EXAMINING THE CURRENT STATUS OF HEALTH PSYCHOLOGY IN CANADA: A QUALITATIVE STUDY OF PSYCHOLOGISTS' ROLE IN INTERPROFESSIONAL HEALTH CARE

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Abstract

This study examined the roles and professional experiences of doctoral-level psychologists working within interprofessional health care settings across Canada. The aim was to identify educational background and clinical training that are needed for psychologists to work in these settings. Semistructured interviews were completed with eight doctoral-level psychologists employed in various health care settings across Canada. The data were analyzed using a thematic analysis design. Participants' professional responsibilities included psychological assessment and treatment, various administrative duties, team collaboration and consultation, and academic involvement. The two overarching themes of psychologists' contributions across health care settings were diagnostic accuracy and comprehensive treatment. Barriers to psychologists' role included funding and access limitations, training experiences, training limitations, mental health stigma, and ethical issues. The findings offer additional support to the benefits of integrating psychologists into primary health care settings, including in health care reform decision-making and actions. A shift in doctoral training program focus and postdoctoral continuing education is needed.

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Chapter I: Introduction

Across Canada, health care providers are increasingly recognizing the need to address both the behavioural and emotional influences on physical health and illness. Additionally, one in five individuals in Canada are affected by mental health problems, resulting in an annual societal cost of $50 billion (Mental Health Commission of Canada, 2012). This economic burden to Canadians includes increases in health care costs, reductions in health-related quality of life, reduced workplace productivity, and higher unemployment rates (Lim et al., 2008; Smetanin et al., 2011). Clinical psychologists have the opportunity and arguably the responsibility to contribute to enhancing the health and well-being of Canadians across the entire health spectrum, helping to provide the best quality and most cost-effective care (Arnett, 2001). As primary health care settings are generally the initial entry point into the Canadian health care system and often critical for continuity of care across the system, psychologist involvement in these settings is crucial for the most efficient treatment of illness (physical and mental) and promotion of health (Romanow & Marchildon, 2003).

Statement of the Problem

The Canadian health care system provides residents with minimal access to publicly funded psychological services (Arnett et al., 2004), with the psychological service sector identified as one of the more underserved and underfunded areas within the Canadian Medicare model (Romanow & Marchildon, 2003). Although psychologists are trained and licensed to offer a wide range of expertise as diagnosticians, consultants, and providers of evidence-based psychological treatments, their services are mostly excluded from primary care services in Canada (Moulding et al., 2009). The shortage of publicly funded psychological services and the reduced role of psychologists in health care settings are in a stark contrast with existing literature

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on the positive effects of integration of medicine and psychology (Arnett et al., 2004; Romanow & Marchildon, 2003).

The implications of the lack of development and availability of integrated health care, which offer public access to both medical and psychological services, deprive Canadians of potentially life-enhancing as well as life-saving services across the health spectrum (Arnett, 2001). The literature has consistently highlighted the significant role of mental health in affecting overall health outcomes and effectiveness of physical interventions (Graff et al., 2012). For instance, research has demonstrated how the participation of psychologists in primary health care settings can assist with the provision of more accurate diagnoses and effective treatment for both mental and physical symptomology (Miller et al., 2009; Robinson & Strosahl, 2009; Zivin et al., 2010).

More specifically, psychological interventions have been found to be beneficial in treating comorbid psychological and physical health conditions through positive effects on suffering, distress, and course of illness (Toumbourou, 2010; Shafran et al., 2017). As a result, the contributions of psychologists in primary health care have been associated with better patient retention, higher treatment adherence rates, improved treatment outcomes, and increased health care and utilization (Thielke et al., 2011).

In 2016, the Canadian Psychological Association published a report outlining potential benefits associated with the inclusion of psychologists in the Canadian primary care system. Some of the highlighted benefits include (a) reducing the burden of care on family physicians in the provision of community-based health services; (b) removing bottlenecks where patients wait for mental and behavioural health assessment and diagnosis; (c) ensuring availability of care at critical points in illness affecting health outcomes that serve to reduce the negative impact on

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productivity, inflation of third-party insurance costs, and negative impact on the economy; and (d) facilitate delivery of seamless collaborative health care within public health care institutions.

Most of the research on this topic, which supports the growing involvement of psychologists in primary care, has been conducted in the United States. This highlights the scarcity of Canadian-based literature and raises questions about the extent to which American findings can be generalized to Canada. Therefore, further research is warranted to address this gap. Related to understanding psychologists' roles in health care, there is also insufficient information identifying the educational and clinical training psychologists have undergone prior to employment within these settings. It is unclear which training opportunities (e.g., graduate-level coursework, practica or internship, professional work, conferences) are most relevant and useful for professional work in health care and in what areas Canadian doctoral programs and internships could strengthen training to better prepare future psychologists for this type of work.

Numerous audiences may benefit from the results of this study on the benefits of incorporating psychological services into the Canadian health care system and defining the roles of psychologists within health care settings. The Canadian health care system and taxpayers may be interested in information regarding the current involvement of psychologists within these settings. Further development of interprofessional health care teams may not only improve timely access to primary health care services but also in turn decrease downstream health care utilization and costs (Hutchison et al., 2011). The Canadian public may also benefit through greater education and access to information regarding the expanding role of psychologists in the provision of primary health care services. This information might include where they can access publicly funded psychological services and what types of services are offered. This would also

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benefit the Canadian public through improved continuity of care that involves a diverse range of health professionals (e.g., physicians, nurses, psychologists).

Lastly, as suggested by Humbke et al. (2004), continued awareness and more regular evaluation of the roles of psychologists within the Canadian health care system are important to reflect on the past growth of the profession and to point to directions for further training and program development in the future. Moreover, an in-depth examination and analysis of the roles and responsibilities of psychologists working within health care settings will help inform training processes and equip both students and current registered psychologists for more successful work within the Canadian health care system (Owens et al., 2013). Canadian educational institutions could also benefit from a better understanding of how graduate-level curricula could be expanded and specialized training programs could be developed to increase future psychologists' effectiveness within health care systems and settings.

Statement of Purpose

The purpose of this exploratory study was to examine and explore the roles and experiences of psychologists working within interprofessional health care settings across Canada. In addition, I aimed to identify the educational background and clinical training that are needed for psychologists to work in primary care settings. Given the limited number of psychologists employed in Canadian primary care settings and related challenges with recruitment, participants included psychologists employed across health care settings. Psychologists not employed in primary health care settings were asked to reflect on ways that their patients may have benefited from earlier access to psychological services when first seeking primary care services.

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Exploration of this topic required a qualitative approach given that there is limited understanding of the roles and experiences of psychologists working within Canadian health care settings. I developed five objectives for this study, which were operationalized into five corresponding research questions:

1. What are the training experiences (educational and professional) of psychologists currently working in health care settings?
2. How do the psychologists working within these settings define their role?
3. In what ways do psychologists contribute to the facilitation of patient treatment and care in a primary care setting?
4. What do the psychologists perceive to be the barriers and challenges that negatively impact their provision of quality of patient care within these settings?
5. Informed by the work psychologists have done in their setting, do they see any benefits or value to their patients having been able to see a psychologist earlier on when first seeking primary care services?

The results generated from this study were expected to create a preliminary source of data regarding the training and career trajectory, as well as general experiences, of psychologists working within primary and other health care settings in Canada. I hoped that the emerging themes from the data analysis would provide a rich narrative on this topic, highlighting areas for development and contributing to informed recommendations for education, training, and policy change.

Assumptions of the Study

Due to the exploratory nature of this study, the primary objective was to add new knowledge to the Canadian literature base on this topic and to describe the current involvement

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of psychologists in health care settings across the country. At same time, it is necessary to note that the underlying rationale for this study was informed by the literature-based assumptions that integrating psychological services as a part of primary health care can increase overall health benefits for the public.

I assumed that psychologists would be able to not only reflect on the positive impact of their involvement within primary care settings, but also expand their thinking to the greater potential of psychologist involvement in primary care by naming the challenges and barriers that limit their role. Self-reported data were gathered through interviews to collect in-depth information about the experiences of psychologists working within these settings. With a qualitative methodology, an assumption is made that participants will answer questions truthfully and candidly. To address this, I explained to participants that all efforts would be made to ensure confidentiality when reporting their responses.

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Chapter II: Literature Review

Within Canada there has been a significant amount of attention paid towards reducing wait times for assessment and treatment of physical health conditions; however, this is not the case for mental and behavioural health disorders (Canadian Psychological Association, 2016). The limited access to psychological services and neglected role of psychologists in the Canadian primary care system have been found to be associated with decreased quality of patient care and increased costs to the overall health care system (Graff et al., 2012). Researchers have estimated that up to 70% of medical visits may be directly attributable to underlying psychological or behavioural factors such as depression, anxiety, and emotional distress due to chronic medical problems (Graff et al., 2012; Grenier, 2010). As a result, some patients may be subject to unnecessary physical examination or inappropriate treatments while missing proper mental health assessment and diagnosis (Thielke et al., 2011).

In recognition of the impact of psychological factors on medical and physical problems, many experts have called for better integration of psychologists across heath care settings in order to improve the quality of patient care (Arnett et al., 2004; Cohen & Peachey, 2014; Romanow & Marchildon, 2003). The following sections provide a comprehensive literature review on the benefits and challenges associated with the integration of psychology in modern medical systems and the current status of the field of psychology in health care.

Historical Background

Theoretical Context: From Biomedical to Biopsychosocial Models

At the turn of the 20th century, modern medicine was focused on the prioritization of the soma, the identification of nature with the physical, and the reduction of the concept of disease to a physical entity (Mizrachi, 2001). The biomedical model dominated industrialized societies as

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the primary medical model, which assumed disease to be fully accounted for by deviations from the norm of measurable biological (somatic) variables (Engel, 1977). The dualistic nature of the biomedical model, which saw the body and the mind as two separate (yet casually interacting) entities, is popularly traced back to 17th-century French philosopher Rene Descartes' development of mind-body dualism (Borrell-Carrió et al., 2004). When mind-body dualism was first introduced, classical science supported the idea of the "body as a machine, of disease as the consequence of breakdown of the machine, and of the doctor's task as repair of the machine" (Engel, 1977, p. 382).

Moving further ahead into the 20th century, as the discovery of antibiotics and improvements in diet and living conditions revolutionized treatment and disease prevention, the biomedical model's failure to fully explain differences in disease course and outcomes became evident (Baum & Posluszny, 1999). In a landmark 1977 article, American psychiatrist George Engel criticized the biomedical model for its lack of attention to the interactions between biological, psychological, and social factors in any given state of health and illness (Engel, 1977). He argued against the consensus that disease is defined only in terms of somatic parameters and the common understanding that psychosocial issues fall outside of medicine's responsibility and authority. Engel developed a new medical paradigm, naming it the biopsychosocial model. This model understands illness as resulting from interacting systems at the cellular, tissue, organismic, interpersonal, and environmental levels (Fava & Sonino, 2000). Through consideration of all areas of a person's life, the biopsychosocial approach is understood to be the most comprehensive approach to understanding and treating illness (Engel, 1977).

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Health Care in Canada: The Separation of Medicine and Psychology

Although the separation of physical and mental health is commonly associated to Descartes' concept of the mind-body dualism, this division between physical body and mind was further entrenched by the separation of health care services within Canada. The development of Canada's public health care system (or Medicare) first began in Saskatchewan in 1947 (Romanow & Marchildon, 2003). One decade later the federal Parliament passed the Hospital Insurance and Diagnostic Services Act, and Saskatchewan's model of universal public health insurance was adopted across all provinces and territories by 1961. Notably, within this model, psychiatric services were separated from those that fell under insured hospital services, with mental health care commonly relegated to psychiatric hospitals (Romanow & Marchildon, 2003). As a result of this governing system, health care in Canada remained focused on the treatment of physical illness, to the exclusion of treatment that promoted mental wellness (Drewlo, 2014; Romanow & Marchildon, 2003).

By 1972 all provinces and territories had implemented universal Medicare, leading to the subsidization, if not full coverage, of additional health services (e.g., prescription drugs; Romanow & Marchildon, 2003). Meanwhile, advances in drug therapy and changes to mental health treatment modalities led to the deinstitutionalization of provincial psychiatric hospitals (Romanow & Marchildon, 2003). Despite this shift in the treatment of mental illness, the medical model remained the norm and most primary care continued to flow through general or family physicians. Most physicians would refer out individuals with serious mental difficulties or treat less serious cases themselves, seldom referring to psychologists (Romanow & Marchildon, 2003). This pattern remains the norm today.

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Related to the dominating presence of the medical model, there remains a lack of emphasis on psychological services, with mental disorders becoming a major burden on the Canadian Medicare model (Romanow & Marchildon, 2003). Although Canada is not alone, with the World Health Organization (2001) suggesting that mental health remains one of the most neglected areas of public health care worldwide, the social and economic burden becomes increasingly evident with consideration of recent statistics suggesting that one in five Canadians are affected annually by mental health problems, addiction problems, or both (Smetanin et al., 2011). With an aging population and the presence of concurrent factors such as heart disease and type II diabetes, Canadian estimates suggest that rates of major mental illness will increase by 31.1% over the next 30 years (Smetanin et al., 2011).

Behavioural Medicine and Health Psychology

It has been long recognized across the field of clinical psychology that there is a bidirectional relationship between psychological well-being and physical health (Ohrnberger et al., 2017). However, prior to the 1970s, psychologists had difficulty being accepted into medical settings largely due to misperceptions of their past roles and training (Sarafino et al., 2015). Psychological services were often seen as unrelated to the medical needs of most patients, and psychologists had little to no training in physiological systems, medical illnesses and treatments, and the organization and protocols of health care settings. However, moving towards the 1980s, the mental health disciplines took an increased interest in somatic health and the public health disciplines in psychological, behavioural, and social influences (Johnston & Johnston, 2017). The following paragraphs provide an overview of literature with regards to the emergence of behavioural medicine and health psychology, both fields that emerged in the 1970s to study the role of psychology in illness (Engel, 1977; Matarazzo, 1980).

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Behavioural Medicine. The first formal attempt to define the term "behavioural medicine" occurred at the Yale Conference of Behavioral Medicine in 1977 (Schwartz & Weiss, 1978). The field of behavioural medicine, research and practice encompass biological, psychological, behavioural, and social sciences as they are relevant to health and illness (Nigg et al., 2017). Behavioural medicine can be described as being at the intersection between communication science, consumer education, industry, medicine, public health, and technology (Nigg et al., 2017). Further, through an integration of these approaches, there is an emphasis on the remedial relationship between health and behaviour.

The field of behavioural medicine is suggested to have two defining characteristics: (a) its membership is interdisciplinary and (b) it grew out of the perspective of behaviourism, which proposed that people's behaviour results from responses to certain stimuli or their individual history (Sarafino et al., 2015). The role of behaviour as it applies to practical applications of medical significance include the effects of unhealthful behaviours and risk factors (e.g., substance use/abuse), the short- and long-term effects of stress, visceral learning, and behavioural therapy within medical settings (Fava & Sonino, 2000). With the role of behaviour at the forefront of the developing field of behavioural medicine, psychologists were able to increase their involvement in research and treatment settings.

Health Psychology. Health psychology was founded in behaviourism and can be defined as a discipline of psychology that emphasizes "the promotion and maintenance of health, the prevention or treatment of illness, and the identification of etiologic and diagnostic correlates of health, illness, and related dysfunction" (Matarazzo, 1980, p. 185). While behavioural medicine and health psychology are quite similar in that they have similar goals, study similar topics, and share the same knowledge, they differ primarily in an organizational sense (Sarafino et al.,

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2015). Behavioural medicine is a broad field, not specifically aligned with any profession, medical specialty, or discipline (Nigg et al., 2017), whereas health psychology is rooted in the field of psychology, drawing from other psychology subfields (i.e., clinical, social, developmental, experimental; Sarafino et al., 2015).

The field of health psychology aims to identify and alter lifestyle and emotional processes that lead to illness and to improve functioning and recovery for people who are sick (Sarafino et al., 2015). To address the impact of psychological and behavioural influences and processes in health outcomes, psychological services have also expanded beyond traditional areas of mental health to include the full spectrum of health disorders (Graff et al., 2012). Research evidence has shown support for the benefits of psychological interventions in reducing symptoms, improving quality of life, and decreasing distress and health care utilization across a range of health conditions (e.g., diabetes, arthritis, and chronic pain; Hunsley, 2003). Moreover, the literature has demonstrated that psychological services can contribute to early detection and prevention of major illnesses by identifying behavioural risk factors that exert a negative impact on physical health while promoting healthy behaviours (Romanow & Marchildon, 2003). Psychologists can contribute to health promotion and disease prevention through interventions that address stress and anger management, improve parenting and caregiver skills, and address addictive behaviours (e.g., tobacco use; Romanow & Marchildon, 2003).

Health Psychology in Practice

The emergence of health psychology as a field has prompted interested psychologists and researchers to form a separate division within the American Psychological Association. The Society for Health Psychology (Division 38) of the American Psychological Association was formed as a “scientific, educational, and professional organization for psychologists interested in

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(or working in) areas at one or another of the interfaces of medicine and psychology" (Matarazzo, 1994, p. 31). In 1984, the American Board of Professional Psychology created a board certification for the specialty of health psychology, further grounding health psychology as an independent professional specialty (Hobart, 2015). The Canadian Psychological Association also developed its own related sections titled (a) Health Psychology and Behavioural Medicine and (b) Psychologists in Hospitals and Health Settings. Both sections of the Canadian Psychological Association are committed to providing information regarding current research, activities, and practice developments for psychologists who are employed, teach, or conduct research in behavioural medicine, health care settings, or both.

The Role of a Health Psychologist

Health psychologists are employed in various public and private health care settings including hospitals, clinics, and academic departments of universities and colleges (Thielke et al., 2011; Tovian, 2016). Clinically speaking, health psychologists generally offer a combination of clinical psychology (application of clinical skills to patients) and health psychology (largely research-based science) services (Stephens, 2004). In general, clinical health psychologists work with people who are experiencing psychological problems that are the result of illness or a cause of it. This includes offering therapy for emotional and social adjustment problems that may result from being ill or disabled (Sarafino et al., 2015). For example, health psychologists may work with a brain cancer patient who is dealing with depression related to their illness or a breast cancer patient who is struggling with issues related to their self-image after a mastectomy. Conversely, health psychologists may also work with people who suffer from anxiety, and as such are dealing with psychosomatic disorders. To put it more succinctly, health psychologists engage in both reactive and proactive interventions. Reactive services provided directly to

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patients through collaboration with other health providers include coping with chronic pain, compliance with medical treatment, physical rehabilitation, and preparation for stressful procedures or surgeries (Prilleltensky & Prilleltensky, 2003). In contrast, proactive services generally focus on prevention and promotion of healthy lifestyles. For example, health psychologists can offer psychoeducation on healthy lifestyle behaviours (e.g., improving diet, stress reduction) for individuals at risk of developing chronic illness (Prilleltensky & Prilleltensky, 2003).

According to Wahass (2005), health psychologists can improve the quality of health care by educating the public about psychological factors that are pertinent to physical health while applying psychologically informed research and methods towards the prevention and management of illness and disease. Another core role of health psychologists in health care settings is clinical assessment, with use of psychological tests and measurements, to make diagnoses, identify and assign appropriate treatment needs, monitor treatment and prognosis over time, and focus on risk management (Grenier, 2010; Wahass, 2005).

In addition to providing psychological treatments and interventions, health psychologists possess unique training and skill sets that differentiate themselves from other mental health service providers. Grenier (2010) outlined a list of skills specific to a health psychologist: (a) being a diagnostician with an ability to provide early detection of mental health issues before they escalate, as well as decipher complex cases involving psychological issues intertwined with medical issues; (b) serve as a consultant in providing invaluable resources for the team involving psychological interventions; (c) being an educator about psychological and behavioural matters to both the team and to patients; and (d) involvement in in-house research including linking science and research to clinical practice, implementation, and evaluation of services. Further,

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knowledge and prioritization of evidence-based treatment and an ability to offer treatment choices to patients when appropriate may also differentiate psychologists from other mental health professionals (Grenier, 2010).

Psychological Services in Primary Care

To understand where the involvement of health psychologists may be most beneficial requires an understanding of how Canadians access services through the health care system. “Primary health care” is an inclusive term that covers a spectrum of services and activities from first-contact episodic care to person-centered and comprehensive care sustained over time (Hutchison et al., 2011). The umbrella term of “primary health care” covers population-based approaches (i.e., community health centres), health promotion, community development, and the social determinants of health. Primary health care is considered critical for patients as it is often the initial point of contact with the health care system (Canadian Alliance for Sustainable Health Care, 2012a). Typically, initial contact for the health care consumer is through a primary care physician, often working within a family practice model of care (Hutchison et al., 2011).

As primary health care is often the initial point of contact for accessing health services in Canada, primary care physicians are at the front line of patient intervention, treating both physical and psychological conditions daily (Cubic et al., 2012). Ideally, patients would be referred by physicians to the health psychologist, who might then use brief, behaviourally based interventions to address relevant mental health problems and lifestyle changes essential for the reduction and prevention of illness symptoms (Stephens, 2004). However, due to the limited presence of psychologists within Canada’s public health care system, this is a rarity. Physicians are frequently limited to making psychological referrals within the private system—namely, to psychologists who receive payment through private insurance, patients’ out-of-pocket expenses,

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or both (Moulding et al., 2009). Patients without the necessary insurance coverage, and unable to pay the hourly fees by their own means are frequently left unable to access such treatment. As such, for low-prevalence mental disorders (e.g., schizophrenia), primary care physicians will typically refer patients to psychiatrists for pharmacological treatment. With more common mental illnesses (e.g., depression), usual care generally involves pharmacotherapy, generic counseling (i.e., listening/giving advice), or both provided by the family physician (Cubic et al., 2012; Moulding et al., 2009). Because the majority of a physician's educational and professional training is focused on biological issues, they are often ill equipped to treat mental health problems (Cubic et al., 2012). In addition to having insufficient time to address patient mental health concerns (Horwitz et al., 2007; Takhar et al., 2010), physicians report discomfort and a lack of confidence in treating psychological issues in their practice (Heneghan et al., 2008; Takhar et al., 2010; Wilkinson et al., 2012).

A Call for More Collaborative Work Across Primary Health Care Disciplines

With triage and treatment decisions frequently falling to physicians only, bottlenecks to diagnosis and appropriate treatment occur, with patients progressing more slowly through the health care system (Canadian Psychological Association, 2016). The significance of this issue becomes clearer with recent estimates suggesting that four to five million Canadians do not have a family physician (Canadian Psychological Association, 2016). By relying on physician resources for services that can be provided by other trained and regulated health care providers such as psychologists, Canadians' access to needed health care services is further limited. As such, to optimize health care benefits to the public, there is a call for better integration of services among health care providers and for mental health professionals to acquire the necessary competencies for work across health care settings (Lee et al., 2012).

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Terminology

Various terms are used both across the health care field and the related literature in discussion of health professionals working together in the provision of health services. These terms (e.g., “multidisciplinary,” “interdisciplinary,” and “interprofessional”) are often used synonymously when describing collaboration among health care providers (Oandasan & Reeves, 2005). However, due to a need for clarity in discussions of educational initiatives, there has been a shift in the literature to using the prefix of “inter-” to imply collaboration towards a common purpose or goal and to using the suffix of “-professional” to make it clear that individuals from different health professions are included (Oandasan & Reeves, 2005). In a series of four briefings by the Canadian Alliance for Sustainable Health Care (2012a), an “interprofessional primary care” team is described as a “group of professionals who communicate and work together in a formal agreement to care for a patient population in a primary care setting” (p. 2). Although the literature appears to be moving towards use of the term “interprofessional” (Canadian Alliance for Sustainable Health Care, 2012a; Oandasan & Reeves, 2005), a significant amount of the literature and professional organizations continue to use the term “interdisciplinary primary health care team” to describe similar work (Interdisciplinary Primary Health Care Teams, 2014). As such, I have used both terms interchangeably throughout this research in discussion of health care professionals working in collaboration to provide integrated health services within the same setting (e.g., hospital, clinic).

Moving Towards Interprofessional Care

Research has demonstrated that less than 25% of physical complaints seen by physicians have clear organic or biological signs and that a significant amount of a patient’s unexplained physical symptomology responds well to psychological intervention (Nezu et al., 2001). As the

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role of lifestyle behaviours has been increasingly acknowledged as playing a vital role in both mental and physical health, behavioural health has increasingly become a focus within biopsychosocial practice. Within many industrialized countries, including Canada, major health care reforms are being developed and implemented to reinforce collaboration among health care providers in primary care. In addition to increasing collaborative care, an extended role for psychosocial resources and more efficient mental primary care organization are areas of focus within these reforms (Fleury & Grenier, 2011). In 2004, in response to concerns about the aging population and the increasing number of Canadians with chronic conditions, a commitment was made to increase the amount of access to primary health care teams by 50% by 2011 (Health Council of Canada, 2009). The focus of expanding the development of more team collaboration in primary care was to improve the care of chronic conditions, promote health, and prevent disease. Increasingly involved in those discussions is a recommendation for reorganization of the mental health systems—more specifically, for further development of a shared-care approach between psychologists and primary health care providers, who often end up providing mental health services (Bradley & Drapeau, 2014).

In Canada, between 2004 and 2006, 10 stakeholder organizations (including the Canadian Psychological Association) worked together on an initiative titled Enhancing Interdisciplinary Collaboration in Primary Health Care, aiming to develop a framework and processes to implement primary care models with greater collaboration across health care providers. In 2007, the Mental Health Commission of Canada was appointed by the federal government with a 10-year mandate. One of the six recommended strategic directions was to expand the role of primary health care in meeting mental health needs. Specific priorities towards doing so included strengthening collaborative approaches to primary and mental health care, ensuring timely access

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for those living with mental and physical health problems to appropriate physical health care, and using technology to foster collaboration to name a few.

Barriers to Increasing Psychologist Involvement in Interprofessional Primary Health Care

Researchers have found that patients tend to prefer receiving mental health treatment and are more likely to attend follow-up meetings in primary care settings as opposed to specialty mental health settings (Thielke et al., 2011). However, there are several notable barriers to expanding the involvement of psychologists in primary health care settings across Canada, including funding and accessibility, stigma against mental illness, clinical training for psychologists, and a lack of role clarity.

Funding and Accessibility. The majority of psychological services are currently funded through private insurance, compensation boards, or self-pay, leaving many Canadians without access to necessary mental health services. Further, despite recognition of the benefits of evidence-based psychological intervention across health care, Canadians are offered limited access to publicly funded mental health services (Peachey et al., 2013). Federal and provincial policies and publicly funded institutions are a barrier preventing psychologists from practising to their full scope in primary care settings (Canadian Psychological Association, 2016). Psychological treatment is accessible under Canada's Medicare model only if clinical psychologists are employed directly by the health care setting (e.g., clinic, hospital; Romanow & Marchildon, 2003). Current efforts are being made towards encouraging further access to publicly funded psychological services. As an example, the Canadian Psychological Association has developed a toolkit for provincial and territorial psychological associations to take to their local governments and funders, outlining both the problem and recommendations for change (Cohen & Peachey, 2014).

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As a result of the underfunding of psychological services, many Canadians are faced with limited to no access to mental health care. A report by Peachey et al. (2013) explored the delivery of mental health services in Canada and suggested that primary care teams have a psychologist-to-physician ratio of 1:10, with 2,000 patients per physician. More specifically, this ratio suggests a rate of one primary care psychologist for every 20,000 individuals served within Canada's primary care models (Peachey et al., 2013). Of course, psychologists would not have major treatment responsibilities for all cases and depending on the setting, for example, might be involved in only more complex or high-intensity cases. In addition to direct patient interventions, psychologists' skill base and expertise may also be utilized through consultation and educational support for physicians and other health care providers, thus achieving greater outreach (Peachey et al., 2013).

Stigma. The negative impacts of stigma towards mental illness are present across all aspects of society, including within the health care system. Within health care, stigmatization occurs on multiple levels (Knaak et al., 2017). It can be observed *intraindividually* (e.g., self-stigma, patient reluctance to disclose a mental illness or seek care), *interpersonally* (e.g., discriminatory behaviours or negative attitudes in patient-provider interactions), and *structurally* (e.g., quality of care standards, organizational culture, and discriminatory or exclusionary policies, laws, and system; Knaak et al., 2017). Structural discrimination can impact the culture of a health care organization through resource allocation (Henderson et al., 2014). For example, by investing in the treatment of stigmatized groups (e.g., racial minorities, the elderly), health care organizations send messages to patients that can influence their health care decision-making. For example, allocating health care resources to stigmatized groups may encourage patients to feel that they are worthy of treatment. In addition to institutional and systemic

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discrimination, resource allocation to stigmatized groups may also address self-stigma (e.g., negative beliefs of self, acceptance of mental illness stereotypes, sense of alienation from others; Henderson et al., 2014) by highlighting the benefits of treatment and empowering patients to seek health services.

In comparison to people without mental illness, patients with mental illness and substance misuse disorders have been found to receive lower quality of care for various physical illnesses, including cardiovascular disease, HIV, and cancer (Henderson et al., 2014). Family physicians are more reluctant to believe that patients with previous episodes of depression have serious medical disorders causing physical symptoms (Henderson et al., 2014). Other indirect consequences of stigma in health care include delays in help-seeking, suboptimal relationships between the health care provider and patient, discontinuation of treatment, and poorer quality of physical and mental care (Knaak et al., 2017). The misattribution of physical symptoms to preexisting mental illness (also known as *diagnostic overshadowing*) and the negative impact of stigma towards individuals with personality disorders, substance misuse, and self-harming behaviours may be reduced through the involvement of psychologists who have the training and comfort level to recognize and address these presenting issues in primary care settings (Henderson et al., 2014).

Education and Training. The field of psychology has been faced with the challenge of transforming its education and training models to develop highly competent psychologists while remaining at the forefront of rapidly changing health care systems and public health needs (Cubic et al., 2012). In a 2001 article, Arnett argued that most Canadian Psychological Association accredited clinical psychology programs focus primarily on mental health and do not meet an acceptable level of coverage on topics of more general health. Although this article is

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over 15 years old, a review of most Canadian doctoral-level psychology programs shows this to remain true today. In comparison to Canada, it appears somewhat more common in the United States for there to be a health psychology "focus" or "track" within one of the stages of education and training (doctoral, internship, postdoctoral, postlicensure; Rozensky et al., 2015). However, even in the United States, most psychologists working within primary care settings typically possess instead a terminal doctorate degree in psychology (Ph.D. or Psy.D.) and have completed their clinical training in the general field of psychology (Thielke et al., 2011).

The training requirements vary for psychologists heading towards traditional roles in specialty mental health from those training specifically for roles destined towards primary (or other types) of health care (Tovian, 2016), and so it is arguably important to begin preparing future psychologists for this work through preinternship training (Talen et al., 2005). Grenier (2010) suggested that the work of psychologists in primary care should involve a way of thinking and approaching practice, just as much as with meeting professional competencies, following procedures, developing time management skills, and having physical proximity to physicians and other health care providers. In addition to the competencies being taught in most doctoral clinical psychology programs, education for employment in primary health care requires an understanding of how the health care system works, knowing the different care and funding models, and recognition of the purpose of interprofessional care at the core of primary care reform (Grenier, 2010). Further examples of practical competencies that may differ from the standard clinical psychology training include flexibility in session time increments (e.g., 15–30 minutes rather than the standard 50–60 minute session), ability to draw swift conclusions and make recommendations based upon limited and diverse sources of biopsychosocial information, understanding of the impact of cultural and gender diversities on patient health practices, and

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understanding of medical conditions, procedures, and medications (Tovian, 2016). Talen et al. (2005) highlighted five clinical skills of focus for educational training that range from foundational skills to systems-based intervention: (a) diagnosis and treatment, (b) consultation skills, (c) program development, (d) evaluation and research, and (e) public policy and health care advocacy. Though Canadian doctoral psychology programs are gradually expanding their health psychology curriculum to provide more instruction in this area of work, it is not yet a standard in clinical graduate training (Graff et al., 2012).

Another barrier to specialized training in health psychology is that postdoctoral training is considered a rarity and as such is not deemed a prerequisite for employment or registration across Canada's provinces or territories (Talen et al., 2005). At the systemic level, the scarcity of advanced and specialized training programs in health psychology in Canada poses a major barrier for practising health psychologists in obtaining and maintaining specific competencies that are required in the primary care setting (Tovian, 2016). This applies not only to recent graduates but also to experienced psychologists who have practised in more traditional mental health care areas and who wish to expand their services within interprofessional or primary care settings (Tovian, 2016). Moreover, the paucity of advanced training in health psychology may inadvertently prevent currently practising psychologists from taking on a supervisory role due to insufficient clinical training and experiences.

Lack of Role Clarity and Practice Scope. A call for improved integration of primary and mental health care has highlighted the need to clarify and define the role of health psychologists working in a primary care setting (Thielke et al., 2011). This is especially important as health care policy makers have been calling for many duties to be performed by less qualified (and lower paid) staff. Job descriptions tend to use generic titles such as "mental health

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therapist" or "behavioural health consultant", failing to recognize variations in training and expertise by listing a wide range of qualifications including psychologist, social worker, registered nurse, and occupational therapist (Murdoch et al., 2015). This is of concern when considering the lack of psychology training (educational and practical) or any related aspects of mental health. The lack of role clarity and understanding among health providers and policy makers may not only impact the quality and effectiveness of patient care but also inhibit the optimization of interprofessional collaboration (Grenier, 2010; Thielke et al., 2011). This is especially the case with the existence of professional silos in various health professions (e.g., psychologists, physicians, nurses) where there is preexisting confusion about the knowledge, skills, and scope of practice of other health care providers (Canadian Alliance for Sustainable Health Care, 2012b). It is necessary for psychologists to differentiate themselves and their specific skill sets to further highlight their role and purpose within primary care settings (Grenier, 2010).

According to Murdoch et al. (2015), at least three characteristics distinguish psychologists from other mental health care providers. The first relates to psychologists' ability to think scientifically—to observe and measure, formulate and hypothesize, intervene, and collect more information and revise hypotheses until problems are resolved. Additionally, psychologists' training in research methods and scientific procedure positions them as arguably one of most qualified health care professions to participate in program evaluation. Second, given psychologists' focused training in the biopsychosocial foundations of human functioning, they hold a breadth and depth of psychological literacy above that of other health care professions. The third distinctive characteristic held by psychologists relates to their unique combination of

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skills and knowledge, which optimally positions them to integrate multiple sources of information towards diagnostic decision-making and formulations (Murdoch et al., 2015).

Gaps in the Current Literature

Following the summary of relevant literature presented above, it is evident that there are many gaps and opportunities for research to focus on building a greater understanding of health psychologists' involvement in the provision of interprofessional primary health care across Canada. This gap becomes even more apparent when searching for qualitative research regarding the specialized training (or lack thereof) of those working in interprofessional primary care teams. Although there is a body of literature on foundational and recommended functional competencies for health psychologists working within interprofessional primary care settings (Grenier, 2010; Talen et al., 2005; Thielke et al., 2011), there is a lack of Canadian-specific literature on the current status of health psychologists involved in primary health care. Although psychologists are working within collaborative care approaches in general health care at some capacity across Canada (Owens et al., 2013), at the time of this writing, I was unable to find any published qualitative research information regarding their specific training, roles, roles within interprofessional teams, and experiences (both the positives and challenges) of working within these settings.

Purpose of the Study and Research Questions

The aim of this study was to examine the current status of health psychology in Canada, specifically within interprofessional health care settings. Five domains of knowledge related to psychologists working in an interprofessional health care setting were identified to guide the formulation of the research questions: (a) education and clinical training requirements, (b) professional role and responsibilities, (c) positive outcomes attributable to the inclusion of

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psychologists in the primary health care system, (d) challenges and barriers that undermine the inclusion of psychologists in the primary health care system, and (e) perceived benefits to patients who were able to see a psychologist when they first sought primary care services.

The corresponding research questions are as follows:

1. What are the training experiences (educational and professional) of psychologists currently working in primary health care settings?
2. How do the psychologists define their role and responsibilities in the primary health care setting?
3. How has their involvement within the interprofessional primary care team improved the facilitation of patient treatment and care?
4. What do the psychologists perceive to be the barriers and challenges (structural and clinical) that negatively impact their provision of quality of patient care within these settings?
5. Informed by the work psychologists have done in their setting, do they see any benefits or value to their patients having been able to see a psychologist earlier on when first seeking primary care services?

The results of this exploratory study were expected to provide preliminary information regarding the roles and experiences of psychologists working in interprofessional primary health care settings across Canada.

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Chapter III: Method

Research Design

This study examined the experiences and perspectives of psychologists working across interprofessional health care settings in Canada. Given the nonexistent Canadian literature base on this topic, the aim was to identify underlying central themes around how health psychologists in Canada operate within this context. Due to the exploratory nature of this study, I did not attempt to test a predetermined hypothesis. Instead, I used the research questions to explore, flexibly and in detail, the training, roles, and experiences of health psychologists employed in those settings. The method used for this study was in-depth semistructured interviews, designed to explore the problem and develop a more detailed understanding from those involved in this field by learning about their personal histories, perspectives, and experiences (Brocki & Wearden, 2006; Smith et al., 2009).

Phenomenological methods are particularly effective at uncovering the experiences and perceptions of individuals from their own perspectives (Austin & Sutton, 2014) and as such it was the chosen methodology for this study. Using a phenomenological research methodology, my goal was to describe the meaning of a phenomenon by those who had experienced it (i.e., psychologists working in health care settings) both in terms of *what* was experienced and *how it was* experienced by a small number of participants (Neubauer et al., 2019; Smith et al., 2009). More specifically, I used interpretive phenomenological analysis, allowing me to perform an active role in the interpretive process of the participants' self-reports (Tuffour, 2017). I hoped that the emerging themes from the data analysis would provide a rich narrative on the topic of investigation, highlighting preliminary areas for further development of educational and clinical training.

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Participants

All participants ($N = 8$) in this study were female. Two participants were between the ages of 25 and 34, four were between the ages of 35 and 44 and one participant was between the ages of 45 and 54. Four of the participants had completed their doctoral degrees in the United States, and four had completed their degrees in Canada. The participants' degrees included a PhD in clinical psychology ($n = 6$), a PsyD in clinical psychology ($n = 1$), and a PhD in counselling psychology ($n = 1$). On average, the participants had been working as professional psychologists for 4.93 years (min. = 2 years, max. = 8 years). Participants reported employment in Ontario, New Brunswick, British Columbia, Nova Scotia, and Alberta. None of the participants described themselves using the term "health psychologist." Instead, reported job titles included clinical psychologist, psychologist, registered psychologist, and staff psychologist.

There is no specific rule regarding how many participants should be included in an interpretive phenomenological analysis; however, it tends to be conducted with small sample sizes (e.g., one to 15 participants; Pietkiewicz & Smith, 2013; Smith & Osborn, 2015). Samples of five or six participants have been recommended as a reasonable size for student research using interpretive phenomenological analysis (Smith & Osborn, 2015). Decision-making regarding sample size may depend on the richness of the individual cases, how the researcher wants to compare or contrast single cases, and the pragmatic restrictions of the study (e.g., time constraints or access to participants; Pietkiewicz & Smith, 2013). For this study, the final sample size of eight participants was influenced by the level of data saturation (i.e., unable to generate new themes or new information; Fusch et al., 2015) and ongoing challenges with recruitment (e.g., difficulty finding willing participants who met the inclusion criteria).

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Participants were employed in various health settings, including a family health team, a rehabilitation and employment centre, a private medical clinic, and hospitals. Six participants worked in public health care settings, and two were employed in private health care settings. On average, participants had been employed in their current position for 4.14 years (min. = 1.5 years, max. = 8 years). Participants reported working within interprofessional health care teams with a minimum of three different health care professions to a maximum of six different health care professions. Health care professionals included general practitioners, nurse practitioners, registered dieticians, pharmacists, social workers, physiotherapists, endocrinologists, kinesiologists, medical lab technicians, psychiatrists, general surgeons, anesthesiologists, and clinical nurse specialists. Reported frequency of collaboration between interprofessional treatments varied. All but one participant reported at minimum weekly consultation with other treatment providers. Four participants reported involvement in weekly scheduled meetings, and one participant reported involvement in a monthly scheduled team meeting. One participant reported consultation with the team only in crisis situations. Participants were on-site within their specific health setting for an average of 2.75 days per week (min. = 1 day, max = 5 days). Only two of the participants were employed full-time within the specific health setting (i.e., 5 days per week).

Inclusion and Exclusion Criteria

To take part in the study, individuals had to meet the following inclusion criteria: (a) be doctoral-level registered psychologists (PhD, PsyD, EdD), (b) speak and understand English fluently, (c) be employed as a health psychologist (or equivalent) in Canada within an interprofessional care setting, and (d) have been in that position for a minimum of 3 months (or another similar position for that time).

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I chose the requirement of being a doctoral-level registered psychologist because this is mandatory for registration as a psychologist in most provinces. Participant proficiency in the English language was assessed by telephone while completing a screening and demographic questionnaire. The inclusion criterion of employment as a health psychologist or equivalent (e.g., psychologist working in a health care setting) was used in consideration of job title variance for psychologists working in different health care settings. To outline what would qualify as employment as a health psychologist (or equivalent) was somewhat difficult given that outlining their training and professional roles was an aim of this study. As such, interpretation of meeting this qualification was determined by the participant. I expected that the other required inclusion criterion (i.e., minimum 3 months in the position) would screen for any prospective participants whose professional work did not in some way fall into the subfield and would ensure that they could speak in-depth to their work.

For the purposes of this study, to qualify as employment within an interprofessional team, the psychologist had to collaboratively work with at least one other individual from a different health care profession (e.g., physician, nurse, physiotherapist). To meet the criterion for employment within a health care setting, the psychologist had to work in a public or private setting where additional health care services are offered. Finally, the criterion of being employed in their current position for a minimum of 3 months was chosen because 90–100 days is the standard time frame for new employees to complete the onboarding process and pass probation across different industries and sectors. Therefore, 3 months would enable participants to gain sufficient understanding of their roles and responsibilities. If an individual had not been employed in their current position for 3 months but was previously employed in a position that met the other necessary inclusion criteria, they were able to participate.

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Exclusion criteria included master's-level registered psychologists and psychologists not currently in good standing with the college of psychologists in their province (i.e., without limitations or restrictions on their registration). I checked participants' registration with the regulatory body within their province and their current standing by reviewing public records prior to scheduling the interview.

Recruitment Methods

Purposeful sampling was applied to individuals and across sites to generate a list of prospective participants. More specifically, homogenous sampling was used to sample individuals and sites that possess the characteristics under investigation in this study (i.e., a health psychologist working in an interprofessional health care setting; Creswell, 2012). For the purposes of this study, participant recruitment consisted of using online search engines to research psychological organizations that focus on health services (e.g., The Canadian Register of Health Service Psychologists) and health care settings that offer interprofessional treatment services. I sent an email with the aim of sharing the study information to administrative staff, service coordinators, or directly to health psychologists at various health care locations (Appendix A). To gain a broader reach across Canada's registered psychologists, I also posted the study information on two of the Canadian Psychological Association section listservs, the Clinical Psychology Section and the Health Psychology and Behavioural Medicine Section (Appendix B).

Snowball sampling, the recruitment of participants through current study participants (e.g., a participant's colleagues), was also utilized as an alternative strategy. More specifically, I requested that those with whom contact had already been made and individuals that had been

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interviewed share the study information with others who fit the criteria and may have been interested.

Measures

All prospective participants completed a brief screening questionnaire over the phone prior to scheduling the interview (Appendix C). Screening questions confirmed that the individual met all of the inclusion criteria. Individuals who met the inclusion criteria completed a semistructured interview protocol (Appendix D) designed to collect information regarding participants' experiences and opinions as a health psychologist. As part of this protocol, demographic information including age, gender, and ethnic or cultural background was collected. This information was for analysis purposes only and was not used to identify the participants in the final report. The interview questionnaire consisted of five principal questions, which were formulated to collect information regarding each participant's educational and professional experiences and roles within primary care settings. Because there is no preexisting standardized interview protocol or measure with which to examine the topic of investigation, I developed an interview protocol. The content of the interview protocol was informed and guided by a thorough literature review and the identified literature gaps. Each interview question was intended to uncover qualitative information that corresponded to a specific research question. The open-ended questions allowed participants to share their experiences and opinions while limiting the influence of the researcher's individual perspectives through specific questioning (Creswell, 2012). Furthermore, I constructed a list of follow-up questions (subquestions) subsumed under each interview question to allow for further elaboration and explanation by the interviewee.

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Procedures

The research project was approved by Adler University's Research Ethics Board on December 6, 2017. I conducted participant interviews from January to December 2018. Participants were recruited by email or through listservs to introduce the purpose and scope of the study and to assess for interest. Through these modes of contact, all interested individuals were provided with an overview of what they could expect including length of the interview, a brief summary and clarification of the scope of the questions that would asked to allow for some forethought to strengthen the quality of responses during the interview, and an opportunity to ask questions. I scheduled interested individuals who met the prescreening criteria (and completed the questionnaire by telephone) for an interview.

Only one participant lived within travel distance of me (i.e., Lower Mainland of British Columbia) and was able to complete an in-person interview at their employment setting. In this case, the participant completed the informed consent form (Appendix E) in-person, prior to the interview. As for participants who lived outside of the Lower Mainland, interviews were scheduled by phone. With respect to the informed consent procedures, a copy of the informed consent was sent in PDF format to prospective participants via email immediately after they completed the screening questionnaire. All prospective participants were asked to read and sign, and then return the scanned consent form via email to me prior to the scheduled interview date. All interviews (in-person or telephone) took place in locations where the interview and I had privacy and could not be overheard by others.

Prior to beginning each interview, I reviewed the signed consent form and provided another opportunity for any further questions from the participant. Part of the informed consent review process included assessing the participant for comfort with the interview being audio-

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recorded. I explained that the purpose of doing so was to ensure a complete and more accurate verbal record of their responses. The consent form also requested permission to contact the participant after the interview in case clarification or a follow-up was needed. Participation in this study was contingent on each individual giving permission for the interview to be audio-recorded and for me to be able to contact them again after the interview.

Each interview spanned approximately 40 to 60 minutes. In following with the interview protocol, I asked each participant for demographic information, followed by the five main research questions. Once the participant finished responding to a main research question with their initial and undirected thoughts, I followed up with the outlined subquestions and clarifying probes to prompt discussion about points that were highlighted by previously interviewed participants. The subquestions were informed by the literature base on the topic of investigation, for example, to assess whether commonly cited training, professional roles, and experiences also apply to a Canadian context. After the completion of the interview, the participants were given an opportunity to offer any further comments or information that they believed was related or helpful to the scope of the research. In line with interpretive phenomenological analysis, this provided participants with an additional opportunity to explore their personal experiences and perceptions of the topic with fewer restrictions following the research questions.

During the informed consent process, I notified participants that they would be able to remove their responses from the study up to 2 weeks after completion of the interview. No participants requested to remove their responses following the interview. I transcribed all interviews in order to facilitate analysis. Participant data were made anonymous during transcription through use of a numeric code system only accessible to me. For security purposes, I kept the data in password-protected Microsoft Excel and Word files held in a secure location on

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a password-protected USB stick. All other participant data from this research (completed screening forms, signed informed consent forms, and audio recordings) were kept in a locked filing cabinet at my place of residence during the study.

After completion of the research project, meaning the dissertation has been defended and accepted as complete, I will delete or destroy all identifiable participant data. The transcriptions of the interviews, which were deidentified, will be kept in a secure location for 5 years, at which point they will be deleted or destroyed.

Data Analysis and Coding Procedures

Technique and Rationale

The data obtained from this study were analyzed using a thematic analysis design, a method commonly used for identifying, analyzing, and reporting patterns (themes) within a dataset (Braun & Clarke, 2006). Thematic analysis is a widely used qualitative method within the fields of psychology, health care research, and social research (Fugard & Potts, 2015). This type of analysis is used to address diverse topics related to experiences, understandings, perceptions, and causal factors underlying phenomena.

Coding Protocols and Procedures

For each of the five main research questions, I followed Braun and Clarke's (2006) phases for thematic analysis, including (a) familiarizing yourself with the data, (b) generating initial codes, (c) searching for themes, (d) reviewing themes, (e) defining and naming themes, and (f) producing the report. Throughout the analyses, I aimed to reduce the codes for each research question to between five and seven themes.

Data analysis began with transcription of the raw data, specifically converting the audio recordings into text in a Microsoft Excel file. This occurred with preliminary exploratory

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analysis to begin to obtain a general sense of the data (i.e., look for any themes in participant responses) and was done throughout the process of participant interviewing. I did this as a way to begin to make considerations about data organization and make decisions regarding data saturation.

To enhance the credibility, dependability, and trustworthiness of the study as appropriate, I took several measures. As mentioned, all interviews were audio-recorded to increase the accuracy of the data and the later coding of responses provided by the participants. I also utilized reflexive journalling throughout data analysis. This journalling allowed for identification of my experiences, opinions, thoughts, and feelings throughout the interpretation process (Ortlipp, 2008). I reviewed and discussed those reflections with my dissertation chair to account for the role of any biases in the interpretation of the data.

Once I had collected and transcribed all of the data, the inductive coding process began. Following Merriam and Tisdell's (2015) criteria guide for the development of themes, I aimed to create theme categories that were (a) *exhaustive* (i.e., categories accounted for all of the relevant data), (b) *mutually exclusive* (i.e., relevant data could be placed in only one category), (c) *sensitive* (i.e., categories captured the meaning of the data), and (d) *conceptually congruent* (i.e., categories were all at the same level of abstraction). Then I moved into the "axial coding" process (Merriam et al., 2015). This process included further refinement of the category scheme by relating categories and properties and placing them into overarching themes. To further increase validity and credibility throughout the coding process, I collaborated with my dissertation chair to review and discuss the themes as they developed. No significant disagreements in coding were identified throughout this process.

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Once the identified list of thematic categories was deemed satisfactory, I conducted and wrote an analysis for each of the final themes and subthemes, ensuring that each was distinct and clearly linked to one of the five research questions (Braun & Clarke, 2006). Reviewing the themes for trends included organizing them into a coherent and internally consistent account, and reporting of the data involved use of a combination of analyst narrative and illustrative data extracts (e.g., quotes) within the final report (Braun & Clarke, 2006). The collected demographic information (e.g., age, gender, ethnicity) was used for descriptive purposes.

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Chapter IV: Results

Data from eight semistructured interviews about participants' experiences and opinions as psychologists employed in Canadian health care settings were included in the analysis. Participants were employed in various health care settings (i.e., family health team, private medical centre, rehabilitative and employment centre, hospital) across five provinces (i.e., Ontario, British Columbia, Nova Scotia, New Brunswick, Alberta). As mentioned, on average, participants had been working as professional psychologists for 4.93 years and been employed within their current health care setting for 4.14 years. They reported working on average 2.75 days per week within their specific health setting. All participants reported working within interdisciplinary treatment teams. Seven out of eight participants provided weekly consultation to other health care professionals.

The collected data have been sorted categorically according to the topics of the five interview questions: (a) relevant training background, (b) roles and responsibilities, (c) contributions to patient care, (d) barriers to role that impact patient care, and (e) benefits to accessing psychology services earlier in treatment. Each topic contains a varying number of themes and subthemes, which are presented here. All themes and subthemes are illustrated throughout this chapter using qualitative descriptors and participant quotes. Each of the following topic sections begins with a table summarizing the themes and subthemes.

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Relevant Training Background

Table 1

Themes and Subthemes of Psychologist Responses to Relevant Training Backgrounds

Themes	Subthemes
Academic training and coursework	Theoretical and intervention
	Psychodiagnostics
	Assessment
Practicum and internship training experiences	Work in health centres
	Work with health concerns
	Work within health care teams
Supervision and job training	

Academic Training and Coursework

None of the participants in this study took a health psychology track or specialization during their master's or doctoral degrees. Additionally, none of the participants completed graduate-level courses specific to working in an interprofessional team or health care setting. Two participants reported taking a single health psychology course during their undergraduate degree. When asked about relevant courses and training experiences, participants cited (a) theoretical and intervention, (b) psychodiagnostics, and (c) assessment courses as most relevant in gaining necessary competencies for their current professional work within an interprofessional team in a health care setting. The following extracts from participant interviews provide an overview on responses related to relevant academic training and coursework:

- Participant 3: "In terms of health, I took health psychology. Just because I found it interesting. I think that might have been in undergrad."

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- Participant 4: "I know in medicine and nursing and some of the other health professions, they actually have specific courses on interdisciplinary work. I've not come across that in psychology. So I can't think of anything that would have been a specific course or training on working in multidisciplinary teams in my training."
- Participant 7: "I can't think of anything I took specifically where that was the focus. … when we would do, let's say, an assessment course and we would get, you know, feedback on reflective listening and clinical skills that we would use to work effectively with other people. It's different, of course, with colleagues versus patients, but I do think kind of that focus on how to work well and understand someone else's position, that kind of thing, I think that probably would help."
- Participant 8: "We definitely had courses in things like psychopathology and assessment and CBT [cognitive behavioural therapy] and things like that. I would say that we didn't have any, as far as I can recall, any specific courses on like working in a team."
- Participant 6: "The general intervention and assessment courses, ethics, and things like that. Nothing was specific to working with kids or anything like that. It was just kind of the general stuff for everything."
- Participant 5: "Anything assessment was good. Psychodiagnostics course. Psychotherapy skills and research."

Practicum and Internship Training Experiences

The majority of the participants indicated that practicum- and internship-level training experiences were the most helpful clinical training experiences. Other helpful clinical training experiences included treating specific populations who live with certain physical health concerns

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(e.g., epilepsy), working within health care settings (e.g., hospitals), and interprofessional work with other disciplines.

- Participant 1: "My job as a practicum student would be to treat psychological issues that came up within the patients that were experiencing epilepsy. Well, I didn't actually have to know anything about epilepsy to treat their depression, but of course, with the health psychology stance, that you also need to be knowledgeable about epilepsy and about the comorbidities with mental health issues. … What are common experiences with epilepsy, what are the medical complications—and so you do some research on that or your supervisor would say, 'Read this article about epilepsy and depression.'"
- Participant 5: "During my internship as well I also had one rotation that was on a rehab floor of a hospital. So that was dealing with patients who had had strokes and also acquired brain injuries from accidents, like car accidents. That was helpful, just being in a hospital setting. And I also had an inpatient psychiatric floor rotation on that as well. So again, just working at a hospital setting was helpful in seeing how those different units operated."
- Participant 2: "My very first practicum was in a hospital setting, but it was psychiatric only, not health psychology. But everybody in my program did like a 10-hour week, combination of doing intake interviews, psychiatric intake interviews, and helping co-lead a group. … I've certainly come across a patient dealing with health concerns and pain issues as well, so it wasn't completely new population for me in that sense."
- Participant 4: "I was involved with a multidisciplinary student-run medical clinic. And that was very, very helpful in learning how to work with other teams and professional disciplines."

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Supervision and Job Training

Several participants highlighted on-the-job training and supervision as helpful and relevant training experiences. This included receiving cross-training with another psychologist who was previously in the role, supervision by a psychologist with a health psychology background, and postdoctoral training experience.

- Participant 2: "Now I didn't get training as a health psychologist, hardly anybody had that specialized degree. … You have to get trained on the job. We need more training for health psychologists. … I had some cross-training when I came here. … I got cross-training with the person who had the job for the previous 9 years. And that's basically the support I got transferring into the role."
- Participant 6: "When I was becoming licensed or registered in [province], my supervisor was a health psychologist. … That was very helpful because when I was working, you know, early like my first year of my career as a sort of independent clinician, I was being supervised by a health psychologist, which gave a lot of good training."
- Participant 8: "Yeah I would say nothing like formal training about working in a team. I did a postdoc in the same clinic where I work now. It was a research postdoc mainly. But we, you know, have a big team here, so we're working a little bit with the people on the team here."

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Roles and Responsibilities

Table 2

Themes and Subthemes of Psychologist Responses to Roles and Responsibilities

Themes	Subthemes
Psychological assessment and treatment	Diagnostic assessment
	Individual and group therapy
Administrative duties	Writing clinical notes and reports
	Attending meetings
	Responding to emails and phone calls
	Completion of organization-specific requirements
	Management of schedule
Team collaboration and consultation	Provide psychoeducation
	Consult on patient diagnosis and treatment
Academic involvement	Research
	Supervision

Psychological Assessment and Treatment

All participants reported involvement in psychological assessment and treatment. This included psychodiagnostic assessment and diagnostic clarification, assessment of suitability and barriers for medical procedures, and identification of risk concerns. Participants highlighted involvement in diagnostic assessment, including for mood disorders, developmental disorders (e.g., autism spectrum disorder), and learning disorders (e.g., attention-deficit/hyperactivity disorder). Participants indicated that the level of their involvement in individual and group therapy work is contingent upon several factors: the specific structure within their setting, patient

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needs, and funding for services. For instance, some participants reported seeing all patients for consultation, whereas others met only with patients who were referred for mental health or general treatment challenges.

- Participant 1: "Practically speaking, my role as a psychologist is to treat anyone who is rostered to the group of doctors that I'm working with, to treat any psychological issues that present. Holistically, that would mean that assisting with general well-being then improves physical health. But I think when I consider more of the interdisciplinary or interprofessional team, I think of my role also as a consultant, typically trying to identify or confirm diagnoses, as well as treating the challenging cases that even the medical components may not be well understood and then that creates psychological components and just becomes a challenging relationship between the medical team."
- Participant 4: "If there is any confusion or there is any need for diagnostic clarification around mental health, that tends to be within my scope of practice within my role. And so that is where the collaboration piece comes in. So for example, we have physicians that are working with the patients and they are wondering if there is a mental health component or they are wondering what specifically the disorder or the concern is, then that's a question that I will then answer. So I will do a consult meeting and then clarify what I think is the diagnosis and/or concern and what approach needs to be taken, whether it's kind of therapy, there needs to be involvement by a psychiatrist, there needs to be some treatment."
- Participant 5: "At the beginning of my job here … I did at first half of my job have regular therapy patients. And then what happened was the demands of our funders, which is the government, kind of increased so we needed to see more patients for assessments,

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which is what we're funded for. So I stopped doing individual psychotherapy. … I do group-based work. So I facilitate a mindful eating group, which is an 8-session protocol, kind of like MBSR [Mindfulness-based stress reduction] or MBCT [Mindfulness-based cognitive therapy]. Yeah and then I also co-run a two-hour CBT [cognitive behavioural therapy]-based workshop, kind of like psychoeducation, for patients as well."

- Participant 7: "Now with some people their mental health is not stable presently. They have, you know, let's say been self-harming or are suicidal. It would not be the right time for bariatric surgery. So sometimes it might be, you know, working with the patient around it not being the best time for them. Or if there are identified mental health issues, we also might come up with a treatment plan with the patient, in conjunction with the team around what would be most helpful for people as they go through the process to make them suitable for surgery or more likely to have a better outcome."
- Participant 6: "My role is to really help the patients and their families with any mental health coping, functioning, and then making sure that if I'm getting into conversation like pacing activity or side effects of medication, things like that, that I don't overstep my competency."

Administrative Duties

Participants described various administrative duties. This included writing clinical notes and reports, attending meetings, responding to emails and phone calls, completing other organization-specific requirements (e.g., hospital surveys), and managing their own schedule. Several participants reported varying levels of autonomy over their schedules and how they organize and prioritize their responsibilities, including ensuring completion of administrative tasks.

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- Participant 3: "I pretty much have my clients scheduled; they come in, I see them, I write their note. Depending on where they are, there might to be a report that needs to be written that's kind of just like a progress report on how they're doing. Or it might just be a phone call like, 'Oh hey, they came, they are kind of stumbling on X, Y or Z,' like they aren't doing their homework or they're not doing the gym. So there's a lot of checking in with the referrals and letting them know how the client is doing. If the client has wrapped up then there will be a discharge report that needs to be completed and sent out."
- Participant 5: "Monday is my paperwork day. So I do stuff like this and work on catching up on reports and also research. … Tuesdays and Wednesdays are my heaviest clinical days, so I have patients booked both of those days, and those are either pre- or post-op assessments. Then Thursdays it is meetings and again paperwork. So we might have a research meeting, which is every other month, that I co-chair. We also have rounds, clinical rounds, every Thursday. That is the entire team. … And then Friday is usually two patients I have scheduled … and then time for research, paperwork, meetings."
- Participant 8: "Because half of my time is research, what I've found works best for me, and it's not always feasible, … is to really kind of group my clinical work into a couple of days and then try to have stretches where I can devote to research. So then when I have individual appointments with clients or assessments, what I try to do is book those on the same days that I have standing other things. And then that way that leaves me certain other days where I don't have any clinical things booked or very minimal things booked. So that I can really try to focus on research and so I get a nice kind of stretch. Because I find it harder to focus on research if it's only a couple of hours here and a couple of hours

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there and you're always getting up and doing other things. So I just try to cram all of the clinical stuff into 2.5 to 3 days and then have a couple of full research days."

Team Collaboration and Consultation

Participants described collaboration to include providing psychoeducation to the team and consulting on patients. All but one participant reported at minimum weekly consultation within the interprofessional team. Most participants reported at minimum weekly scheduled consultation meetings with the treatment team and more informal consultation throughout the week as needed. Participant 3, who did not attend weekly consultation meetings, described "casual" and unscheduled consultation with the team due to scheduling (i.e., back-to-back appointments) and location challenges. Across participants, the consultative role included addressing specific questions or concerns by the treatment team for individual patients (e.g., identified symptom elevations) and more generally across patient populations (e.g., educating team about psychological variables that may be complicating medical treatment). Several of the participants interacted with all patients who accessed services within the health care setting (e.g., assessment and treatment prior to surgery, brief consultation), whereas others met with patients only when identified and referred by the health care team as needing psychological intervention.

- Participant 1: "I also think that my role, not as often as potentially I would like but, it's also to work with challenging some of the thinking of the medical team that other components might be at play, so more psychological components. So even just educating, you know, softly educating the team, not in a formal sense but softly educating the medical team what are the other things that might be complicating the medical presentation."

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- Participant 3: “We don’t consult much, like if I knew it would be like a casual ‘Oh hey I have this client, ta da da da,’ but like it doesn’t happen that often. Just because we’re kind of in our office and have patients back to back, they’re [the physiotherapists] in the gym. So you are kind of like in two separate worlds.”
- Participants 7: “Someone’s developed a problem with alcohol after surgery and there can be real risk with that, in particular after surgery. So we might get involved and they might consult with us and they might bring them in to see us after. So definitely we’re always talking about patients. And making decisions. … I think it’s mutual; I also go to them a lot or the nurses, for example, around if I think something is a medical concern and they need to see the nurse that day. Or, you know, when I can’t judge that as a nonmedical professional. So yeah, we’re doing a lot of consulting for sure.”
- Participant 1: “I work in the same building as all of my medical team and it still often feels as though we are siloed in our work—that I do my part, they do their part. So what I try to do that addresses part of this question, sometimes I use the patient to help link us. And the advocacy is a big piece of that, helping the patients to understand, to advocate for themselves based on you know what I’m observing.”
- Participant 4: “I think another benefit to having psychologists within health care teams has been that it helps improve the visibility of the profession in general. Because typically our profession is quite kind of fragmented—most people are in private practice. And I think in health care teams, when we are out there and contributing, then there is better understanding of what we’re trained to do, what our background is, what our competency areas are, and what our roles can be. And so I think that that has been very helpful in general in my experience. Often people don’t know.”

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Academic Involvement

Three participants reported involvement in both on-site research and supervisory roles. The participants who reported involvement in research described involvement in practice-based clinical research, where the research becomes fully integrated with a common element of their clinical practice (e.g., population-specific treatment group, pre- and postsurgery outcome measurement). For example, Participant 5 reported how she was part of developing the pre- and postsurgery patient questionnaire package used for outcome measurement. Participant 7 explained how she and other psychologists are often involved in the development and implementation of clinical research studies specific to the treatment population within their specific setting. Participants reported supervision of clinical work conducted by practicum students and other mental health professionals (e.g., psychometrists).

- Participant 5: “In terms of outcome measurement, I helped with putting together the questionnaire package we give to our patients, which is partly clinical and also partly research in that if patients consent, we use it for research. So it’s presurgery, 6 months post, and then yearly for 5 years after that. And I manage that database of lots of data coming in.”
- Participant 7: “We do a lot of research within the programs. Psychologists are involved with various projects. … So I’m one of the cofacilitators but also involved in the research study. So part of doing the treatment but also helping with looking at the results and writing it up, presenting it at conferences. So definitely more involved in the academic side as well.”
- Participant 8: “I think just really being so involved in research, like having a big chunk of my time to be research-focused allows me to keep up on the current literature. And so

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being able to really kind of bring in that knowledge in terms of what is current and how we might approach particular problems a client is facing in an evidence-based way."

- Participant 5: "Our program is super well-funded and there is a lot of opportunity with research and I have students and a lot going on. It's fun though. I like the variety."
- Participant 7: "I also supervise students doing a practicum placement. They will sometimes see some patients for treatment under our supervision. I don't have time to see people individually, unfortunately, but I supervise students. So I think taking a leadership role in those areas I would say for sure."

Contributions to Patient Care

Table 3

Themes and Subthemes of Psychologist Contributions to Improving Patient Care

Themes	Subthemes
Diagnostic accuracy	Comprehensive assessment
	Diagnostic clarification
Comprehensive treatment	Identification of treatment challenges and barriers
	Provision of psychoeducation
	Collaborative treatment

Diagnostic Accuracy

Participants reported that their training was critical in providing necessary psychological assessment to improve diagnostic accuracy on mental health problems. Benefits of improved diagnostic accuracy included improved identification of psychological risk factors, diagnostic clarification, and increases in prevention-focused treatment for patients. For example, Participant 4 described how each patient consultation contributed to gathering information on the patient's

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baseline functioning, identifying subclinical or undiagnosed symptoms, and increasing use of prevention-focused treatment in response.

- Participant 4: "At [workplace] we also have something called a consultation, which means every patient that walks through our clinic, who is a patient at our clinic, automatically gets one consultation with a psychologist. And there have been so many times where during that consultation, we have determined a mental health component that the patient or physician was not necessarily aware of or it didn't come up previously. … Based on that consultation, if someone is doing really well, then that is giving us a baseline that we can kind of compare how the patient is doing over time. And if there have been concerns that weren't previously picked up, then we can pick that up in our [consultation]. … It has been a really important part of providing comprehensive and more preventative-focused treatment for patients, rather than always retroactively trying to do something for something that has already happened."
- Participant 1: "With autism … I think it's in some way sort of a scary topic for physicians if an adult or adolescent comes in and there is that query about autism. And so, I have helped guide patient's families in the right direction about whether in fact this is what we're seeing, whether we need to consult with other experts. Opposed to um the practitioner or medical team sometimes feels they need to make a decision about yes or no. And they don't necessarily have all the information that they need. And so that has very much changed the outcome for patients, so someone they're thinking has autism in fact I can test and find out that they have intellectual disability and in fact now we are on the stream of um support programs financially for the family, and it just changes everything, but it changes it in the appropriate and the right way for patients."

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- Participant 8: "For example, sometimes we have clients … maybe they are struggling with the eating disorder treatment because, you know, the rigidity around their OCD [obsessive compulsive disorder] … and sometimes their OCD and their eating disorder is really intersecting. … And to really try to tease that apart and to try to provide some adjunctive support around the OCD or to just even teach them some skills to manage things so that they can engage with the eating disorder treatment. We're not fully treating the other problems but even just to tease those things apart and to provide support. Or you know sometimes our clients have other impulsive behaviour, self-harm or substance use, so being able to identify and address those needs within the context of our treatment program."
- Participant 1: "Before I was available, then a typical interaction would be a patient would come to their family doctor and say, 'I think I have ADHD [attention-deficit/hyperactivity disorder] or some attention issues,' and the doctor would really just decide one way or the other whether or not they are going to treat symptoms of ADHD … and typically that would be with medication. Now the practice seems to be when that comes up in an appointment, it's a direct referral to me, to clarify a yes or no for the diagnosis. And of course, that changes patient care in terms of—it's a much more thorough assessment and so there is a lot more confidence in the answer. And the answer is not always yes or no, you have ADHD as the end result. It might be yes or no to that question, but you know what, we're not actually looking at the question that you have significant anxiety—which of course if you just went to your doctor for the 10-minute appointment and you only talked about attention symptoms, you might be treated inappropriately, right, with the medication or the recommendations when in fact, we've

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got this other issue. So I think that's really important because then there is a more accurate diagnosis and better outcome for the patient because we are getting the right treatment."

Comprehensive Treatment

Participants described improvements in patient care related to comprehensive treatment. Comprehensive care included a holistic approach to treatment, with focus on both physical and mental health aspects of patient care. Subthemes included identification of treatment challenges and barriers, provision of psychoeducation to both patients and the interprofessional treatment team, and increased collaborative and holistic treatment approaches. In terms of identification of treatment challenges and barriers, participants reported how psychological expertise allowed early and ongoing identification of risk factors to treatment and an ability to address common patient challenges through appropriate treatment decisions or program development.

- Participant 5: "Psychology actually can be a gate-keeper. So if we see a patient presurgery who has really active mental health symptoms, and we decide that they are not suitable for surgery, no one has a problem with that—that will be respected. And then they will be discharged with recommendations for treatment. Or if they have some symptoms but not so severe that we would want to discharge them, then we would provide some planning recommendations and reassess the patient after a number of months and see how they are doing."
- Participant 7: "In the context of bariatric surgery, so there are a lot of lifestyle changes that they have to do with surgery … so being able to kind of conceptualize and, you know, anticipate what could be some difficulties that people could have after surgery given what is going on for them now. … Occasionally we've had people who had bulimia

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and that is a contraindication for surgery, so being able to identify that and get them help … kind of the eating disorder psychopathology side of things. You know, is this person at risk of actually, you know, developing an eating disorder or worsening of eating disorder symptoms after surgery. … We can't totally predict how things will go but we use the research to help us make those decisions. But being able to, I guess, flag concerns and help the team come up with a good plan for a particular person, whether that's doing the surgery or making the decision that it's not a great time for them to have it."

- Participant 1: "[I can provide] a different view about what is happening with a patient. … [which] as well as program development I see as a really important role. … The mental health team hears about problems that are happening with groups of patients or about common complaints, not really complaints, but common issues that are being brought up by the medical team and we have this unique ability to say, 'What are the common factors here and is there something that we can provide'? … So we can either be the leadership of the programs or we can simply guide new programming with others. … I've done a few different things where [I am] educating teams of nurses or getting together with groups of local mental health teams and being able to change either perspectives on something or idea sharing."
- Participant 7: "Definitely just doing the assessments. So we have been following patients for up to 5 years after surgery. … We then have some history from, you know, prior to surgery what problems have people had from a mental health perspective. … It can help us to determine someone's treatment plan, if we delay surgery for some time so that they can access treatment … and to make them more likely to be successful after surgery. So I would say we would help in that way because in some ways we're identifying problems

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or helping the team to see. … They may not be thinking about that, how their depression could get in the way of, you know, implementing changes after surgery. So I think not only identifying the problems, helping patients to understand that, but also helping them or getting them access to services that help them to make some changes to be better prepared for what is to come. And then you know, they are more likely to have a better outcome after surgery."

The provision of psychoeducation to other care providers promotes patient treatment adherence and improves communication with patients. This includes sharing information with other health professions on how to improve patient treatment adherence, address common patient presentations (e.g., health anxiety or somatization), and differentiate clinical presentations (e.g., diagnosable substance use disorder versus substance use behaviour). Patients also benefit from psychoeducation including what to expect after physical treatment (e.g., heightened depression postsurgery) and help with self-advocacy throughout their treatment.

- Participant 2: "One big issue is identifying, you know, keeping patients engaged and identifying, you know, motivation to be adherent to treatment, right? So I do some psychoeducation with other members of the team. If I find articles around assessing motivation or around motivational interviewing techniques that anyone in the medical community can use, not just mental health professionals, and just share some of that knowledge and some of the resources with the team. So that, that big piece is helping the team address treatment compliance."
- Participant 4: "Oftentimes a lot of health care professionals would very naturally want to provide a lot of reassurance and support to patients who have a lot of anxiety around health. And when we've determined that there is health anxiety as a primary concern for

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the patient, I've been able to work with our health care team so that they don't provide reassurance the same way that they might have in the past. And the patient is very involved in that process so that they know what is going to happen, that it's part of their treatment. So I think helping our team kind of have improved psychological literacy has been something that has been part of my role and has been something that I think the team appreciates."

- Participant 6: "[My team sometimes suspects] what used to be called Munchausen by proxy, because a lot of people think that might be relevant with some of our patients who have presentations or parents who are overly distressed or seem to be making a bigger deal of the patient's pain than the patient is making themselves. … So really talking with the team about the difference between, you know, the clinical presentation of a diagnosis versus the parent's distress about the experience and that they might be really distressed about it and trying to make a bigger deal about it because they want the support, not because they are actually causing any symptoms in their children."
- Participant 7: "Giving some psycho ed as well in our psychological assessments. … We don't have time to cover everything but tailor it to, you know, if somebody is really concerned about the loose skin after surgery, we might dedicate more time to educating and exploring that aspect with them. … If someone has a history of recurrent depression then we might talk a bit more about their vulnerability after surgery with that. So we kind of tailor it a bit to what might be post helpful for the patient."
- Participant 2: "A lot of time, I know patients, even if they like and respect the doctors and feel like they are getting adequate health care, they sometimes are a little bit afraid to challenge the doctors or ask questions. So then just sometimes helping identify some of

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the patients' concerns and needs, helping advocate for them or working with them to help them on developing their confidence to self-advocate or encouraging them to not be afraid to ask more questions."

With respect to collaborative and holistic treatment, participants described their roles in advocating for more well-rounded care on behalf of their patients. This included identification of the professional most appropriately trained to address the presenting issues (e.g., psychologist performing full autism assessment prior to diagnosis and treatment), provision of other supports in patient treatment (e.g., spiritual and palliative care), and psychologist involvement at various levels to support the patient throughout treatment (e.g., psychologist following up on exercises provided by the physiotherapist, team consultation).

- Participant 2: "Seeing patients with chronic renal failure, I do have patients that are end of life too, so I just try to help them identify how to make the best balance between quality of life and quantity of life. … Working with them on finding that balance between taking care of themselves so they can live longer, but also not giving up everything they like so they feel like the quality of life is no longer worth something either. So I work with them both individually and also with the team. … There's a lot of pressure sometimes from the medical doctors: 'Oh they have to do this, this, this, this, and this if they want to live longer,' but they don't always feel that it's worth living longer if they have to do all these things. So I'm also consulting with their spiritual care or palliative care, you know, helping patients and their family to make that decision to end dialysis, which in most cases doesn't mean dying sooner rather than later but deciding that dialysis is no longer adversely affecting their quality of life."

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- Participant 4: "The patients get comprehensive care. So they are not getting little fragments of care, which has been really helpful. … It's been really helpful in terms of appropriate allocation of resources. So our physicians have more availability to focus on physical concerns and then our psychology team might focus more on mental health concerns. And so it's improved allocation of resources as well and it has made our clinic more efficient, which means that patients get to spend time, more time, on their mental health concerns if they have those concerns."
- Participant 6: "I've worked really well with the physios on our team to … do back-to-back appointments sometimes, where the physio will meet with them, with the patient, give them the exercises, and then the patient meets with me and I'm like, 'Ok, the physio just gave you a bunch of exercises, now let's talk about how to make that happen within your current functioning and coping.' And so we work as a team back-to-back rather than in the same moment. And that seems to work quite well."
- Participant 3: "I think it gets all of the aspects of sort of recovery and what someone is going through. That it's not just physical and that it's not just mental, that it's kind of both and we the have the ability to address both. So I think that kind of helps the overall picture. And we have a lot of people with concussions too, so building that endurance like walking on the treadmill and doing certain exercises, and then working with an OT [occupational therapist] to do work simulations and things like that. And then coming in here where they will try to focus on all of the physical stuff like 'I've got a headache that I'm worried about., is my next week going to be a write-off'? And I'm like 'Well, that's psychological, that's anxiety, that's health anxiety, let's talk about that' instead of like trying to rush over it and like focus on the physical symptoms."

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- Participant 4: "We have patients with quite significant health anxiety and so they're visiting with our physicians quite a lot for … primarily health anxiety rather than any organic and/or physical symptoms. And so I have been involved a lot in those kinds of cases where once we've treated the health anxiety then the patients' visits to emergency have significantly gone down or the patients' visits to the family doctor's office have drastically declined. And so it just makes for a more efficient use of resources, of costs."

Barriers to Role that Impact Patient Care

Table 4

Themes and Subthemes of Perceived Barriers that Impact Patient Care

Themes	Subthemes
Funding and access limitations	Long wait times
	Limited resources
Training experiences	Role overlap
	Differentiation of role from other mental health professionals
Scope of role	
Mental health stigma	
Ethical issues	

Funding and Resource Limitations

Long wait times and limited resources were described by participants as perceived barriers to patient care. This was a commonality among participants employed at provincially funded hospital settings, a rehabilitation centre primarily funded by third-party payers (e.g., insurance companies), a primary health care team, and a private health clinic. Funding and

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resource limitations meant delays in services due to long wait times, space limitations, and funding limitations to patients who cannot pay out of pocket for psychological services.

- Participant 1: "Let's take kind of a worst-case scenario: someone is having suicidal ideations. In our rural communities we have some crisis services, but they also suffer from the same funding and resource scarcity issues, so they're not great. And so everyone is sort of reliant on everyone else trying to just help patients, but a patient might wait 4 months to see me and maybe they have another suicide attempt. Right, and that if you think about that, so they have survived, great, but think about the emotional toll that that had on themselves or their family … and all of those other pieces that potentially, not by any means guarantee but potentially could have been prevented … if they could be seen earlier."
- Participant 7: "My sense is that actually a bigger problem than funding, although funding is a problem, a bigger one would be space. … The team is probably four times as big as it used to be. So there are, you know, a lot of people working in work rooms and moving in and out of assessment rooms, which has its pros and cons. I think I've heard that they have the funding to hire more staff clinicians because our workload, like our patient load, just gets bigger with more referrals. But we can't hire anyone because we have nowhere to put them. …We have a busy case load and not enough people, not enough staff, and then not space to have that staff."
- Participant 8: "Going back to the funding piece, I mean there are very few specialized treatment centres like where I work in [province] and the funding is quite limited and specific. And I don't know if that is stigma or just a misunderstanding of these kinds of issues, whether that plays a role in the amount of funding that's available on like a

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province level. You know, I wonder if there was more awareness about eating disorders, and the amount of disability that they can create, and all the medical complications that can come out of them, and that sort of thing, if that could potentially impact having more funding that is available. So on a day-to-day level I don't notice it, but from that bigger perspective thinking 'Oh well, in this province we have a limited number of [workplace] providing care to a limited number of patients at a time.'"

- Participant 4: "This is a little bit different from the clinic I am a part of because it is a private medical clinic, which means that it serves a very particular type of clientele where funding may not be as much of a concern for all patients. But in general I would say even within our clinic there are certainly times where access to the on-site psychologist because of the fee structure has been really limiting. So there are lots of times where some of our patients may not be able to fund $200 an hour to come and see the psychologist. So funding is probably the main barrier to access to the psychologist, even at our clinic that is a more affluent clinic."

Training Experiences

Overall, participants did not report any significant barriers related to training experiences and reported that broad graduate-level training, relevant practical training experience, and doing their own continuing education as necessary (e.g., reading articles) were sufficient to performing in their role. Although participants did not identify any significant training-related barriers, they suggested that additional training in a few specific areas would have been beneficial (e.g., grief and end of life, pharmaceuticals, specific physical and mental health interactions).

- Participant 3: "My school had a health track; it just wasn't what I took. I'm sure if I took that I'd have a much better background. I've been here almost 6 years, so I think just

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from doing enough files, seeing enough people, and hearing about what they are doing at concussions clinics, health institutes, and with chronic pain/pain management, like just from that I feel like I have a good enough training background. … I guess if I had taken the health track, I probably would have come in with that."

- Participant 7: "When I was at [university] … they had a new health psych certificate thing going on, like subprogram. It wasn't something I could foresee as being important for me now. So if I was to go back, maybe I would do that. But as it turns out I'm actually working on getting my health psych extension now. Which you can do in [province] like after you register with clinical and counselling, which I have, you can add on other areas of specialization. You just need to do a clinical training plan, which involves reading and doing some clinical work under supervision."
- Participant 1: "I think that not having additional knowledge of the pharmaceuticals that are prescribed within our patients is a barrier. Now I say that having had an internship that every day I was on a team and I was part of recommending medication. And so I would say I have above average knowledge and experience. … I know other health psychologists that never had that sort of training. … I think part of my answer is also because I work in rural communities where we just have so little access to specialists, like psychiatry for instance. And so what my role has morphed into is also providing some guidance to the medical team, like on the family doctor sort of level about whether medication should be on board or not, what types of medications. … I'm deferring to their expertise and making sure I'm not going outside my bounds but at the same time additional pharmaceutical knowledge would be even more helpful. … But I do think that that would be really the only barrier that I see because I think that the training, my

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training was, it was broad, but it needed to be because of so many different avenues a psychologist can go into. And then it's really up to the practitioner to, once they are deciding to focus in on an area, … have the continuing education."

- Participant 4: "I think one of the challenges has been … having more flexibility maybe in standards of practice for psychologists or more clear guidelines maybe around how to really participate in multidisciplinary care. … I think in my experience a lot of psychologists have a lot of doubt or hesitation because again I don't think that we're trained right away to think as members of a team. We are trained to think of ourselves as more isolated. So I think that's probably one of the biggest barriers."

Scope of Role

Several participants described lack of clarity and scope of their role as a barrier to their work. More specifically, a lack of role clarity was related to a psychologist's integration into treatment teams. Participants reported that treatment teams were often confused about what psychologists could offer (e.g., diagnostics, program evaluation) and how their expertise and skills differ from other mental health–related professionals (e.g., social work). Participants also reported a lack of role clarity related to the performance of their individual work, including confusion around how to best triage patients to the most appropriate treatment for their presentation. These issues around scope of practice were described as a barrier to patient care as they contribute to (a) silos among the treatment team, (b) delays in patients receiving treatment, and (c) ineffective use of resources.

- Participant 1: "I think that the toughest one that I've experienced is for anyone to understand the difference between a psychologist and a social worker. … I work in these mental health teams that really just have, you know, three players. … The general sense

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is to just lump me in with the social workers, and that has taken some training and education about well what I actually can, a psychologist can, bring to the table to help you and what is unique like the diagnosis or program evaluation. That piece. And so sometimes they don't actually rely on me enough. There could be more simple consultation questions that are asked that might be beneficial to patients, but I don't even think it's thought about, like in terms of a diagnosis."

- Participant 6: "The big barrier that we're dealing with right now is that a lot of inpatients in the hospital have pain. But the psychologists are with the chronic pain team. And so then there is a lot of confusion between the acute pain service, which doesn't have a psychologist, and chronic pain service, which does have a psychologist. And then there are patients in the hospital who are experiencing pain acutely—there is confusion about why isn't there a psychologist there, right? And I think that's where a lot of confusion comes in with other teams and other professionals and other providers in the hospital, who they know that we exist, but they don't understand kind of where our roles are."
- Participant 8: "One thing that sometimes happens is because we have a lot of people from different disciplines doing psychotherapy, for example, maybe there might be certain times when you know maybe a social worker would be a better fit. Or a psychologist would be a better fit because of different presenting problems. You know, if someone is having a lot of troubles with housing, for example, or things like that, maybe a particular type of person might be a good fit, versus if someone has a lot of comorbidities."
- Participant 4: "In my experience, I have found that the majority of physicians or physicians in training don't get a lot of information about the training and scope of practice in general. So they may not be familiar. So I think the onus is on the individual

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psychologist that may be working within the health care setting to really inform and educate the other team members about what their areas of competency are and what their scope of practice is. And I think that if the psychologist shies away from that then they could really run into some challenges."

- Participant 1: "You wait 4 months to see me. I then have a patient in front of me, I do my assessment and very quickly it appears to me I can help them, but we actually have a specialized service within the community, like for instance eating disorders program. And really what I should be doing is referring them off to the eating disorders program. But I know in my mind that that program also has a 2-month wait. And so they've waited 4 months, so am I just going to say, 'You shouldn't see me. That's not the most appropriate care, you need to go on this wait list' and now ultimately, they will have waited 6 months or more? And so what ends up happening is I see them and I refer them, but I see them during that 2 months—but that means now someone else could have been taking their spot, that they now have to continue to wait, when in fact we had something all along that was a better fit for them. And so, we've tried more recently to make changes to our triage program. … We're working on that."

Mental Health Stigma

None of the participants reported any challenges in their current position due to stigma within the treatment team (e.g., not valuing the role of mental health). Patient stigma was described as hesitancy to address the psychologist as their therapist, delays in attending their appointment with the psychologist, and not returning to therapy after a negative experience with a previous provider.

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- Participant 3: "I think they [other providers] are usually happy to have someone else to address the issues. Like GPs [general practitioners] are so happy that there is someone else that they can send like depressed people to and not waste their time. … You get that sense. There are patients that have stigma about it still. … They'll call it something different, like they'll come up with like a different name for it like, 'Oh yeah, you're my coach.'
- Participant 6: "Patients and parents, if they have had a bad experience with a mental health provider, they have cut themselves off from any mental health provider in the future. So they are like 'I didn't like my psychologist when I was 7, I'm never seeing a psychologist again.' But if someone has a bad experience with a physician or a physio or a dentist or a massage therapist, they are much more likely to say, 'Yeah, I didn't like that person, but I'll try it again.'
- Participant 1: "What I do hear is the apprehension the first visit, people saying, you know, 'It took me a long time to make the first appointment. I wasn't sure what this would be about. Are you going to tell me whether or not I'm crazy?'"
- Participant 5: "We have an orientation session. The very first thing patients do is 2 hours long and they get told what the patient flow is—like who they are going to see as they get assessed. So when they come to see me, no one is like, 'Oh why am I here?' or expressing being disgruntled about it. But for many of our patients, it's the first time they've had contact with a mental health person."

Ethical Issues

Participants described several ethical dilemmas related to working in a treatment team and within health care settings. Specifically, ethical standards of practice for psychologists were

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increasingly difficult as they strayed away from the traditional psychologist role as a sole practitioner in private practice. Ethical challenges included lack of confidential meeting space, varying ethical standards across disciplines, and seeing individuals for therapy from the same family.

- Participant 2: "So occasionally there are just scheduling problems where they have an abnormal number of folks in the hospital on dialysis who are in isolation for various reasons and are short on private rooms. … Some of them are okay with my talking to them when their roommate is in the room."
- Participant 3: "As a psychologist we have really strict standards around confidentiality and things like that. And I'll get an email that has a full patient name in it. … I'm just like 'Oh God, get that off my screen.' And then they'll like cc my personal email and I'm like 'Oh my gosh, make this go away' … from other disciplines that are not regulated from the same code of conduct or regulations that we are. So they are a little more able to kind of just chat about the clients without consent."
- Participant 4: "I think one of the main challenges, in my perspective, that has come up, because psychology and psychologists have traditionally been more geared toward either private practice and working as sole practitioners, I think sometimes some of our ethical, not ethical principles, but some of our suggested standards of practice and those types of things don't fit as nicely in a health care team or a multidisciplinary team. So for example, an ongoing challenge that comes up time and time again within multidisciplinary teams is … the dilemma around what to do with the notes. Like the case notes and whether they should be shared within the electronic medical system or with other professionals or not and to what extent. Oftentimes the feedback that I get from

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other medical professionals is that 'I want to be able to see the notes so that I know what you're doing.' … There are a lot of regulations and standards that don't fit as smoothly within a team approach. And confidentiality is generally one of the big ones that I think comes up. There has even been times where colleagues have come to me with questions and we have had to navigate around how we answer the questions. So one of the things that we've done at our clinic has been we've just built it into the informed consent that this is a collaborative team and we will share unless the patient specifies otherwise. … I anticipated that the patients might have a lot more objections than they do. So typically they're like 'Yeah, that's why I'm here. That is why I am coming to this specific clinic. I want you to talk to each other.'"

- Participant 4: "Different professions approach things very differently. … In a primary medical care clinic, a physician sees family members all the time, it is just very standard practice. And in terms of psychology treatment, we might be a lot more hesitant to see multiple members of the same family for treatment. So again, some challenges like that come up and oftentimes if I know this person is family members with that other person, I won't necessarily see them … but sometimes I don't know that ahead of time and I don't do my bookings. So then you get into some interesting, almost like working within a small community situation, where when you're working within a family medicine practice you are almost working in a small community. And because most of your referrals are coming from the physicians that you are working with, then your practice becomes smaller to the group of patients at that clinic. And sometimes there are some interesting ethical scenarios that come up. Like I said, the example being you end up seeing family members without realizing they are family members until halfway through

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treatment. And then you don't really have a way out either because now you are halfway through the treatment. So really, balancing some of those things can be an interesting part of working in a family medicine clinic or primary care setting."

Benefits to Accessing Psychology Services Earlier in Treatment

Table 5

Themes and Subthemes of Benefits to Earlier Access to Psychology Services in Primary Care

Themes	Subthemes
Early intervention	Prevention
	Appropriate diagnosis and treatment
	Improved overall health

Early Intervention

Overall, reported benefits to early psychological services in primary care included prevention, improvements in appropriate diagnosis and treatment, and improved health. Participants highlighted how early recognition and treatment of symptoms resulted in fewer resources and less need for ongoing treatment, reduced reliance on long-term medication use, fewer patients requiring hospitalization, and improved patient experiences in the health care system.

- Participant 6: "I think some people's pain experience is pretty, I'm using kind of colloquial terms here, but some people's pain is really straightforward, right? They have the pain, it's, you know, CRPS [chronic regional pain syndrome], they do mirror therapy and their brain rewires, and they realize they can move this and that's okay. Some people's pain is much more complex where their family dynamics are feeding into … there are secondary gains, there is a lot of history of pain, you know? So then obviously

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the sooner they can meet with someone who can talk with them about that stuff, the better off they are going to be. … For me it's really difficult to say that every patient that has pain should immediately see a psychologist. Well, maybe for like a 20-minute appointment to just screen it, I guess? But not everybody would need treatment. … I'm a big advocate generally of what we would think of as behavioural medicine, where there is a psychologist in the primary care physician's office who can just see people for 20 minutes to screen any concerns and then follow up if needed. Like I really support that concept."

- Participant 4: "Because we do have [consultations] and we see all patients, there has been a lot of times where we've been able to identify just subclinical anxiety or subclinical depressive symptoms, where we've been able to intervene without any ongoing treatment even, where I have been able to suggest mindfulness or mindfulness resources that patients can access or just quick kind of strategies that can be done in one session. And we've actually had feedback from patients where they've gone and learned all about mindfulness on their own by using apps that I might have recommended and then they've emailed us back 6 months later saying, 'Oh my gosh, my sleep is so much better' or 'Oh my gosh, my stress levels are so much better.' Where had that maybe continued on the path it was on without any intervention, that might have resulted in something bigger. So I think those consultations, and again that preventative kind of focus, has been potentially really beneficial for a lot of our patients. … And those are very like low-resource heavy for us because I mean I give somebody a recommendation for a book or an app they could use entirely on their own. And they are seeing some benefits from it so that's great."

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- Participant 2: "It would be good to see more psychologists in preventative, primary health care as well, whether it's helping with weight loss or helping with smoking cessation. … Making those healthy lifestyle changes before you get to the point of being in the hospital, being on dialysis."
- Participant 4: "Patients that I've seen that have been taking medication for depression for, I don't know, 20 years. … Medication had been the first line of treatment, which is appropriate in some cases and others may not have been. That may have been also mitigated if it was mild or moderate depression that would responded with therapy alone even or a combination. So sometimes I certainly see patients that have become quite dependent on medication that may not have needed to become dependent on the medication."
- Participant 8: "It would be good if they could see a psychologist earlier, just in the sense that, you know, we know for eating disorders, the sooner that they get treatment, the better the outcomes are. Typically, by the time they get to us, their symptoms are pretty significant. So I guess just that if they could see someone sooner, in an outpatient way, they wouldn't need to come to us. But I don't know, I'm assuming they'd be seen by psychologists working in a hospital covered under public health care. But anyone working independently, that's all private, so people can't just always go and see someone privately because it's pretty expensive. So one thing that happens for us is that people come to us and maybe they could have benefited from seeing someone a year or 2 years ago, whatever, 5 years ago. But they, you know, couldn't afford it or didn't know how to. And you know, by the time they get to us, it's been pretty significant."

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- Participant 4: "I had a patient that had disclosed to the family physician about … not a family physician I was working with but in a different setting, but they had disclosed to the family physician about their thoughts about harming somebody. And without a lot of further assessment, the family physician had actually gone ahead and hospitalized the patient and was also traumatized by the whole experience. And it took them [the patient] many, many, many years before they started bringing it up again and talking about it. It actually turned out they weren't having thoughts with intention of harming anybody; they were having homicidal obsessions and intrusions. And so that experience really affected that patient's perception of the medical system. They had been really hesitant to bring it up, so they suffered from a fairly severe level of obsessive-compulsive disorder for I think 7 years before they ever considered getting help for it again. And when this patient came to our clinic and we actually diagnosed them appropriately and then provided treatment, they improved significantly with a combination of medication and therapy. But the comment and feedback that this patient made really stood out to me. They said, 'I just wish that my first experience hadn't ended in me hospitalized and just my worst fear being confirmed, that I was going to hurt people.' And my thought was, had that clinic maybe had a psychologist or mental health professional that was well versed in obsessive compulsive disorder, this patient may not have suffered unnecessarily for 7 years. And so that story really sticks out to me, because that feedback the patient gave us was that they reestablished their trust in the medical system after they experienced kind of comprehensive care that was working together, physicians and psychologists working alongside together, providing the best treatment that that patient needed."

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Chapter V: Discussion

Advocacy efforts for the inclusion of psychologists in Canadian primary care settings has been under way for many years. In 2012, the Mental Health Commission of Canada published its National Mental Health strategy entitled *Changing Directions, Changing Lives: The Mental Health Strategy for Canada*, which highlighted the benefits of expanding the role of primary health care in meeting Canadian's mental health needs. In 2017, the Canadian Psychological Association and College of Family Physicians of Canada wrote to the federal minister of health requesting integration of mental health services providers (e.g., psychologists) into primary health care teams (Canadian Psychological Association, 2017). Following additional advocacy efforts, most Canadian provinces have developed interdisciplinary care models to better address the mental health needs of Canadians (Canadian Psychological Association, 2017). Although the case for integrating psychologists into primary care has been made, there is a lack of literature and research on this particular topic in Canada.

The purpose of this exploratory study was to examine and explore the roles and experiences of doctoral-level psychologists working within interprofessional health care settings across Canada, as well as to examine the progress and challenges faced by health psychologists employed in the Canadian health care system. In addition, I explored the educational background and clinical training of a sample of psychologists working in a variety of Canadian health care settings. The findings of the current study shed some light on psychologists' perspectives and opinions about the current state of psychology in primary care and future development. Moreover, the findings appear to be consistent with the preexisting literature and support the benefits of integrating psychologists into the primary health care system.

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A Case for Psychologists in Primary Health Care

Across systems and health care settings, all participants described involvement in clinical assessment or treatment related to both mental and physical health issues. Similar to the literature that summarizes the functions of psychologists across primary care settings (Fischetti & McCutchan, 2002), the participants' roles and responsibilities varied somewhat in terms of their involvement in (a) psychological assessment and treatment, (b) various administrative duties, (c) team collaboration and consultation, and (d) academic involvement (e.g., patient centered research). Additional functional roles not identified in the current study can include developing quality improvement initiatives, training primary care physicians and residents, and improving sensitivity to cultural diversity (Nash et al., 2012).

A report by the Canadian Psychological Association (as cited in Peachey et al., 2013) stated that "the inclusion of psychologists' services in the funding envelope should be seen as a logical progression of the overall transition to more effective and efficient primary care in Canada" (p. 8). Though most participants in this study were employed in secondary health care settings (e.g., hospitals, rehabilitation and employment centre), the findings can be generalized to psychologists' roles and contributions across primary care settings. In the current study, improvements in diagnostic accuracy and comprehensive treatment were highlighted as the two overarching themes of psychologists' contributions across health settings. Through psychological intervention within health care settings, participants reported benefits to include (a) identification of subclinical symptoms, (b) overall prevention of worsening health symptoms, (c) reduced reliance on long-term psychopharmacological treatment, (d) increased use of low-resource treatment approaches (e.g., mindfulness), (e) appropriate diagnosis and treatment of mental health symptomology, and (f) improved overall health outcomes.

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These reported benefits are also supported by the current literature. For instance, Cordeiro et al. (2015) found that integrating psychology into primary care can contribute the following benefits: less burden on primary care physicians, reduced economic impact of mental illness, less frequent emergency department visits, decreased number of referrals made to outpatient clinics, and shorter wait times for mental health services compared to traditional settings. Furthermore, the integration of psychological services in Ontario family medicine practices have shown improved patient-reported quality of life and high satisfaction ratings from patients and physicians, as well as reductions in doctors' mental health billing (Chomienne et al., 2010).

Areas in Need of Ongoing Development

Training Experiences

Given the benefits of clinical health psychologists' involvement in health care, which have also been reported here, researchers have suggested that all professional psychologists receive adequate training as "health psychologists" to be competent to function in a health care environment (Larkin et al., 2014). However, training programs and credentialing systems are still tied to the traditional view of psychologists as mental health professionals as opposed to behavioural health specialists who can offer a unique and varied skill set to health care settings. Only a few graduate programs, clinical practica, internships, and fellowships are specifically designed to provide training on the unique knowledge and skill set for work in primary care (Mullin & Funderburk 2013). Of the three participants who completed their doctoral degrees in the United States and five who completed them in Canada, no one completed graduate-level training in the subfield of health psychology. This is not surprising considering Canadian doctoral training programs do not offer clinical-focused specializations or tracks in health

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psychology or primary care. The University of British Columbia has a PhD-level graduate program in health psychology; however, it is research-focused and does not provide any clinical or practical training. York University offers a Health Psychology Diploma program, where doctoral-level psychology students conduct research, complete coursework, and attend a weekly colloquium in health psychology methods, topics, and research.

Despite a lack of formal training in health psychology, all participants reported general graduate-level courses, practicum and predoctoral internship training experiences, and supervision and job training as sufficient for doing this type of work. Broad theoretical coursework in intervention, psychodiagnostics, and assessment were considered to be an adequate foundation for clinical work, and practicum and internship training, along with on-the-job training (including supervision), provided additional exposure to working with health care issues, in health care settings, and within treatment teams. Only one participant reported that they were currently working on completing a health psychology extension. Notably, this psychologist shared that they had made this decision for themselves out of interest and because they thought it would be helpful for their work, not because their workplace required it. Goodie et al. (2018) highlighted how psychologists working in health care settings, particularly primary care, must be aware of their boundaries of competence, especially given that recognized standards for preparatory training do not exist. Van Allen et al. (2015) highlighted how for the field of psychology to move forward, it is essential to determine consistency of experiences and agreement on the basic skills and foundational knowledge necessary to be a competent health service psychologist.

Although there is evidence to highlight how psychologists with broad professional training are well suited to work in health care, there is still a case to be made that psychologists

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working in health care settings should receive additional training in order to provide the most efficient and effective team-based care. One study highlighted that organizations had difficulty finding clinicians with the necessary skills and experience for working in integrated practice and ultimately that clinicians lacked relevant training for effective work within integrated care teams (Hall et al., 2015). It is likely that even psychologists with professional experience in health care settings may lack awareness of their training blind spots. For example, psychologists may be able to successfully integrate psychological services into a health care setting but experience unnecessary hurdles due to a lack of training or support on how to do this more effectively. A few online certificate courses have been developed in the United States, such as the University of Massachusetts's Primary Care Behavioral Health Certificate or the University of Michigan's Certificate in Integrated Behavioral Health and Primary Care. Both provide advanced online training courses for behavioural health clinicians to work in integrated health care settings.

It is important for clinical health psychologists to have an understanding of how individual and sociocultural diversity (e.g., developmental, cultural, socioeconomic, religious, sexual) influences patient beliefs about health care, health practices, access to health care services, and health outcomes (Larkin et al., 2014). To address health and health care disparities, "psychologists must continue to develop strategies and techniques that increase their knowledge and skills to meet the high demand for quality care" (Richmond & Jackson, 2018, p. 305). However, many psychologists employed in primary care settings struggle with how to integrate a sociocultural lens within their roles as behavioural health providers (Richmond & Jackson, 2018). Training programs should focus on preparing psychologists to (a) recognize the effect of various sociocultural factors on health care; (b) modify interventions for behavioural health change in response to sociocultural factors; and (c) implement culturally sensitive measures and

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procedures when conducting research, assessing and evaluating patients, or completing quality improvement projects (McDaniel et al., 2014).

Ethical Challenges

The type of ethical training provided in most clinical psychology programs does not adequately prepare psychologists for various encounters faced in health care settings (Larkin et al., 2014). Ethical and legal challenges including end-of-life decisions, decisions about whether a patient should have surgery, and issues with organ donations are not addressed in most training programs and can have serious legal and ethical implications. And yet even common ethical standards within the field of psychology may have blurred lines within the broader health care system. For example, informed consent, an ethical focus of both training and clinical practice, may be compromised due to pressures to quickly assess and treat patients in primary health care settings (Ashton & Sullivan, 2018). Participants in the current described study reported ethical challenges including having to meet with patients in shared rooms, varying patient confidentiality standard across disciplines (e.g., sharing full clinical notes in the electronic health record), and dual relationships (e.g., seeing multiple members of the same family for therapy). Although solutions to ethical challenges will vary based on the individual psychologist, the specific setting and team, and evolving provincial and organizational (e.g., Canadian Psychological Association) legal and ethical standards, it is important that psychologists continuously consider ethical decision-making tools to enhance clinical care.

Ashton and Sullivan (2018) provided a list of best practices for psychologists employed in academic health centres to address various common ethical issues: some key suggestions focus on best practices for dual relationships (e.g., "discuss and document whether the dual relationship is appropriate," p. 246), issues with confidentiality within an integrated health care

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team (e.g., “guard against voyeurism”, p. 243 “keep details limited, brief, and “pertinent,” p. 243), cultural competence (e.g., “provide multiple teaching methods,” p. 244; “self-assess for biases for populations,” p. 244), information sharing through the electronic health record (e.g., “keep language behavioural and neutral,” p. 242; “write notes as if the patient will read them,” p. 242;) and general competence issues (e.g., “practice within the limits of competence,” p. 247; “stay current in the literature of both medical updates and psychological issues affecting the medical condition,” p. 247). Participation in professional listservs and ongoing education activities are also recommended to increase awareness of common ethical and legal issues and to continue with ongoing learning (Larkin et al., 2014). Although participation in continuing education was not directly examined in this study, none of the participants reported involvement in professional organizations or activities that might address common ethical and legal issues within health care settings.

Limitations

Biased Responses

One possible limitation of the study may be biased responses from the participants. It is quite possible that their responses were influenced by factors related to their current role, training background, work setting, and social desirability. For example, despite efforts made to ensure the confidentiality of the participants, some participants may have been less forthright in their responses due to concerns about potential retribution if identified by colleagues based on their responses. Participants’ views may also be biased by their training background and modality. For instance, schooling and training based in Canada versus the United States may have affected participants’ beliefs and expectations associated with psychological services in primary care. Participants may also have responded with varying levels of bias depending on whether they are

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employed in public versus private health care settings. Finally, social desirability bias may have influenced participant responses by leading participants to overreport positive aspects of their role (e.g., benefits to patient care) or underreport challenges related to their professional work (e.g., challenges effectively integrating into treatment team). Given that the participants had an awareness of the topic being explored in this study, they may also have responded in a way they thought would support the findings and conclusions that the researcher aimed to develop.

Sampling

First, the study's sample size was small ($N = 8$), which limits the generalizability of experiences. The data for this study were collected from English-speaking psychologists across Canada, as I am not proficient enough in French or any other languages. Participants were located in Ontario, Nova Scotia, British Columbia, New Brunswick, and Alberta, excluding five of Canada's provinces and all three territories. In addition, participants included doctoral-level (PhD or PsyD) registered psychologists only and not master's-level psychologists (which are permitted only in Alberta and Saskatchewan). Finally, most participants were employed in secondary health care settings, which may vary from primary health care settings due to differences in health care models and funding.

Purposive sampling was one method used to recruit participants for this study. More specifically, I contacted individuals that were believed to meet the inclusion criteria. This type of sampling is prone to researcher bias as the researcher relies on their judgment and subjectivity when selecting how to identify prospective participants, determining who might meet criteria and ultimately who is contacted. Because I relied heavily on internet search engines to identify prospective participants, it is likely that qualified individuals were missed.

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Consequently, the study's sampling process and outcomes may have influenced the representativeness of the sample, potentially limiting the external validity of the findings. However, I made efforts to include individuals working in different health care settings across provinces to receive variance in responses as much as is possible. Further, throughout the process of participant interviewing, I was concurrently completing preliminary exploratory analysis of the data from completed interviews. Approaching the completion of the final interview, the data were no longer generating new themes or significant information (i.e., data saturation had been reached). As such, the sample of participants was sufficient in providing a typical overview of this topic in Canada and highlighting variations across provinces.

Methodology

Given the qualitative phenomenological nature of this study, limitations included a high reliance on subjective reports and a lack of statistical analysis of the data. I developed a semistructured interview protocol for the purposes of this study, making efforts to select interview questions that informed identified gaps in the current Canadian literature.

All but one of the interviews were conducted by telephone, which may have impacted the amount of self-disclosure or extent of information that was obtained. This might be related to inconsistencies in communicative practices (e.g., rapport, probing, interpretation of responses) or through data loss or distortion (e.g., lack of access to contextual and nonverbal cues when conducted by telephone; Novick, 2008). Fortunately, there has been limited evidence suggesting that interpretation or quality of findings is compromised when qualitative interview data are collected by telephone (in comparison to face-to-face collection; Novick, 2008). Further, to limit variation in probing of responses, I took precaution to ensure that all points of discussion were addressed in each interview with the use of subquestions informed by the literature.

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Implications of Findings

Encouraging Further Integration of Psychologists in Primary Care

This study highlighted the current roles and responsibilities of psychologists in primary and other health care settings in Canada. The complex roles of psychologists in health care settings highlights how psychologists' involvement within health care teams contributes to improved patient care through more comprehensive assessment, appropriate diagnosis and treatment of mental health symptomology, increased prevention-focused treatment, and improved overall health outcomes. Although these findings provide additional support to the literature base on the benefits of integrating psychologists in health care, continuing to educate the medical field, policy makers, health care executives, funding sources, and the public of these benefits is necessary.

Individual psychologists and psychological organizations can continue to increase their visibility within the general health care field is by attending different health profession conferences. Psychologists may utilize this as an opportunity to network with and educate health care providers and organizations on the roles of psychologists and the benefits of their participation within primary health care. On a larger scale, this might also include submitting poster or presentation abstracts to conferences on topics related to how psychology can be used to address common medical presentations or treatment challenges. Psychologists may also utilize networking opportunities at conferences to explore the potential for cross-disciplinary collaborative research. Increasing the recognition of other health care providers of the benefits of psychologists in health care settings is a crucial step towards further integration in primary care.

Psychologists may also attend medical and nursing schools and residency programs to provide training to students on a variety of topics pertaining to the role of psychologists and the

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benefits of interprofessional collaboration. Training topics might include recognizing psychological symptoms and knowing when to refer to a mental health provider, the roles and responsibilities of psychologists and how they differ from other mental health care providers, and the benefits of interprofessional collaboration (e.g., patient treatment outcomes, reduced physician burnout). Reaching health care providers early in their training and educating them on the roles and benefits of psychologists in health care could encourage increased and more effective interprofessional collaboration in the future. A similar approach may also be effective for educating policy makers, funding sources, and health care executives of the benefits of increasing access to psychological services within primary health care for all Canadians.

Addressing Barriers

Although the participants in this study did not report significant concerns or a perceived impact related to a lack of graduate-level or professional training in the field of health psychology, several related implications are worth emphasizing. Various challenges related to scope of role (e.g., differentiating role as psychologist from other mental health care providers), ethical issues (e.g., managing varying ethical standards across disciplines), and a lack of knowledge related to working with common medical presentations and treatments (e.g., pharmaceuticals, end-of-life decision-making) highlight educational and professional training needs. This information is important for supporting paradigm shifts in clinical training program focus and postdoctoral continuing education given that most Canadian training programs and credentialing systems have their foundation in the traditional view of psychologists as individual practitioners (e.g., in private practice). It is imperative for the field of psychology to evolve with the rapidly changing health care system in order to treat individuals who are unable or unwilling to access mental health services outside of primary care (Cubic et al., 2012). For example,

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mental health stigma was highlighted by participants as a barrier to effective patient care. Further integration of psychologists in primary care settings could help to reduce the impact of mental health stigma and encourage patients' willingness to engage in mental health treatment through increased familiarity with psychological services as a standard part of health care treatment. A major part of providing improved and more accessible primary care mental health services begins with examining and adapting educational and training models within the field of psychology.

As gradual shifts are being made towards further integration of psychologists into primary care within the Canadian health care system, I hope that graduating students will increasingly find themselves in positions within those settings. Though this shift in health care delivery remains in the early stages of development, it is important that psychologists be effectively trained for successful integration into primary health care teams. Impressive efforts have been made towards outlining competencies and curricula for educational and training programs in primary care psychology (American Psychological Association, 2013; Cubic et al. 2012; Dobmeyer et al., 2003; Talen et al., 2005); therefore, these were not be explored in significant detail here. However, based on the aforementioned barriers to patient care highlighted in this study, specific training and curriculum gaps were identified. Doctoral-level educational programs should familiarize students with common ethical challenges faced in health care settings and provide the skills necessary to navigate ethical decision-making. Exploring case examples of common and complex ethical challenges within health care settings would help students to consider the influences of decision-making on individual professional approach, interprofessional collaboration, patient care, and even policy development. Additionally, course curricula should focus on how psychologists can successfully integrate themselves into primary

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care settings where they did not previously hold a role. This might include educating psychologists on how they can differentiate themselves from other mental health care providers and building competencies to effectively utilize their psychological skills and expertise through various roles (e.g., clinician, consultant, and program developer).

In addition to enhanced focus on primary care psychology at the graduate level, increased access to practicum and internship training within Canadian medical settings and interprofessional health care teams is needed. Early practical experience and close supervision can increase a practitioner's effectiveness at providing brief psychological interventions (e.g., 15- to 30-minute sessions), contributing to interprofessional collaboration, navigating health care systems, and developing general and health-related psychological knowledge (Cubic et al., 2012). Students would also benefit from practicum, internship, and postdoctoral training experiences in Canadian health care settings where they can learn from and collaborate with peers (e.g., medical students) and heath care professionals (e.g., licensed physicians). In addition to standard psychological training (e.g., psychological assessment, individual therapy), training activities should include clinic huddles, shadowing of other health care providers, participation in pull-ins and warm hand-offs, collaborative and integrated treatment planning with other health care professionals, and so on.

Suggestions for Future Research

The results from this study provide a strong foundational understanding of the experiences and training of psychologists employed across Canadian health care settings. However, further research in various areas would be beneficial. Further exploration with a larger sample and a more diverse group of psychologists (e.g., in terms of health care settings, province of employment) would provide a more generalizable understanding of this topic. Although the

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experiences and training of psychologists working in primary care settings versus other health care settings are not understood to vary significantly, further attempts to examine the perspectives of both psychologists and other stakeholders (e.g., patients, various health care professionals) would be beneficial. For example, previous research has examined the experiences of physicians and patients in family health teams where psychologists were integrated into the practice (Chomienne et al., 2010). Additionally, Drewlo (2014) examined factors in optimal collaboration between psychologists and physicians in primary care. Further research that both demonstrates the value of psychologists across primary care settings and addresses psychologists' effectiveness within those settings may support efforts for future training and health care integration planning.

Current graduate psychology training programs fail to prepare the next generation of psychologists for providing services across health care settings, especially in more fast-paced primary care environments (McDaniel et al., 2014). Following the 2012 American Psychological Association's presidential initiative, the Interorganizational Work Group on Competencies for Primary Care Psychology focused on outlining competencies for psychology practice in primary care in six broad domains: science, systems, professionalism, relationships, application, and education (McDaniel et al., 2014). Because this document was meant to serve as a guide for training programs' curriculum development and psychologists' self-monitoring, future research should utilize these outlined competencies to explore how current Canadian training programs and psychologists employed in health care settings compare. Additionally, and supported by the fact that participants attributed the majority of their relevant training to their practicum experiences, future research should focus on curriculum development for practicum- and

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internship-level training with an emphasis on integrated behavioural health in the context of the Canadian health care structure.

Conclusion

With this study, I aimed to add novel information to the Canadian literature base with respect to the experiences and roles of psychologists employed in health care settings. The results of this study support and call for further integration of psychologists into Canadian primary health care settings. This lofty goal can be achieved by funding more doctoral and postdoctoral training opportunities in primary care settings and developing specific standards of employment and guidelines for practising psychology in health care settings. Finally, it is important to highlight that as doctoral programs in psychology strengthen training in health psychology and increase cross-functional collaboration, the field will continue to cultivate a new mindset about the roles and responsibilities of psychologists in primary care settings.

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Appendix A: Participant Recruitment Email

Subject: Research Participants Needed – Doctoral-Level Health Psychologists in Health Care Settings

Dear [Name of Psychologist],

My name is Marla Korecky and I am a student in Doctor of Clinical Psychology (Psy.D) Program at Adler University. I am contacting you with regards to my dissertation research study which is a part of my doctoral degree requirements.

The purpose of this exploratory study is to examine and explore the roles and experiences of doctoral-level psychologists working within interprofessional health care settings across Canada. This research is intended to help provide valuable information to the Canadian literature base on the training and career trajectory, professional role(s), and the experiences (both positive and negative) of health psychologists within an interdisciplinary or interprofessional health care team.

Eligible participants:

- Have a doctoral degree in psychology
- Be employed as a health psychologist (or equivalent) in Canada
- Currently be working as part of an interdisciplinary or interprofessional team in a health care setting (private or public sector)
- Have worked in that position for a minimum of three months (or another position that meets the above criteria for that time)

Ineligible participants include:

- Master's level registered psychologists
    - This exclusion criterion was chosen due to the variations in training across master's and doctoral degrees (e.g., length of training), which may confound the results.
- Doctoral-level psychologists not currently in good standing with their respective province's regulatory body (i.e., College of Psychologists)

Participation

I would greatly appreciate your help with collecting this information. I am looking for participants who would be willing to participate in a semi-structured interview that could be held in person (if you are located in the Greater Vancouver Area), or via telephone. This interview would take approximately 60 to 90 minutes. Interviews will be held in English. You will receive a $15 Starbucks gift card for taking part in this study.

Those who participate will be asked to complete a brief five to ten-minute phone-call prior to scheduling the interview. This phone call will consist of confirming eligibility criteria (as outlined above) to confirm suitability to participate in this study. If the criteria are met and choose to proceed with the interview, you will be sent the informed consent form by email for your review. A future date and time for the official interview would be scheduled at this point.

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<u>If the screening criteria is met and you choose to proceed with the official interview, these are a few of the main questions you can expect to be asked:</u>

1. How have your training (academic and/or professional) experiences informed your work in a health care setting, within an interdisciplinary or interprofessional team?

2. How would you define your role as a 'health psychologist' within the interdisciplinary or interprofessional health care treatment team?

3. Based on your experience, how has your participation as a health psychologist within the interdisciplinary or interprofessional health care team improved the facilitation of treatment to improve patient care?

4. Specifically related to your work within an interdisciplinary or interprofessional health care treatment team, what barriers have you experienced within your role that might have impacted the provision of patient care?

5. Informed by the work that you have done with clients in your setting, do you see any benefits/value to your clients having been able to see a psychologist earlier on when they first sought primary care services?

Confidentiality
All participant responses will be strictly confidential, will be made anonymous, and will only be used for the purposes of this research study.

I would like to thank you in advance for taking the time to read this email. If you are aware of any others who may be interested in participating in this study, please feel free to forward this information to them.

If you would like to further discuss the possibility of participating in this research or have any questions, please feel free to contact Marla Korecky at mkorecky@my.adler.edu or. If you have any questions, please contact the Dissertation Chair, Dr. Johnson Ma (jma@adler.edu).

All the best,

Marla Korecky
Doctoral Student in Clinical Psychology
Adler University- Vancouver Campus

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Appendix B: Listerv Recruitment Post

Subject: Research Participants Needed – Doctoral-Level Health Psychologists in Health Care Settings

Hello,

My name is Marla Korecky and I am a student in Doctor of Clinical Psychology (Psy.D) Program at Adler University. I am contacting you with regards to my dissertation research study which is a part of my doctoral degree requirements

The purpose of this exploratory study is to examine and explore the roles and experiences of doctoral-level psychologists working within interprofessional health care settings across Canada. This research is intended to help provide valuable information to the Canadian literature base on the training and career trajectory, professional role(s), and the experiences (both positive and negative) of health psychologists within an interdisciplinary or interprofessional health care team.

Eligible participants:

- Have a doctoral degree in psychology
- Are employed as a health psychologist (or equivalent) in Canada
- Are currently working as part of an interdisciplinary or interprofessional team in a health care setting (private or public setting)
- Have worked in that position for a minimum of three months (or another position that meets the above criteria for that time)

Ineligible participants include:

- Master's level registered psychologists
    - This exclusion criterion was chosen due to the variations in training across master's and doctoral degrees (e.g., length of training), which may confound the results.
- Doctoral-level psychologists not currently in good standing with their respective province's regulatory body (i.e., College of Psychologists)

Participation

I would greatly appreciate your help with collecting this information. I am looking for participants who would be willing to participate in a semi-structured interview that could be held in person (if you are located in the General Vancouver Area) over via telephone. This interview would take approximately 60 to 90 minutes. Interviews will be held in English. You will receive a $15 Starbucks gift card for taking part in this study.

Those who participate will be asked to complete a brief five to ten-minute phone-call prior to scheduling the interview. This phone call will consist of confirming eligibility criteria (as outlined above) to confirm suitability to participate in this study. If the criteria are met and the individual chooses to proceed with the interview, they will be sent the informed consent form by

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email for review. A future date and time for the official interview would be scheduled at this point.

If the screening criteria is met and you choose to proceed with the official interview, these are a few of the main questions you can expect to be asked:

1. How have your training (academic and/or professional) experiences informed your work in a health care setting, within an interdisciplinary or interprofessional team?

2. How would you define your role as a 'health psychologist' within the interdisciplinary or interprofessional health care treatment team?

3. Based on your experience, how has your participation as a health psychologist within the interdisciplinary or interprofessional health care team improved the facilitation of treatment to improve patient care?

4. Specifically related to your work within an interdisciplinary or interprofessional health care treatment team, what barriers have you experienced within your role that might have impacted the provision of patient care?

5. Informed by the work that you have done with clients in your setting, do you see any benefits/value to your clients having been able to see a psychologist earlier on when they first sought primary care services?

I would like to thank you in advance for taking the time to read this post. If you are interested in participating or know anyone else who also may be interested and meets the above criteria described above, please feel free to forward this information to them.

If you would like to further discuss the possibility of participating in this research or have any questions, please feel free to contact Marla Korecky at mkorecky@my.adler.edu or. If you have any questions, please contact the Dissertation Chair, Dr. Johnson Ma (jma@adler.edu).

All the best,

Marla Korecky
Doctoral Student in Clinical Psychology
Adler University- Vancouver Campus

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Appendix C: Screening Questionnaire

"Hello, Dr. (insert potential participant's first and last name),

My name is Marla Korecky and I am a student from Adler University in the Doctor of Psychology in Clinical Psychology Program. I am calling you with regards to my dissertation research study which is a part of my doctoral degree requirements. I would like to thank you in advance for your expressed interest in participating in my research study.

As outlined in the email I had sent you, the purpose of this exploratory study is to examine and explore the roles and experiences of doctoral-level psychologists working within interprofessional health care settings across Canada. In addition, this study aims to identify educational background and clinical training that are needed for doctoral-level psychologists to work in health care settings. As part of this process, I would like to ask you some initial questions in order to ensure that you meet the inclusion and exclusion criteria for this study. Regardless of whether or not you participate in this study, all of your responses will be kept confidential and at no point would this information be used in a way that might reveal your identification to others.

Do you have any questions or concerns before I begin with these questions?"

"Great. I will start first with questions more specifically related to your academic training and professional experience?"

1. Do you have a doctoral degree in psychology?

2. If yes,

    a. What is the title of your doctoral degree?

3. Are you currently registered as a doctoral-level psychologist in Canada?

4. If yes,

    a. In which Canadian province are you currently registered and practicing?

    b. How long have you been registered within this province?

5. Have you ever been registered to practice psychology in another Canadian province (or territory) or in another Country?

6. If yes,

    a. Where else have you been registered/licensed to practice psychology?

    b. How long did you practice in that (those) location(s)?

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7. Are you currently in good standing with the College of Psychologists within the province in which you are registered?

8. Are you currently employed within a health care setting?

9. If yes,

    a. What is your current job title?

    b. What is the name of your current employment location?

    c. Is this a public or private institution?

    d. Are your services within this clinic offered to patients as part of the publicly funded health system?

10. Are you currently working as part of an interdisciplinary or interprofessional treatment team?

11. If yes,

    a. Excluding other psychologists, how many other individuals from different health care professions do you work?

    b. Generally speaking, how often do you collaborate with those individuals within any given week?

    c. How long have you been employed in your current position?

    d. Is this your first time employed in a health care setting as part of an interdisciplinary or interprofessional team?

12. If no,

    a. Where were you employed previously?

    b. How long did you work there?

Participant meets inclusion and exclusion criteria:
"Thank you so much for taking the time to answer all of these questions. Based on the information you provided, you meet the inclusion and exclusion criteria required to participate in this research project. If you are still willing to move forward with your participation in this research study, the next step will be to schedule an in-person interview *(if close in proximity to the General Vancouver Area)* or a telephone meeting *(if outside of the General Vancouver Area).* The entirety of the interview process should take approximately 60 to 90 minutes. I will send you

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a copy of the informed consent form by email today for your review prior to the interview. If you have any questions or concerns about moving forward, you can contact me by the telephone number and/or email provided on this informed consent form. You and I will also go over the informed consent form together prior to beginning the interview.

Would you be willing to provide me with an email address where I can send you a copy of the informed consent form?

Do you have any questions or concerns about moving forward? If not, what does your availability look like in the near future for scheduling an interview date and time?

Participant does not meet the inclusion and exclusion criteria:
"Thank you so much for taking time to answer all of these questions. Based on the information you provided, unfortunately you do not meet the inclusion and exclusion criteria required to be a participant in this research study. Again, I very much appreciate you taking the time to answer these questions. Enjoy the rest of your week."

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Appendix D: Interview Questions

Background Questions:

"I am now going to begin by asking a few questions focused on your personal background. If you prefer not to answer any of the questions asked, you are free to refuse to do so. Doing so will not impact your ability to participate in the study."

1. In what age range do you fall?
   - 25 to 34 years
   - 35 to 44 years
   - 45 to 54 years
   - 55 to 64 years
   - Age 65+

2. What gender(s) do you identify as?

3. What is your ethnicity/cultural background?

4. What is the name of the graduate school/doctoral program you attended?

5. Since graduating with your doctoral degree, how many years have you been actively practicing as a psychologist?

Research Questions:

1. **What is your training background?**

   a. Did you take any courses during your doctoral training or professionally, that helped you to gain competencies for this work?

   b. Did you receive any other useful training experiences that were not provided via your psychological doctoral training?

   c. In your opinion, over the course of your education, training and professional work, which training experiences were most helpful to you to feeling competent in your role as a health psychologist?

2. **How would you define your role and responsibilities as a 'health psychologist' within the interdisciplinary or interprofessional health care treatment team?**

   a. How would you describe your day-to-day duties? Can you provide any examples?

   b. How do you allocate your time and energy to fulfill your many responsibilities (e.g., within the treatment team, in providing patient care)?

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3. **As a psychologist working within an interdisciplinary or interprofessional health care system, how does your role contribute to overall patient care in terms of planning, delivery, and outcome measurement?**

    a. Could you provide any example of how your role may have contributed to improved health care for patients?

    b. What about any benefits related to your role as a diagnostician? Can you provide examples?

    c. Has your role involved consultation work with the interdisciplinary or interprofessional team that might have resulted in improved patient care? Can you provide examples?

    d. As part of your role, have you been able to offer education to patients and/or the treatment team on psychological and behavioural matter, that might have facilitated better patient care? Can you provide any examples?

    e. Does anything else come to mind in terms of benefits of your role in this setting, as it impacts patient care?

4. **Specifically related to your work within an interdisciplinary or interprofessional health care treatment team, what barriers have you experienced within your role that might have impacted the provision of patient care?**

    a. What has been the most challenging part about your role as a health psychologist?

    b. Have you noticed any limitation to fulfilling your role within this setting as a result of funding and/or accessibility reasons? Do you have any examples?

    c. Are you aware of any barriers related to your training experiences (or maybe lack thereof) as it applies to fulfilling your role within a health care setting and/or an interdisciplinary or interprofessional team? Do you have any examples?

    d. What about barriers as a result of lack of clarity and scope of your role? Do you have any examples?

    e. Have you noticed any barriers to your role as a result of stigma? This might be within the health care system itself, by health care providers, and/or by patients. Do you have any examples?

5. (THIS QUESTION IS SPECIFIC TO PSYCHOLOGISTS NOT WORKING IN PRIMARY CARE SETTNGS) **Informed by the work that you have done with clients in your setting, do you see any benefits/value to your clients having been able to see a psychologist earlier on when they first sought primary care services?**

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a. If yes, what benefits?

b. If no, why?

Wrap up question: Finally, do you have any further comments or information that you believe might be related and/or may be helpful to the scope of this research topic?

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Appendix E: Participant Informed Consent Form

<u>Title of the Study</u>: Examining the Current Status of Health Psychology in Canada: A Qualitative Study of Doctoral-Level Psychologists Role in Interprofessional Health Care

<u>The Researchers</u>

My name is Marla Korecky I am doing this research as part of my Doctor of Psychology Degree in the Clinical Psychology (Psy.D.) Program at Adler University (Vancouver Campus).

If you have any questions about the research, you can contact me or my Advisor. Our contact information is below:

Principal Investigator:	Name: Marla Korecky Phone: [telephone number]	E-mail: mkorecky@adler.edu
Research Advisor:	Name: Dr. Johnson Ma Phone: [telephone number]	Program: Psy.D. E-mail: jma@adler.edu

The Adler University (Vancouver Campus) Research Ethics Board (REB) and has approved this research.

<u>This Research</u>

Purpose of the study
The purpose of this exploratory study is to examine and explore the roles and experiences of doctoral-level psychologists working within interprofessional health care settings across Canada. This research is intended to help provide valuable information to the Canadian literature base on the training and career trajectory, professional role(s), and the experiences (both positive and negative) of health psychologists within an interdisciplinary or interprofessional health care team.

We are asking you to take part because you**:**

- Have a doctoral degree in psychology
- Are employed as a health psychologist (or equivalent) in Canada
- Are currently be working as part of an interdisciplinary or interprofessional team in a health care setting (private or public sectors)
- Have worked in that position for a minimum of three months (or another position that meets the above criteria for that time)

Procedure
As part of the process, you have completed a screening questionnaire by telephone to confirm your eligibility to participate in this study. As a participant, an interview with the Principal Investigator will take place either in person or by telephone. As part of the interview, we will also ask you some questions about yourself – for example, we would like you to tell us your age, gender, and ethnic background. This information will only be used to describe the group of

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people who take the survey and participant anonymity will be maintained. Participant interviews will be audio-recorded to allow for more accurate transcription.

These interviews will be anonymous and will be held in a private location. We are asking for between **60 to 90 minutes** of your time. We will meet somewhere private and quiet that works for both of us.

You will receive a $15 Starbucks gift card for taking part in this study.

The Research is Voluntary

Your participation is voluntary and you are able to revoke your participation at any point, for any reason. You can decide if you want to answer any question.

The Research is Confidential

You will be given an ID number at the beginning of the interview. All data files from this study will contain only this ID number. Your personal contact information (i.e., name or contact information) will not be part of study data files. ID numbers and names will not be linked together in any stored data file. Only the Principal Investigator and her Advisor will know which number goes with which name. No one else will know your name or what your answers are to the different questions. Background information will only be used for analysis, not identification purposes.

Please be aware that the interview will be audio-recorded. These audio-recordings will be stored on a password protected, encrypted drive at all times. The principal investigator will transcribe the interviews. During the transcription process, the research student will replace any identifying information with generic labels, such as, but not limited to: [Name], [Colleague], [Program], or [Place]. Any paper copies of the completed transcripts will be stored in a locked filing cabinet, located at the principal investigator's residence. These transcripts will be given a numeric code to identify them. This numeric code will be used to refer to participants' quotes in the study.

Signed informed consent forms will be kept in a locked filing cabinet, and all data will be stored on a password-protected file that only the researcher will have access to. All collected information will be maintained in a secure location (i.e., locked cabinet) for five years, after which it will be deleted and destroyed. The data obtained from this interview will only be used for the graduate dissertation project.

Limits to what is Confidential

If the participant themselves reveal that they are at imminent risk of harm OR reveals information to suggest there is a vulnerable child or adult at risk of harm. If the Principal Investigator understood that the participant was unable to seek appropriate support or if a vulnerable person is in need of protection, she may report this to the proper authorities.
If the participant's records were subpoenaed by the court of law, the research team would need to comply with this legal order.

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The Results of the Research

The Principal Investigator will publish the results of the research in her dissertation. The Principal Investigator may also write or speak about the research. Your name or any other information that might identify you will NOT be included in any writing or presentation.

If you are interested in learning more about the results of this study, please provide your e-mail as indicated at the bottom of this form. The Principal Investigator, Marla Korecky, will send you a written report via e-mail once the study is complete and the results have been fully analyzed. All results will be presented as a descriptive summary, with no information on any one participant.

The Risks and Benefits

The risks to participation include:
This study involves no more than minimal risks to participants (i.e., the level of risk encountered in daily life). There is no deception involved in this study. If for any reason you begin to feel uncomfortable as a result of any of the questions being asked, you may skip that question.

The benefits to participation include:

- By engaging in self-reflection through the interview process, participants may develop new insights regarding the experience(s) that they choose to share. For example, participants may experience validation and/or positive emotions about their work experiences.
- Participants having the opportunity to contribute to research in an area that is personal to them and may aid other professionals in the health care field

If you have any concerns about your treatment as a participant**,** you may contact the Chair of the Research Ethics Board. Her contact information is below:

REB Chair: Debbie Clelland PhD [telephone Number]
E-mail: dclelland@adler.edu

Consent for this Research:

- I have read the explanation of this study. I have been given an opportunity to discuss this study and my questions have been answered to my satisfaction.
- I know that the researcher(s) will not use my name and will remove any information that will identify me.
- However, I realize that my participation is voluntary and I am free to quit this study at any time. I can refuse to answer any question.
- I understand that signing this consent form does not waive my legal rights in any way.
- I know that I have will opportunities to remove my responses from the study until two weeks after completion of the interview.

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- By consenting to participate, I am agreeing to share my data with the Principal Investigator and the research advisor, provided that the data is protected as described in the consent form.
- I consent to allow my interview to be audio-recorded. I know that what I say may be used as de-identified direct quotes in a publication or presentation.
- I consent to the possibility of being re-contacted after completion of the interview, only in the case that the Principal Investigator felt there was a need to follow-up on a response and/or ask for clarification.

____ _______________________

Participant Signature Date

____

Participant Name (Print)

____ _______________________

Researcher Signature Date

____

Researcher Name (Print)

I would like to receive a summary of the results of this research.

______ Yes ______________________________________ e-mail address

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