

# Psychology in Primary Health Care: Theory, Practice and Innovation – Introduction to the Special Issue

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Definitions of *primary care* vary, although common themes include the first point of contact that an individual has with the health service, continuity of care over a period of time, comprehensiveness of care across health domains, and a gate-keeping function. The slightly less technically minded definitions also note the importance placed on the development on sustainable relationships between the patient and their primary health care team, and the fact that healthcare is being delivered within a family and community context (Bray, Frank, McDaniel, & Heldring, 2004). These latter descriptors evoke the traditional view of the old General Practitioner (GP) who is considered a family friend, like an old uncle; and the District Nurse who visited the house when grandma needed her dressings changed every day. However, the primary care landscape is changing.

Schulte, Isley, Link, Shealy and Winfrey (2004) draw attention to the traditional but unhelpful separation of mental and physical health, with the activities of psychologists being largely focussed on the former domain. However, they also comment on a paradigm shift which has slowly been occurring in health care in America. For example, they observe an attitudinal shift that is apparent in the Health Care Safety Net Amendments of 2002 which along with other enhancements; (a) expanded the definition of mental health providers and services to include the word 'behaviour', and (b) defined psychologists as primary

care providers along with physicians, nurses and dentists. These changes in definitions seem important considering recent statements from the American Psychological Association (APA) regarding healthcare reform (APA, 2009) which start by observing that *modifiable behaviours* such as smoking, improper diet and lack of physical exercise are the leading causes of many chronic health problems. They contend that psychology, being the science of behaviour, has much to offer. The APA outlines eight priority areas for healthcare reform, including the more complete integration of behavioural and mental health into primary care services, ensuring access to quality mental and behavioural services, and ensuring the development of a diverse psychology workforce. Of course, America has a much larger health care sector than New Zealand and the APA has over 150,000 members. What does the primary care landscape look like currently in Aotearoa New Zealand?

In a discussion document released by the Ministry of Health in 2004 the New Zealand Institute for Economic Research (NZIER) presented data to show that from 2001-2021 the population of New Zealand will increase by 16%, while the population over the age of 65 years will increase by 72%, making up 18% of the citizenry (NZIER, 2004). With this will come the inevitable increase in demands on the health budget that accompanies an aging population. Health problems which will require increased resourcing include diabetes, unipolar depression,

osteoarthritis, dementia and related conditions, visual impairment, renal failure, and cancer. Alongside this is a projected mismatch in health workforce supply and demand. The NZIER offered three scenarios, the most optimistic of which suggested that by 2011 there will be an 11% shortfall in the health workforce, increasing to 28% by 2021. It should be noted that the NZIER tendered two less optimistic projections, and also indicated that the baselines figures taken for 2001 assume an optimum balance of supply and demand, which may not have been the case. While these figures may be challenged, and the continual development of medical technology allows for the more efficient use of practitioners' time within some speciality areas, the general direction of these data remains clear. There will not be enough practitioners to provide future health services in the way that we have become accustomed to them.

These data suggest both challenges and opportunities. The challenges are: to remain healthy, to detect changes in health status quickly and accurately, assist people in taking effective remedial action themselves and to support members of their family/whānau and communities to do likewise, to use a wide range of health practitioners in a timely manner, to ensure that programmes are evidence-based and effective, and to ensure that practitioners are properly trained and regulated. The NZIER report raises a number of points for discussion within this context, including the inevitability of equating primary care with general practice, the

potential role for case managers, the redefinition of jobs and occupations, greater emphasis on team working, shared modular interdisciplinary training, and so on (NZIER, 2004). Each of these challenges is an opportunity for the further development of psychology as a discipline, and its practitioners. However, they also provide avenues for psychology to make a telling contribution to the health of our communities.

In Aotearoa New Zealand one of the first and most indefatigable psychologists emphasising the importance of mental health care within general medical practice was John Bushnell, now Professor at the University of Wollongong's Graduate School of Medicine. Before he left Wellington for Australia, Bushnell took the lead in the research programme known as MaGPIe, which is explained and referred to by a number of the present contributors. Another significant pioneer of the role of psychologists in health workforce development and services is Professor Andrew Hornblow (University of Canterbury). While certainly not alone, these psychologists have been at the forefront of communicating an internationally recognised finding—that about 60% of the concerns brought to primary care physicians (General Practitioners) are actually psychological in nature.

Despite these prescient contributions, what has often been missing from New Zealand services providing primary health care has been a clear recognition of psychological difficulties when they are presented, and a credible response when they are identified. The lack of direct access to well resourced non-medical responses has often left primary care practitioners with limited options, these being either medication or referral to secondary services that are remote from the primary care environment and subject to long delays. This is despite the substantial international literature supporting the efficacy of psychological interventions across a very wide range of health presentations.

It is against this background that the current special issue of the *New Zealand Journal of Psychology* was proposed. The brief extended to potential contributors was broad. We were chiefly interested in publishing psychological

theory and practice that was either being applied, or could be applied within the primary health care sector in Aotearoa New Zealand. Given the paucity of psychological work being conducted in that particular domain at this time we were keen to consider a wide range of formats (empirical, theoretical, review, case study, and single-case designs) with the key consideration being the exploration of potential health gains, for the profession, the primary care sector, and for the community.

It is not surprising that mental health is well represented in the papers included here. Paul Wynands and Libby Gawith, and John Fitzgerald, Karma Galyer and Juanita Ryan present evaluations of brief therapy interventions within primary care settings. The former involves the provision of cognitive-behavioural therapy by a small number of practitioners; the latter reports an evaluation of a larger scale service where therapy interventions were delivered primarily by counsellors. Both teams of authors conclude that service users benefit from receiving brief mental health interventions, usually 4-6 sessions, when delivered in an accessible and timely manner. It is also clear from their contributions that conducting service evaluation research within the primary care sector is difficult. This may be due to a lack of familiarity with psychological practice and/or this type of evaluation focus within the sector. There is clearly still much to learn about what interventions work, for whom, and under what conditions.

The third paper with a mental health focus is authored by Rosemary Lyons and Pam Low. They are working in the service with probably the longest experience of delivering brief psychological interventions to the sector—ProCare Psychological Services, in Auckland. Their focus is on the application of the Biodyne Model, originally developed by Cummings, who was the first psychologist in the United States to report hard evidence that brief psychological services dramatically reduced the costs of health care. As they explain, this is not a therapeutic model, but a contextual heuristic that is used to guide practice. There are a potentially large number of such frameworks which could be applied to the provision of brief

psychological intervention; Lyons and Low use two very nice case studies to illustrate the use of this one.

Carol Barber's contribution to this special issue considers the topic of perinatal care. While this has a mental health focus, it is certainly not a presentation that is regularly encountered in mainstream secondary mental health services. After a brief summary of core themes, Barber turns her attention to assessment and intervention issues, encouraging practitioners to become more aware of perinatal emotional disorders. In extreme cases such difficulties may come to the attention of specialist secondary mental health services. However, most 'cases' will not, with GPs, Community Midwives, or other childbirth organisations offering what help they can. Barber's view is that psychology and psychologists have a positive contribution to make in this area.

While the application of psychology to physical health care and medicine flourishes internationally, it continues to have difficulty gaining traction in New Zealand. This is probably a function of training and workforce difficulties, rather than a complete lack of awareness of the contribution that the discipline could make. New Zealand has Health Psychology programmes, and some psychologists (e.g., health, clinical, community) involved within the physical health sector; however, there is practically no translation of this into the numerically largest health market in the country - primary care.

Kirsty Ross and her colleagues at Massey University's Psychology Clinic, Palmerston North, examine the psychological sequelae of chronic physical illness, and outline the new psychological services being developed in their region to address these. They observe how even the basic psychological techniques that will be familiar to many applied health practitioners can be used to good effect with this client group. Two short case studies are used to show the techniques in action.

The authors of the final paper consider a public health issue that is regularly mentioned on the nation's airwaves and in the print media, but just doesn't appear to progress much further ... obesity. Jo McClintock and

Barbara Hedge present findings from their survey of health practitioners with regard to child and adolescent obesity. The focus of the survey was to collect data on the assessment, management and treatment processes used in everyday practice. The findings are regrettably disappointing: that while protocols and guidelines are available they are not applied consistently within the domains of interest. The authors conclude that models of health behaviour-change, which incorporate sound psychological principles, could significantly contribute to meeting this health challenge – “We have met the enemy and he is us.”

We would certainly agree that the six papers included here leave much un-said about New Zealand’s primary healthcare system and its users. However, this usefully illustrates the point that there is much work to be done by our discipline. The contributors, with one exception, make little mention of services to children and young people. There is no mention of older people, no description of ethnicity specific or specialist services, no consideration of disability related community health services. Because we cannot assume that assessment and intervention practices will transfer across service delivery contexts, we must continue our efforts to formulate the appropriate questions and apply study methodologies that will furnish the community with robust and meaningful answers regarding efficacy in each of these areas. We hope that this special issue has made a creditable contribution to this effort. Hopefully, too, it will stimulate not only new and innovative programmes, but inspire a response to the critical need for outcome evaluations and controlled trials that has been made so apparent by the contributors.

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