care professionals about the role of behavior in health/illness; they can teach other psychologists about primary care; they can teach administrators about how interdisciplinary teams improve health care and reduce costs, etc.

RESEARCH ROLES

KNOWLEDGE	SKILLS
GENERAL 1. Knowledge of the research literature with respect to: a. Health care policy and service provisions b. Types of problems commonly seen in primary care; c. Efficacy of different assessment and intervention techniques, matching modality of treatment to problems, etc. d. The efficacy of interdisciplinary approaches to assessment and intervention e. A biopsychosocial approach in conceptualizing presenting problems and in identifying interventions appropriate for an individual patient.	**GENERAL** 1. General research skills to: a. Design and conduct research in relevant areas b. Understand and evaluate the research findings of others
CLINICAL 1. Knowledge of the clinical research literature with respect to: a. Research methodology in general, and in interventions or behavior change and maintenance of changes in particular; b. Efficacy of assessment, interventions, and cost effectiveness; c. Reliability and validity of assessment and intervention instruments or techniques;	**CLINICAL** 1. Skills in research methods for both qualitative and quantitative measures of effectiveness of assessment and intervention techniques. 2. Ability to evaluate the utility of different types of measurement according to the needs of the situation. 3. Implementation of research methods in the evaluation of service provision, including patient satisfaction, evaluating the efficacy of screening programs, conducting a needs assessment/analysis, etc. 4. Ability to design research to develop more sophisticated models of behavior change and maintenance of that change.

ADMINISTRATION ROLES

KNOWLEDGE	SKILLS
1. Knowledge of general principles and practice of business as they relate to health care services 2. Economics of health care in general. 3. Health care access and reimbursement policies, including indirect and direct service time. 4. Understanding time and resource limitations in primary care with respect to assessment and treatment. 5. Understanding the culture of teams and the community; including leadership roles, potential activities and roles of the various professional disciplines, managing interprofessional conflicts, negotiations, etc. 6. Understanding of the larger system of health care services.	1. Budgets, performance evaluations, program development, and evaluation. 2. Learning specific details about health care plans, etc. 3. Managing accountability, time, and other resources. 4. Cost-benefit analysis of assessment strategies. 5. Learning effective and efficient intervention techniques. 6. Develop and maintain effective teams. 7. Specific consultation skills. 8. Learn about the community—resources, etc. 9. Balance fostering interprofessional care at the clinical level with program administration in a hierarchical system.

PRINCIPLES OF INTERDISCIPLINARY TRAINING

Although the need for interdisciplinary or interprofessional training is discussed extensively in the he health care literature, in practice such training is rare. Where it has occurred is primarily in settings that focus on the care of persons with disabilities (e.g., DeGraw, Fagan, Parrott, & Miller, 1996) or the geriatric population (e.g., Clark, 1994). More emphasis on interprofessional training in all areas of health care is needed. The following principles related to interdisciplinary training were derived from the literature on interdisciplinary training.

1. **Interdisciplinary training requires a strong commitment on the part on the part of the administration of the university or training agency and adequate funding. Administrators should recognize that the traditional structure (e.g. of universities) is a barrier to interprofessional education that must be overcome. In addition, the administrators also must provide sufficient financial support for interdisciplinary training.**

   References: Casto, 1994; DeGraw, Fagan, Parrott, & Miller, 1996; Edmunds, Canterbury, Connors, & Schoener , 1994; Garner , 1994; Heinemann, Zeiss, Waite, Tsukuda, & Brown, 1998; Kahn, Davis, Wartman, Wilson, & Kahn, 1995; Pinkerton, Moorman, & Rockwell, 1987.

2. **Professionals must be trained together in the same setting so that they (students/professionals) have consistent interactions with other professions.**

   References: Brandon & Meuter, 1995; Bandler, 1973; Casto, 1994; Clark, 1994; DePoy, Wood, & Miller, 1997; Lesse, 1989; Pinkerton, Moorman, & Rockwell, 1987.

3. **Cross-training provides each profession with the necessary knowledge of the other professions—their skills, values, training, expectations, etc.**

   References: Bassoff, 1976-77; Casto, 1994; Clark, 1994; DeGraw, Fagan, Parrott, & Miller, 1996; DePoy, Wood, & Miller, 1997; Edmunds, Canterbury, Connors, & Schoener, 1994; Heinemann, Zeiss, Waite, Tsukuda, & Brown, 1998; Hinshaw & DeLeon; 1995; Ivey, Brown, Teske, & Silverman, 1988; Pinkerton, Moorman, & Rockwell, 1987; Sorrells-Jones, 1997.

4. **Experiential learning, in addition to academic classes, is a vital part of learning to work in interdisciplinary teams.**

   References: Brandon & Meuter, 1995; Bassoff, 1976-77; Clark, 1994; DeGraw, Fagan, Parrott, & Miller, 1996; DePoy, Wood, & Miller, 1997; Goldstein, 1989; Heinemann, Zeiss, Waite, Tsukuda, & Brown, 1998; Hinshaw & DeLeon; 1995; Kahn, Davis, Wartman, Wilson, & Kahn , 1995.

5. **Faculty must serve as role models for interdisciplinary collaboration.**

   References: Bandler, 1973; Bassoff, 1976-77; Clark, 1994; DeGraw, Fagan, Parrott, & Miller, 1996; DePoy, Wood, & Miller, 1997; Kahn, Davis, Wartman, Wilson, & Kahn, 1995; Lary, Lavigne, Muma, Jones, & Hoeft, 1997; Pinkerton, Moorman, & Rockwell, 1987.

6. **Clear communication is important as different professions have different languages. Thus, interprofessional training must develop a common language or an understanding of the languages of other professions. Communication difficulties can be a significant barrier to effective interprofessional team functioning.**

   References: Brandon & Meuter, 1995; Bassoff, 1976-77; Clark, 1994; DeGraw, Fagan, Parrott, & Miller, 1996; Garner, 1994; Goldstein, 1989; Lary, Lavigne, Muma, Jones, & Hoeft, 1997; Miller & Swartz, 1990; Pinkerton, Moorman, & Rockwell, 1987; Sorrells-Jones, 1997; Waite, Harker, & Messerman, 1994.

7. **Shared decision making and shared responsibility is important. All team members must be equal; leadership is usually rotated among team members.**

   References: Bassoff, 1976-77; Brandon & Meuter, 1995; Casto, 1994; Clark, 1994; Edmunds, Canterbury, Connors, & Schoener, 1994; Goldstein, 1989; Heinemann, Zeiss, Waite, Tsukuda, & Brown, 1998; Hinshaw & DeLeon; 1995; Kahn, Davis, Wartman, Wilson, & Kahn, 1995; Miller & Swartz, 1990.

8. **Each profession must recognize the values and ethics of one's own profession and have a through professional identity.**

   References: Casto, 1994; Clark, 1994; DeGraw, Fagan, Parrott, & Miller, 1996; Ivey, Brown, Teske, & Silverman, 1988; Pinkerton, Moorman, & Rockwell, 1987.

9. **Team members must respect and trust expertise of others and work together for the common good of the patient.**

   References: Bassoff, 1976-77; Casto, 1994; Clark, 1994; DeGraw, Fagan, Parrott, & Miller, 1996; DePoy, Wood, & Miller, 1997; Garner, 1994; Hinshaw & DeLeon; 1995; Ivey, Brown, Teske, & Silverman, 1988; Pinkerton, Moorman, & Rockwell, 1987.

10. **Regular team meetings, with a clear communication about the purpose of the team and a recognition of the interdependence of the teams/professions, must occur.**

    References: Bassoff, 1976-77; Clark, 1994; DeGraw, Fagan, Parrott, & Miller, 1996; Edmunds, Canterbury, Connors, & Schoener, 1994; Ivey, Brown, Teske, & Silverman, 1988.

11. **Conflict within teams often is caused by lack of knowledge of other professions, turf and power issues, differences in theoretical orientations, lack of common language, etc. Conflict resolution skills are a must.**

    References: Bassoff, 1976-77; Drinka, 1994; Edmunds, Canterbury, Connors, & Schoener, 1994; Garner, 1994; Ivey, Brown, Teske, & Silverman, 1988; Miller & Swartz, 1990.

12. **For effective team functioning, education about group processes and training in collaborative skills are important.**

    References: Brandon & Meuter, 1995; Casto, 1994; Clark, 1994; DePoy, Wood, & Miller, 1997; Drinka, 1994; Heinemann, Zeiss, Waite, Tsukuda, & Brown, 1998.

APPENDIX D

EXAMPLES TRAINING PROGRAMS PREPARING PSYCHOLOGISTS FOR PRIMARY CARE SERVICES

The examples of education and training programs cited below are relevant to the education and training of psychologists at the doctoral or postdoctoral level to function in managed care/primary care settings and roles as members of interprofessional health care teams. The examples listed are not necessarily exhaustive of all programs in which such training occurs. Rather, they represent examples cited in the professional literature or that are otherwise known to the author of this report and advisory panel for this project. For programs listed, additional information can be obtained from the author (s) of the articles cited or from the contact person(s) otherwise listed.

Addelton, R. L., Tratnack, S. A., & Donat, D. C. (1991). Hospital-based multidisciplinary training in the care of seriously mentally ill patients. Hospital and Community Psychiatry, 42(1), 60-61.

Describes a four-week training for service providers in public psychiatric health care at a state hospital in Virginia. The program familiarized in medicine, occupational therapy, pharmacy, psychiatric nursing, psychology, and social work with the range of care for chronic mentally ill patients. Discusses the needs for multidisciplinary training and describes their training program (which included a multidisciplinary training curriculum). Because students and faculty represented the professional groups that form the typical hospital treatment team, students learned and practiced what they learned in true multidisciplinary fashion. Multidisciplinary training decreases professional differences, creates a shared body of knowledge, promotes more harmonious working relationships, and generates a positive attitude toward team approach to psychiatric treatment. Despite the need for multidisciplinary training, few such programs exist in mental health settings. Participants in the hospital-based multidisciplinary training program considered it a positive experience.

American Psychological Association, Office on AIDS (1998). HIV Office for Psychology Education (HOPE) Programs (1991-1998). Washington, DC: American Psychological Association. Unpublished reference.

The HOPE Program, originally funded in October 1991 by a three-year contract with the Center for Mental Health Services (CMHS) of the Substance Abuse and Mental Health Services Administration (SAMHSA), has developed seven continuing education curricula on mental health services for people infected with and affected by HIV/AIDS. Over 320 psychologists have been trained and certified to deliver these seven standard curricula at local continuing education programs for mental health providers. In January of 1995, CMHS funded a second contract which expanded the capacity of the HOPE Program through the recruitment of new trainers, the production of new curriculum modules, and the development of a new faculty resource entitled, *A Guide for Including Information on HIV/AIDS in Graduate Courses in Psychology*. By the end of the second CMHS contract in June 1998, over 9,000 mental health providers were trained by HOPE Program Trainers. A third CMHS contract to support of HOPE Program training activities is anticipated to begin on September 1, 1998.

Baylor College of Medicine, Houston, TX
Department of Family Medicine and Community Medicine
Contact Person: James Bray, Ph.D.

Offers interdisciplinary primary health care training for psychology doctoral students and postdoctoral residents in the Department of Family Medicine and Community Medicine. Also offers continuing education training for practicing psychologists using the Linkages Training Models developed by Bray & Rogers.

Boccellari, A. (1998), University of California San Francisco/San Francisco General Hospital. Integrated primary care mental health. Unpublished manuscript.

Describes a proposed model of care (and recommendations for a pilot study) for an integrated Mental Health and Primary Care Consultation Program developed in conjunction with specialty mental health treatment provided by the San Francisco General Hospital Psychosocial Medicine Clinic and Community Mental Health Services. The model is will be tried in San Francisco hospitals starting July, 1998. It consists of three levels of care and the mental health provider will be on-site at the clinics.

Brantley, P. J., & Applegate, B. W. (1998). Training behavior therapists for primary care. The Behavior Therapist, 21(4), 74-76.

In order for psychologists to function successfully in medical settings in general, and in primary health care settings specifically, they must be equipped with the knowledge and skills necessary to make them a valuable member of the primary care team. The article reviews some of the recommendations for the content of training, but they note that the degree to which psychology can integrate into the primary care market depends on the ability of the training programs to train graduate students with the requisite skills. This article highlights a clinical training program at Louisiana State University designed to train psychologists to work in primary health care settings. The program is described in terms of how it addresses the training needs of graduate students preparing for careers in primary care medical settings.

Bray, J. H., & McDaniel, S. H. (1998) Continuing Education Workshop on Practicing psychology in primary care. San Francisco: American Psychological Association Annual Convention.

Continuing education workshop led by James H. Bray, Ph.D., Department of Family Medicine, Baylor College of Medicine and Susan H. McDaniel, Ph.D., Departments of Psychiatry and Famuly Medicine, University of Rochester Medical Center held in conjunction with the 1998 American Psychological Association Annual Convention in San Francisco. At the same convention, Dr. Bray served as chair and Dr. McDaniel as discussant for a symposium, "Models of Collaborative Primary Health and Mental Health Care." Further information can be obtained from Drs. Bray and McDaniel.

Bray, J. H., & Rogers, J. C. (1995). Linking psychologists and family physicians for Collaborative practice. Professional Psychology: Research and Practice, 26(2), 132-138.

Bray, J. H. & Rogers, J. C. (1997) The linkages project: Training behavioral health professionals for collaborative practice with primary care physicians. Family, Systems, & Health, 15, 55-63.

This is a follow-up piece to Bray & Rogers (1995). This paper describes the actual training program and the content that was covered.

These articles describe a training program intended to facilitate collaborative linkages between rural family physicians and psychologists. The goals of the program were to a) facilitate linkages between rural family physicians and psychologists; b) educate psychologists and family physicians regarding the treatment of alcohol and drug abuse and a model of collaborative practice; c) increase knowledge base of providers on substance abuse (e.g., identification) and d) enhance treatment options for patients with drug or alcohol problems. The training program is described in detail on pages 134-135. Training programs should provide more information about psychologists' training and their approaches to patient evaluation and treatment and more information about different mental health professionals and what these professionals can and cannot offer. Barriers to collaboration include: 1) differences in theoretical orientation, 2) lack of a common language, 3) different practice styles, 4) lack of accessibility to the different providers, and 5) varying expectations for assessment and treatment. Based on observations of

these barriers, the authors recommend that we develop a set of principles or guidelines for training and fostering collaborative relationships—include these in the training sessions, negotiate language barriers, clarify theoretical models, acknowledge the differences about maintaining confidentiality, recognize the different time constraints, and note the possibility of competition for areas of practice.

Brochstein, J. R., Adams, G. L., Tristan, M. P., & Cheney, C. C. (1979). Social work and primary health care: An integrative approach. Social Work in Health Care, 5(1), 71-81.

An interinstitutional, interagency Consortium has been formed in Houston to develop an innovative service model and provide interdisciplinary primary care/mental health training. The Houston Consortium Program integrates mental health professionals and trainees into the primary care framework of a neighborhood center serving a low income, predominantly Mexican-American population…. The social workers' full participation as members of primary care teams builds upon their traditional training to provide them the experience and skills required to function effectively in the expanded coordinative capacity of health/mental health manager…[Abstract]. Authors note even back then that the splitting up of medical care into specialties has caused problems and draws attention to the need to address the problem in primary care medicine, which has been defined as entailing the individual physician or primary care team providing "first contact" care. The program's trainees include graduate social work, psychiatric nursing and clinical psychology students; residents in psychiatry, pediatrics, internal medicine and the prototype primary care; and medical students. It appears that a number of their strategies and comments are still relevant today for the integration of mental health and primary care.

Erickson, C. (1998). WYO HealthCare project. Article retrieved from the internet: http://www.uwyo.edu/asa/ucc/WyoHealthCare/index.html

WYO HealthCare (an interprofessional training team program) is separate from the general clinical psychology training program at the University of Wyoming. It trains students from social work, psychology, nursing and medicine in an interdisciplinary curriculum with faculty from all areas participating. Two students from the clinical psychology program are enrolled in this interdisciplinary program each year. The program is designed to address some of the gaps in rural service delivery, interdisciplinary health collaboration training, and community-based options that are unique to Wyoming's frontier communities.

Goldberg, R. J., Tull, R., Sullivan, N., Wallace, S., & Wool, M. (1984). Defining discipline roles in consultation psychiatry: The multidisciplinary team approach to psychosocial oncology. General Hospital Psychiatry, 6, 17-23.

Attempts to define the unique contributions of psychiatry, social work, nursing, and psychology in relation to an oncology consultation program in a general hospital setting. The definitions of each discipline's contributions are proposed as a model that can be generalized to other consultation programs. Knowledge of the unique contributions of each team member and interdisciplinary training is important and barriers to collaboration include confusion about the potential contribution of different professions, lack of clarity about what to expect, lack of role definition and inability to speak the language of the others (especially biomedical and psychological disciplines). Traditional administrative boundaries to collaboration need to be removed.

Hinshaw, A. S., & DeLeon, P. H. (1995). Toward achieving multidisciplinary professional collaboration. Professional Psychology: Research and Practice, 26(2), 115-116.

The article is oriented towards psychologists, physicians, advanced practice nurses. The authors discuss the integration of mental health care with other health care disciplines, describing issues to consider, and

training for interdisciplinary (they call it multidisciplinary) collaboration. They also describe three model programs. The authors define inter-, intra-, and multi-disciplinary, with multidisciplinary collaboration involving experts from different disciplines working together (e.g., psychologists and physicians). Joint training provides early learning that shapes future thinking and molds practice styles in a manner that is not acquired later in one's training. Joint training encourages the development of respect and appreciation for other health care disciplines, valuing working together in teams and consulting with colleagues of other health professions.

Jackson, G., Gater, R., Goldberg, D., Tantam, D., Loftus, L., & Taylor, H. (1993). A new community mental health team based in primary care: A description of the service and its effect on service use in the first year. British Journal of Psychiatry, 162, 375-384.

This article describes the formation and effects of a new community multidisciplinary team (e.g., including general practitioners, social workers, occupational therapists, and clinical psychologists), with some recommendations for the creation of successful teams. Provides a higher degree of detail than most articles on the actual teamwork processes involved (e.g., how often meetings were held, who attended, what the hierarchical structure was, what events occurred during meetings, etc.). In spite of the team's efforts to provide information and its willingness to accept hospital referrals, they were at first rarely used as a resource. The availability of specialists to help GPs with neurotic disorders may be more cost-effective than treating those disorders in general practice.

Katon, W., Von Korff, M., Lin, E., Simon, G., Walker, E., Bush, T., & Ludman, E. (1997). Collaborative management to achieve depression treatment guidelines. Journal of Clinical Psychiatry, 58 (Suppl. 1), 20-23.

The article describes two models that integrate the psychiatrist into treatment of depression in primary care and the evaluation of the models. In the psychiatrist/primary care model, a psychiatrist alternated visits with a primary care physician. In the psychiatrist/psychologist model, the psychiatrists worked with a team of psychologists. When compared to the primary care physician alone model of treatment, both collaborative models were associated with improved adherence to treatment, increased patient satisfaction with care, and an improved outcome. The success of these models indicates that collaboration with primary care physicians in the care of depressed patients is effective.

Lefley, H. P. (1988). Training professionals to work with families of chronic patients. Community Mental Health Journal 24(4), 338-357.

The article describes a multidisciplinary (psychiatry, psychology, social work) training program which prepares clinicians to work in a collaborative relationship with families of the chronically mentally ill. The training model includes a didactic component on relevant research and theory, incorporating social policy and cross-cultural issues and emphasizing the actual experience of patients and families within a framework of coping and adaptation. Training in patient and family education, problem management, supportive counseling, and resource knowledge is accompanied by practicum experiences involving longitudinal work with chronic patients and families. Special features in psychiatric residency training are highlighted.

Madsen, M. K., Gresch, A. M., Petterson, B. J., & Taugher, M. P. (1988). An interdisciplinary clinic for neurogenically impaired adults: A pilot project for educating students. Journal of Allied Health, May, 135-141.

The authors describe a pilot project for educating students in interdisciplinary team work. The project was designed for students in Occupational therapy, speech pathology, audiology, medical record

administrations, and social work, but is applicable to all mental health disciplines. The authors describe a class/clinical experience for students to grow accustomed to working in interdisciplinary groups. The students jointly identify problems and determine an interdisciplinary plan; write daily progress notes, jointly counsel patients and families regarding progress and recommendations, etc.

Paulsen, R. H. (1996). Psychiatry and primary care as neighbors: From the promethean primary care physician to multidisciplinary clinic. International Journal of Psychiatry in Medicine, 26(2), 113-125.

Describes the development of a training program in primary care psychiatry and a co-practice model for psychiatry in primary care practice. Describes hypotheses as to why the program succeeded, and general elements that could be applied in efforts to develop similar practices in different settings. Relevant for integration of primary care and mental health practitioners in general, not just psychiatry. The HCA primary care faculty joined in co-teaching the multidisciplinary seminar taken together by the disciplines. Adaptations for psychiatrists (or other mental health professional in general) may need to make in order to successfully integrate into a primary care setting. Clarity of communication is important as is understanding the differences between the traditional "50 minute hour" and the primary care setting (e.g. clinician may have to learn to handle interruptions, wear a pager, work within the computer-based records system, and make calls to managed care, etc.). Discussion and planning of treatment (e.g., who does what) is vital. Since the medical staff may vary in their desire to engage in this type of activity, it is important to discuss this with the PCP to assess their preferred level of counseling and support this while delineating what will be referred on, and to whom. Remember, isolated practices are not conducive to collaboration but making mental health services accessible at the front line of primary care enhances delivery of care and does not detract from any service. In fact, patients are more likely to be willing to seek mental health services in this context than in the private office context.

Pruitt, S.D., Klapow, J.C., Epping-Jordan, J.E., Dresselhaus, T. (1998) Moving behavioral medicine to the "front line": A model for integration of behavioral and medical sciences in primary care. Professional Psychology: Research and Practice, 29 (3), 230-236.

Primary care is one of the rotations available jointly sponsored the University of California San Diego and Veterans Administration Medical Center internship program. Dr. Pruitt is in charge of the primary care rotation in the internship program and she has described their training model in several articles. The Med-Plus model trains students to work with primary care physicians to provide consultation and brief psychological interventions to primary care patients. Psychology residents and interns see patients with the primary care physician in the primary care setting. Later they may see the patient for additional, brief sessions. More extensive mental health care is referred to other providers. Collaborative consultation is the foundation of the model. Psychologists also participate in teaching activities for the primary care residents.

Sorrells-Jones, J. (1997). The challenge of making it real: Interdisciplinary Practice in a "seamless" organization. Nursing Administration Quarterly, 21(2), 20-30.

The author describes a hospital which was reorganized from unidisciplinary units to interdisciplinary service centers in an effort to reorganize into a "boundaryless" organizational structure with more highly developed interdisciplinary clinical and administrative practice. In the reorganization, the direct care service providers worked in interdisciplinary teams of equals and collaborated by pooling knowledge in an interdependent manner to develop/evaluate a plan of care for the patient. This model emphasized difference between multidisciplinary (team where members of different disciplines assess/treat patients independently, then share information with each other) and interdisciplinary (deeper level of collaboration; develop and evaluate a plan of care jointly, with professionals in different disciplines

pooling knowledge in an interdependent manner. Barriers to collaboration were: 1) fear of downsizing because of the loss of the familiar, unidisciplinary "home" departments; 2) lack of understanding of how to work in teams of equals; 3) lack of knowledge about each other's fields; and, 4) limited ability/willingness to confront and handle conflict. Honest communication about one's lack of knowledge, etc. (above) led to much better team functioning and successes fed enthusiasm and personal investment/effort. However, eradicating unidisciplinary units is not without problems. The major problems can be overcome by electing a "lead person" from each discipline who convenes regular meetings of the staff of that discipline to maintain their own professional identity and practice and to deal with discipline-specific practice issues and standards.

Strosahl, K. (1996). Confessions of a behavior therapist in primary care: The odyssey and the ecstasy. Cognitive and Behavioral Practice, 3, 1-28.

Excellent resource article. Strosahl summarizes the key learning experiences from a 5-year primary care integration project, organized by three behaviorally trained psychologists. He examines the major principles underpinning effective health and behavioral health integration and highlights main sources of organizational and disciplinary resistance, as well as some "tried and true" strategies for countering that resistance. He introduces the concept of primary mental health care as a distinctive form of behavioral health service that shares many of the philosophies of primary medical care. The changes in the structure of clinical practice are discussed as well as the more viable model of consultation. The defining characteristics of a consultant (vs. therapist) model are stated along with the core clinical services that are most valued in primary care settings. Psychologists must adjust their practice style to accommodate the demands of the primary care setting.

University of Florida Health Sciences Center, Gainesville, FL
College of Health Related Professions
Department of Clinical and Health Psychology Graduate Program
Contact Persons: Dr. Cynthia Belar (Health Psychology Program) and Dr. Samuel Sears (Rural Health Program)

This doctoral program follows a scientist-practitioner model of clinical training in psychology, with the opportunity for students to pursue emphases in clinical child/pediatric psychology, health/medical psychology, or neuropsychology. The program is able to offer practicum experiences not usually available to clinical programs in academic departments outside medical or health science colleges. Core practicum experiences include rotations within a primary care setting. An additional program, in rural health psychology has been established as a cooperative program between the University of Florida Department of Clinical and Health Psychology and the Cooperative Extension Service at the University of Florida. In addition to generalist clinical training, students in this program obtain supervised practice experience in primary care settings serving rural populations.

University of Mississippi Medical Center, Jackson, MS
Department of Family Medicine
Contact Person: Patrick O. Smith, Ph.D.

The University of Mississippi Medical School is starting a primary care training program for psychology fellows and eventually interns. They also want to develop clinical and research practicum for advanced students in the clinical doctoral program at Jackson State University. The plans sound promising but are not yet in place.

University of Missouri School of Medicine, Columbia, MO
Department of Family and Community Medicine
Contact Person: Daniel R. Longo, Sc.D.

The University of Missouri School of Medicine, Department of Family and Community Medicine, is initiating a new multi-year program with support from the Health Resources and Services Administration (HRSA) to train health professionals or others to conduct research in primary health care settings. Psychologists at the postdoctoral level will be eligible to apply for this program. Training will be carried out in an interprofessional context of services.

University of Southern California/California Hospital Medical Center, Los Angeles, CA
Family Medicine Residency Training Program
Contact Person: Leine M. Delker, Ph.D.

The USC/CHMC Family Medicine Residency Training Program is located at California Hospital Medical Center in downtown Los Angeles. The program trains family medicine residents and psychology interns collaboratively in both the inpatient hospital setting and at the Family Health Center outpatient settings, located across the street from the hospital. Primary health care and mental health services are provided in an integrated way to a population of underserved, multi-ethnic patients of all ages.

Winder, A. E., Michelson, L. A., & Diamond, D. (1985). Practicum training for pediatric psychologists: A case study. Professional Psychology: Research and Practice, 16(6), 733-740.

This article describes the development of a practicum training program in pediatric psychology. The program represents a collaborative effort of the two areas of clinical and developmental psychology, as well as joint efforts between pediatric residents and pediatric psychology students. The academic component of the training involves shared coursework between psychologists and pediatric residents. The clinical component includes consultation, assessment, and short-term treatment of children with combined medical, developmental, and psychological problems. An evaluation of the training program using several effectiveness indicators is presented. This collaborative training model can greatly facilitate student training and research in the field of pediatric psychology.

Zilberg, N. J., & Carmody, T. P. (1995). New directions for the education of clinical psychologists: The primary care setting, the VA's PRIME program, and the in-depth generalist model. Journal of Clinical Psychology in Medical settings, 2(1), 109-127.

As part of a special issue on psychology in primary care settings, the authors describe the VA's new approach to education for practice in the primary care setting and concurrently address some general issues related to the education of clinical psychologists for practice in this setting. They argue that the primary care psychologist, in parallel with the generalist in medicine, must have a strong generic background in clinical psychology in order to gain the broad range of clinical skills necessary to function effectively as an "in-depth generalist" (IDG) who is capable of addressing the variety of psychological issues that emerge in the primary care setting. The IDG model of professional practice, which the authors believe is best suited for primary care/managed care settings, requires extensive training in generic clinical skills and increased time devoted to its implementation at both the predoctoral and the postdoctoral levels.

The Department of Veterans Affairs (VA) has been a sponsor of professional training in psychology for 50 years. That federal agency's programs provide clinical and counseling psychology interns and postdoctoral residents the opportunity to obtain a wide range of experiences in working with a variety of psychiatric, medical, and surgical patients (both inpatient and outpatient), and to work with other health care professionals and their students. The following VA Medical Centers are self-identified in the 1997-98 Association of Psychology Postdoctoral and Internship Centers (APPIC) Directory of Internship and Postdoctoral Programs in Professional Psychology as providing a major clinical training rotation in primary care or have been otherwise identified in association with the VA PRIME Program described in the preceding literature citation.

1. **VA Palo Alto Health Care System ***
   Psycholgy Service (116B)
   3801 Miranda Avenue
   Palo Alto, CA 94304-1290
   Training Director: Toni Zeiss, PhD

2. **VA Medical Center, Miami ***
   Psychology Service (116B)
   1201 N. W. 16th St
   Miami, FL 33125-1693
   Training Director: Gwen Findley, PhD

3. **James A. Haley Veterans Hospital ***
   Psychology Service (116B)
   13000 Bruce B. Downs
   Tampa, FL 33612-4798
   Training Director: Rodney D. Vanderploeg, PhD

4. **VA Chicago Health Care System, West Side Division ***
   Psychology Service, (116B)
   PO Box 8195
   Chicago, IL 60680
   Training Director: Janet Willer, PhD

5. **VA Medical Center, New Orleans ***
   Psychology Service (116B)
   1601 Perdido Street
   New Orleans, LA 70146
   Training Director: Kevin Brailey, PhD

6. **Baltimore Area VA Predoctoral Psychology Residency Program ***
   Baltimore VAMC
   10 n. Greene Street
   Baltimore, MD 21201
   Training Director: Elaine Karp-Gelernter, PhD

7. **VA Medical Center, Minneapolis ***
   Psychology Service (116B)
   One Veterans Drive
   Minneapolis, MN 55417-2300
   Training Director: Charles A. Peterson, PhD

8. **VA Medical Center, Biloxi ***
   Mental Health Service (116B-1)
   Biloxi, MS 39531-2410
   Training Director: Kenneth R. Jones, PhD

9. **VA Medical Center, Kansas City**
   Psychology Service (116B)
   4825 Troost, Suite 206
   Kansas City, MO 64110-2499
   Training Director: Peggy J. Cantrell, PhD

10. **VA Western New York Healthcare System, Buffalo ***
    3495 Bailey Avenue
    Buffalo, NY 14215-1129
    Training Director: Kerry Z. Donnelly, PhD

11. **Cleveland VA Medical Center ***
    Psychology Service (116B)
    10701 East Boulevard
    Cleveland, OH 44106
    Training Director: Robert W. Goldberg, PhD

12. **VA Medical Center, Mountain Home ***
    Psychology Service (116B)
    Psychology Service 116B VA Medical Center
    Mountain Home, TN 37684-4000
    Training Director: Jerry V. Buchanan, PhD

13. **VA Medical Center, Salt Lake City ***
    Psychology Service (116B)
    800 Foothill Blvd.
    Salt Lake City, UT 84148
    Training Director: Patrick J. Miller, PhD

14. **VA Medical Center, Salem ***
    Psychology Service (116B)
    1970 Roanoke Boulevard
    Salem, VA 24153-6478
    Training Director: M.K. Johnson, PhD

15. **VA Medical Center, Washington, DC ***
    Psychology Service (116B)
    50 Irving Street, NW
    Washington, DC 20422
    Training Director: Neil, Bien, Ph.D.

*** offers major rotation in substance abuse in addition to primary care**

APPENDIX E

PRIMARY CARE SURVEY QUESTIONNAIRE FOR TRAINING PROGRAMS IN PSYCHOLOGY

PRIMARY CARE SURVEY FOR TRAINING PROGRAMS

Questions to ask of the training programs:

Inform the program director (doctoral, internship, or postdoctoral residency) that his/her program was identified through public materials or by someone familiar with their program, as one that affords training in primary are psychological services. We understand primary care services by psychologists include psychological or behavioral health services that are an integral part of physical healthcare in addition to mental health and substance abuse services.

1. Describe the setting in which this training is provided and the nature of the population served.

2. Are the trainees working in a managed care, fee-for-service, or mixed system of reimbursement?

3. Is the setting a carve-out service delivery system or an integrated service delivery system.

4. What is any training is provided to your trainees about practicing in a managed care environment, other than what they learn "on the job."

5. Does the training prepare psychologists to function as primary health care providers of general behavioral health services or is the psychologist'' role specifically limited to mental health/substance abuse problems presented?

6. Is there formal didactic training afforded the psychology trainees about the differences in their roles and practice functions in primary acre, as distinct from secondary and tertiary care roles and functions. If so, what is the nature of that training and by whom is it provided?

7. Is the experiential training in primary c are provided as an option or requirement of all trainees in your program? Is there a licensed psychology supervisor available on site to participate in the supervision of this experiential training?

8. What other health professions (for medicine, specify specialty) are involved with psychologists work in the setting described? Are trainees of these professions also working alongside the psychology trainees and, if so, at what level in their professional education and training are they (please specify by profession or specialty therein)?

9. Is there conscious effort made to prepare the trainees to function as members of in inter-professional health care team? If so, is this training focus in lieu of or in addition to intra-professional training for each profession involved? Is there team teaching and role modeling involved in the inter-professional training/?

10. How are cases assigned to the psychologist or psychology trainee in this setting and who is responsible for workload distribution or case management decisions?

11. What role has the psychologist or psychology trainee in the setting, once a case is assigned to her/him? Is that role one of providing psychological services as an integral part of an inter-professional team or as a specialist consultant to other primary care provider(s) in the setting?

12. How are issues of cultural competencies among the health service practitioners addressed in your program?

13. Do you have any training guidelines or curricula that you have developed specific to training psychology students/interns in primary care, inter-disciplinary teams? If so, could you send a copy of the materials you have?

14. Would you be interested in a copy of the final report?

Thank you for your cooperation.

APPENDIX F

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