Canadian Psychological Association
Section on Psychologists in Hospitals and Health Centres

Guideline for the Organization of Psychology
in Hospitals and Health Centres

October, 2014

Purpose

This Guideline provides recommendations on the organizational structures and activities that optimize psychological service delivery in hospitals and health centers.

Following the recommendations is an overview of professional practice in psychology as well as a summary of the information reviewed for the development of these recommendations.

Recommendations

Psychologists optimally apply their knowledge and serve patient and client needs in health care organizations when their professional and employment needs are met. The following recommendations for the organization of psychology in health care settings are designed to meet this overarching purpose.

The organization of psychology in hospitals and health centers should include:

- An organizational structure with a psychology professional practice leader who is a senior member of the psychology profession (e.g., Professional Practice Leader, Department Head, Chief). The role of that leader is to be responsible for professional practice, including human resource activities related to psychology staff (e.g. position descriptions, position postings, applicant screening and hiring, performance management and discipline, performance reviews, etc.), as well as responsibility for maintenance of professional standards and accountability; psychology tests and materials; etc.
- Support for the full scope of psychological practice in keeping with provincial/territorial College requirements and legislation, and commensurate with the psychologists' training and competence.
- The allocation of time and clarity of expectations in regard to professional activities including clinical responsibilities, program evaluation, program development, teaching, training and research responsibilities, in keeping with an organization's mandate.
- Access to assessment and treatment materials and equipment that meet the standards of the profession and to enables appropriate service delivery.
- Opportunity and support to provide training and supervision of psychology students and residents/interns.

- Access to professional knowledge and empirical research findings to foster patient care excellence and to provide service and consultation to interprofessional team members, trainees, and the organization for program development/evaluation and research, as appropriate.
- Academic appointments and linkages with universities and colleges.
- Support for knowledge generation and dissemination activities.
- Regular connection with both intra and interdisciplinary colleagues for the mutual exchange of knowledge, ideas, consultation, and support
- Compensation and benefits that are commensurate with the achieved level of academic and practical training and years of experience
- Financial support and leave for continuing education and professional development in keeping with professional obligations and expectations.
- A work environment that includes adequate private space to ensure patient confidentiality, staff and patient safety, access to professional materials, freedom from distraction and availability of information technology and communication tools.
- Administrative support to efficiently and cost-effectively enable a primary focus on delivery of professional services
- Recognition of clinical practice contributions, and organizational and academic achievements through verbal recognition, compensation, title and position.

Psychology Professional Practice

Professional practice in psychology involves: clinical service, training, teaching, program development/evaluation, consultation and research.

These activities all relate to optimal patient care – either immediately through direct service or by advancing knowledge designed to improve future services. For example, psychologists contribute to organizational improvements and service innovations though program development and evaluation. Teaching and training excellence ensures trainees will be competent to offer the array of psychological services needed in diverse health care settings. Research, like program development, advances and improves tomorrow's patient care.

Not all psychologists are involved in all professional practice areas, and not all health settings have a mandate for all professional practice activities. While many community health settings focus primarily on clinical services and program development, academic health centers often expect psychologists to contribute across all professional practice elements. Most health settings have training mandates and many have accredited professional training programs in psychology.

Each professional practice activity is multifaceted. For example, psychologists provide a diverse set of assessments, treatments and consultation services to patients, across the continua of age, severity of symptoms, medical disorders, psychological disorders and intensity of service delivery. Treatments can be directed at individuals as well as couples, families and groups. While group interventions have a long history in health care, stepped care approaches have been developed more recently to address

expanding community needs due to increased incidence of chronic disease (e.g. cardiac rehabilitation, chronic pain management, insomnia interventions, etc.).

Psychological services are provided in a wide array of health settings, including mental health, health, rehabilitation and addiction services and programs and in acute, tertiary and quandary hospitals. Professional psychology (often called clinical psychology) consists of various competency areas, and psychologists most commonly employed in health settings have one or more of the following competencies: neuropsychology, health psychology, rehabilitation psychology – who typically deliver services outside of traditional mental health services. Clinical psychology is a competency within professional psychology and most often associated with mental health services.

Health care organizations are encouraged to employ psychologists to provide cost-effective and cost-offset services in the following areas:
- Addictions and substance use and abuse
- Mental health issues such as anxiety, depression and psychosis
- Psychological assessments for differential diagnoses (e.g., dementia versus depression)
- Particular populations or specialties (e.g. Pediatrics, adults, geriatrics, neuropsychology, rehabilitation)
- Complex presenting issues such as personality disorders and disorder comorbidity
- Primary health care settings promoting and maintaining healthy behaviors
- Psychological results of abuse
- Traumatic stress
- Psychological factors and problems associated with physical conditions and diseases (e.g., obesity/bariatric surgery, diabetes, heart disease, epilepsy, hypertension, cancer, burns, perinatal care, MS, HIV)
- Terminal illness for both the individual involved and family
- Brain injuries or degenerative brain diseases or other central nervous system dysfunction
- Disability and working to maximize ability and minimize the effect of the disability
- Pain management
- Cognitive functioning such as learning, memory, problem solving, intellectual ability, developmental level, etc.
- Developmental and behavioral abilities and issues across the lifespan
- Individuals within the criminal or legal system, services for victims and perpetrators of criminal activity
- Stress and anger management
- Marital and family relationships
- Educational and vocational functioning
- Determinants of health and illness
- Management of terminal illnesses

Given the complexity and chronicity of many health condition, holistic and integrated interprofessional care is becoming mainstream. Integrated teams have a long and strong history of improved outcomes for various interventions e.g. chronic pain, physical rehabilitation, addictions, etc. Psychologists in health care settings uniformly affiliate with their treatment teams to collaboratively offer interprofessional care to patients and clients.   In addition, psychologists are often involved in training psychology students, as well as other health professions, about interprofessional care.

Training of Psychologists

In order to insure a supply of adequately trained psychologists with the preparation for the delivery of health care services in the community and hospital, it is necessary for hospital and clinic based psychologists to be available to provide supervised training experiences. This generally occurs at four levels:

1. Practicum: Students in accredited psychology training programs generally require about 1200-1500 hours of pre-internship supervised practice in order to be accepted into a required residency/internship. Ideally, at least 50% of this should occur in health care settings such as hospitals and clinics in which there is an opportunity for interdisciplinary interactions such as in health care teams. A diversity of health care experiences including both diagnostic assessment and intervention is required.
2. Residency/Internship: All accredited training programs in Canada require a one year supervised internship. The majority of accredited residency programs are hospital based, and this is required to provide a steady supply of psychologists to the public health care system. Ideally residency/internship programs are accredited with CPA in order to insure an adequate breadth of training and intensity of supervision.
3. Supervised Practise for College Registration: Most regulatory Colleges require a period of post-degree supervised practice while the practitioner is on a provisional registry. Often, health care organizations hire new graduates who require varying levels of supervision by psychologists who have certain qualifications.
4. Mentoring of new staff and continuing education: The mentoring of newly hired psychology graduates should be normative and mandatory to insure the quality of services, consistent with Accreditation Canada standards.

It is encouraged that all hospital and clinic based psychologists regularly providing training for students in accredited training programs be affiliated with the relevant university department in order to provide input into training requirements and maintain standards of supervision.

Collaborative Practice and Education

While there are various models of professional heath care management and professional organization in hospitals (program management, matrix models, etc.), good patient care (e.g., as defined by Accreditation Canada standards) increasingly emphasizes interdisciplinary collaboration and team work. In addition, health care professional and medical education increasingly encourages and promotes interprofessional training

Interprofessional interaction may occur in defined teams with continuously assessed roles and responsibilities, but is a requirement of all psychological services within and beyond a formal team structure. Patient care requires the communication and coordination of services between service providers in hospitals and primary care or community agencies or clinics, inclusive of all health care staff and sites. The patient should be the centre of interprofessional services, with every effort made to coordinate services to the patient in a seamless manner.

In order to train psychologists for interdisciplinary collaborative health care work, practicum students, residents, or new staff require mentors and models of psychology practice that demonstrate the full utilization of psychology training and skills within a respectful interprofessional climate. Each profession should be respected and encouraged to provide maximized services within defined scopes of practice,

allowing for overlapping skills in a mutually supportive environment. Psychologists should be encouraged to share their skills and training with other professionals and their students in a respectful manner.

Review of Hospital Psychology Services

The following themes were found across published articles (1987-2013) that surveyed hospital psychology practice.   These results are most relevant for psychologists in academic health centers, where results indicated that psychologists in these settings:

- are motivated by autonomy in their practice, more than by salary;
- value academic activities, including clinical research that develops and documents cost-effective interventions;
- support administrative models or structures that foster autonomy and full scope of psychology practice.

Health sciences centres which offer these conditions are more likely to be experienced as positive and will be quickly recognized in the psychology community. In turn, this will facilitate the recruitment of the most skilled individuals as well as the retention of excellent staff once hired.

As compared with an earlier survey in 1999, Owens et al. (2013) reported an increase in hospital association with educational institutions, greater movement towards a matrix organizational model and a decrease in the provision of psychological assessment and individual as well as family therapy

Organizational Structures

Psychology is organized in various models within health care settings. While independent departments of Psychology were the norm in the 1980's, they were replaced to a large degree with program management modes. Of the various differences between the models, the key difference is the responsibility and authority over the staff and their professional activities. The department model centralized these within the professional department while program management models centralized these within services and programs. Nonetheless, pure departmental or program management models are rare. So-called departmental models were often matrices between professional departments and services, and program management models are often matrices between services and professional departments. In recognition of that, some health care centers define their models as matrix models. Overall, this has resulted in confusion, as knowing the organizational label of a given health setting does not correlate highly with specific structures.

The rationale for the move from departmental models to program management structures was multifaceted but primarily to reduce barriers to collaboration and care. However, in reviewing hospital psychology practice noted, no support was found for the premise that functional structures raised barriers to interprofessional collaboration and patient-centered care in Psychology (see Appendix A for a review of selected literature on organizational models).

Models, Leadership and Psychology Practice

Organizational models of professional practice interface with the services offered and their outcomes as well as the scope of psychological services provided. As reviewed, stronger professional leadership resulted in stronger professional practice with patient and team benefits .

Professional leadership in psychology in health care fosters the development and promotion of training programs, service development and evaluation as well as the research needed to advance care. For example, in regard to teaching, criteria for accredited internship/residency training programs (Canadian Psychological Association, 2011) in psychology require:

1) Support of the host department and the institute in which it sits,
2) A Psychology Training Director that is independent of the Psychology Professional Practice Leader Head, or Chief,
3) Dedicated program budgeting, and
4) A cohesive training faculty.

In addition, psychologists in academic health centres have advanced patient services through research and research funding and facilitated clinical research with real-world implications for Canadians. The demonstration of the impact of psychological variables in mitigating health care expenses and improving outcomes underscores the essential need for continued knowledge development and transfer (Arnett, 2006).

Psychologists who are scientist-practitioners can be faced with two opposing forces. On one hand, research is often not viewed as the mandate of the health care setting but rather than of universities and on the other hand, the most pressing clinical questions and needs for improvements are most apparent to those working in health settings. Some academic health science centers in Canada have fostered alliances with University Departments (e.g. the Department of Clinical Health Psychology in Winnipeg). Other settings have fostered research success by initially supporting research activities with the expectation that success will lead to grant funding which can lead to personnel support, Fellowships etc. that, in the long run, contribute and add to direct clinical services – in addition to advancing clinically relevant research and program development.   The importance of leadership in advocating for and developing these successes is clear.

Future Directions for Psychology Services in Health Care

A paper by Romanow and Marchildon (2003) highlighted where psychology makes substantive contributions and, given population needs, how psychological services should be oriented in the future in order to improve health outcomes and best address increasing health care expenditures.
The key areas where psychological services should be offered, because of the demonstrated evidence-based outcomes and cost effectiveness of the interventions, were as follows:
-        Brain-related disorders (stroke, ABI etc.)
-        Rehabilitation services
-        End-of life care

- Primary Care
- Provision of cost-effective drugless therapies for the treatment of:
depression, anxiety, addictions, conduct, mood and personality disorders.

Comparing these recommendations with the teaching and research activities that Humbke et al (2004) outlined indicates a substantial increase in research from 1982 to 1999 in the areas of brain injury, rehabilitation and mental health. This relates to important contributions that can be made by psychologists in advancing knowledge and cost effective alternatives to current treatment approaches. Romanow and Marchildon (2003) concluded that to effectively marshal scarce public resources the focus needs to be on cost-efficient interventions – and psychological services have demonstrated such outcomes. The clinical research that led to the conclusions of cost-efficacy cited by these authors was done primarily in academic health science centres. Without these data, these authors would not have been able to point to the efficacy of these interventions. Given rising health care costs and increased interest in and importance of the contribution of psychological variables that mitigate and/or improve outcomes, continued knowledge development in these areas is essential.

While these forecasts are ten years old, they remain at the front of the agenda in health care settings for psychological service needs. It is important that organizational structures are able to support and develop the clinical care, training, and research needed in these areas.

Two factors will likely provide challenges to the provision of psychological services in health care settings. First, it is anticipated that health services will be increasingly delivered in program managed models of care. There may be a greater emphasis on allegiance to health care teams rather than professions. In addition, Program Managers may not have a full understanding of the training, competencies and ethical requirements of psychologists. Second, pressures to contain health care costs may have an effect on non-direct service professional activities including training, research and program development. As such, it will be important to ensure that the discipline of psychology is strongly represented. Advocacy to support psychologists in practicing to the full scope of their skills, with appropriate materials, work environments and continuing education opportunities, will be needed. Creating networks and processes whereby psychologists can remain connected to and supported by their colleagues will be important.

Appendix A
Health Care Organizational Structures

According to Boyce (2004), program management did not become a dominant organizational structure in Australia; however, program-based management structures have been adopted to a greater extent in Canada. Davis, Heath, and Reddick (2002) described a Professional Practice Model that was developed to address the professional issues inherent in a program-based management structure brought in when the Health Care Corporation of St. John's Newfoundland was formed with the merging of eight health care institutions in 1995. The core components of the model include: standards, education, utilization, professional strategic planning, evidence based practice, and performance management. Although the model was in place for six years before this article was published, it was not fully operationalized and has not been formally evaluated for all disciplines.

Two reports reviewed Canadian health care organizational structures, one prepared by the Coalition of Ontario Professional Bodies for Speech-Language Pathology and Audiology, Psychology and Occupational Therapy (1995) as well as one from the Saskatoon Health Region (2009).

The Coalition outlined the essential elements of professional practice that must be preserved within any organizational structure. It was developed in response to the move to program management organizational structures in the 1990s. The essential elements outlined were:

professional standards and credentialing;
recruitment/hiring; training/orientation of new staff; and staff coverage;
performance evaluation and discipline; accountability and liability;
professional supervision and mentoring;
supervision of non-regulated personnel; student supervision;
profession appropriate productivity targets;
access to records; space and resource allocation;
quality management; continuing education;
accreditation by national bodies;
advocacy; liaison/communications;
research;
professional identity; and peer support.

This Saskatoon Health Region surveyed 12 different organizations in six provinces in 2009. The organizations interviewed were evenly divided among functional, program and mixed organizational structures. The shifts towards matrix management were reported to be designed to address the perceived weaknesses of program management by strengthening the functional management/leadership aspects of organizations.

The report noted that the most developed and widely referenced professional practice model is that of The Ottawa Hospital. Their concluding comment was that in order to balance the weight of the number of nurses compared to other health professionals, there must be a structure that gives the health professions a voice and communication channel to Senior Management.

Two Australian articles examined the organizational structure of the health care settings and described these models: a) Integrated Decentralization, b) Classical Medical and c) Unit Dispersement (Boyce, 2001; Rowe, Boyce & Boyle, 2002). Note: The term "allied health" was used in these reviews and has been changed to the more appropriate term "health professions".

The Integrated Decentralization Model is a complex matrix arrangement for the internal organization of health professions. It is based on recognizing the importance of professionally managed services to maintain professional identity, service management and development and a focus on patients through health professions service teams. Directors of clinical units/ programs do not have managerial control over the health professions but negotiate with the senior health profession staff about service issues.

The advantages of this model are considered to be:

- relationships at management level based on trust rather than notions of power and legitimacy;
- health professions were perceived as an organized influential stakeholder both internally and externally;
- facilitates the development of innovative, cooperative work practices across disciplines;

- staff are unified and have a strong super ordinate identity;
- higher level of professional stability;
- more harmonious environment conducive to staff training, professional development and mentoring;
- more stable resource environment with a focus on asset growth rather than asset protection.

The Classical Medical Model involves individual health profession-managed departments reporting to a medical director who represents the interests of medical and allied health staff at top management forums. Health professionals provide services to clinical units/programs across the organization according to professionally perceived priorities. Directors of clinical units/programs do not have managerial control over the health professions but negotiate with the senior allied health staff about service issues. A number of disadvantages were noted with in this model including: no single allied health representative with leadership over the professions; no united stakeholder identity; externally perceived as having low power and legitimacy; competing visions and an arbitration type model of management; and fractured, fragmented hierarchy with competing allegiances between team and discipline membership.

The Unit Dispersement Model, most comparable to what is described in Canada as pure program management models, involves individual professionals being dispersed among clinical units. Professional management is eliminated although professional leadership positions acting in an advisory capacity may be retained. Many disadvantages were outlined in the model including lack of support by health professional staff.

Boyce's research recommends the Integrated Decentralization Model where profession-managed services are part of a larger group of Health Professions who's Leader is a member of the health organization's executive team. Care is provided to patients through health care delivery teams.

This model allows for:
- a focus on service delivery
- maintenance of professional identity, development, and standards
- service development
- research activities
- promotion of collaborative practice
- engagement of professionals in the organization.

This approach has been applied to managing health services across organizations and regions in Australia and, more recently, in Canada.

References

Arnett, J.L. (2006). Psychology and health. Canadian Psychology, Vol 47(1), 19-32.

Arnett, J.L., Martin, R.M., Streiner, D.L., & Goodman, J.T. (1987). Hospital Psychology in Canada. *Canadian Psychology*, 28(2), 162-171.

Boyce, R.A. (2001). Organizational governance structures in allied health service - a decade of change. *Australian Health Review*, vol 24, Number 1.

Coalition of Ontario Professional Bodies for SLP and Audiology, Psychology, and Occupational Therapy (January 1995). *Conserving the Integrity of Professional Practice During Organizational Restructuring.*

Canadian Psychological Association (2011). Accreditation Standards and Procedures for Doctoral Programmes and Internships in Professional Psychology, Fifth Revision, 2011.

Humbke, K.L., Brown, D.L., Welder, A.N., Fillion, & D.T., Dobson, K.S. & Arnett, J.L. (2004). A Survey of Hospital Psychology in Canada. *Canadian Psychology*, 45(1), 31-41.

Nicholson, I.R., Velikonja, D., & Bisnaire, L. (2004). Hospital Psychology in Canada: Issues and Strategies. *Healthcare Management Forum.*

Owens, S.J., Wallace, L.M., Liu, I., Newman, K.R. Thomas, C., Dobson, K.S. (2013). Hospital psychology in Canada: An update. Canadian Psychology, Vol 54(3), 147-152.

Romanow, R.J. & Marchildon, G.P. (2003). Psychological Services and the Future of Health Care in Canada. *Canadian Psychology, 44(4),* 283-295.

Rowe, P, Boyce, R., & Boyle, M. (2002). Models of organizing at two health services organizations. A case study approach. *Contemporary Nurse*.

Rozensky, R.H. (2004). Freestanding psychology: The only way in academic health centres. *Journal of Clinical Psychology in Medical Settings. Vol. 11(2),* 127-133.

Saskatoon Health Region (June 2009). *A report of a survey of reporting structures for allied health professionals.* Submitted to Richard Dagenais, Project Manager, Service Alignment, Corporate Planning.