

## original article

**Integration of Psychologists in the European health care system. Challenges and opportunities from a Swedish perspective.****Sven Ingmar Andersson**

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The Swedish Board of Health and Welfare recently (February, 2009) recommended use of psychological methods, e.g. cognitive behaviour therapy (CBT), as a first-hand option in the treatment of depression disorders and anxiety syndromes ([www.socialstyrelsen.se](http://www.socialstyrelsen.se)). This was big news and both a challenge and an opportunity for professional psychology to enhance and to protect its qualified professional expertise and patient safety on the first line. It is a challenge to provide, insofar as possible, such availability of professional psychologists in each health care centre, thereby guaranteeing patient access to appropriate diagnosis and treatment. There is also a need to enhance beneficiary access to the range of services of primary care psychologists. Failure to achieve this involves a risk that health-care personnel who lack the qualifications of the psychologists will take over or that the present over-prescription of drugs will prevail. This may not only cause harm but also decrease patient confidence in the quality of care that psychologists provide.

What has now happened with regard to the initiative taken by the Board of Health and Welfare in Sweden? Because the recommendations were criticized from many quarters such as psychiatrists and other types of psychotherapists than cognitive behavioural ones, the National Board of Health and Welfare has decided to postpone the ratification of the recommendations until next year. In their comments, The Swedish Psychiatric Association argues that publication of the preliminary guidelines was “premature” and could be damaging from a public educational perspective when statements such as “cognitive behavioural therapy is better than drugs” is given national mass media circulation ([www.svenskpsykiatri.se](http://www.svenskpsykiatri.se)). The association argues that recommendations concerning treatment must be based first of all upon scientific evaluations of effects and side-effects, other matters involved being resources (economical considerations and accessibility). According to the psychiatric association, the recommendations provided of always recommending cognitive behavioural therapy (CBT) – or, as far as that goes – electro-chock therapy (ECT) prior to use of



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drugs are not in harmony with international practice and contain so many uncertainties that the legitimacy of the National Board to make statements on psychiatric treatment has been damaged.

With regard to effects and side-effects, the Swedish Psychiatric Association argued that there are several evidence-based treatments of depression of both a pharmacological and a psychological nature with authoritative studies showing anti-depressive drugs to be better than CBT in treating depression and no studies showing that CBT is better than anti-depressive medication. In practice, these recommendations can result in higher priority being given to milder depressions than to severe ones for which the evidence-base for effects of CBT is weak. As to side-effects, the National Board of Health and Welfare concluded that there are no side-effects of CBT. This was criticized by the Psychiatric Association in terms of there being no evidence for such conclusions, since side-effects in psychotherapy are seldom taken note of, quite in contrast to studies of drug effects. The psychiatric association mentions attachment to the therapist, problems in concluding therapies, rebound-effects and lack of attention to co-morbidity on the part of psychologists, and the need of further medical investigation and treatment to ►

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determine whether there are side-effects that have not been studied scientifically.

With regard to resources (economy and accessibility) the psychiatric association argued that in Sweden today there are 500-600 educated cognitive behavioural therapists who hardly can carry out 15-20 consultations with the one million Swedes who suffer each year from depression or anxiety. Also, CBT is regarded by the psychiatric association as being very expensive, neither the costs of establishing CBT on a broad front nor the capacity or energy of patients to adhere to the therapeutic method being adequately borne in mind. The psychiatric association welcomes computer-assisted CBT but argues that studies of CBT and computer-assisted CBT are scarce and provide no sufficient basis for conclusions in support of it.

The Swedish Psychological Association argues that about 5-7 % of the grown-up population suffers from depression and about 6% from anxiety and that some 455 000 persons or more of the adult population are in need of psychological treatment for depression or anxiety ([www.psykologforbundet.se](http://www.psykologforbundet.se)). Today, less than one out of 10 persons who consult health care for psychological problems are given specific psychological treatment, indicating that some 420 000 persons do not receive such care. It is argued that offering these persons good evidence-based psychological care would cost some 420 000 000 EURO. If half the patients suffering from mild to moderate depression or anxiety benefitted from such treatment, this would result, according to the Psychological Association, in a yearly saving of some 1 140 000 000 EURO. Providing an additional 420 000 patients evidence-based psychological treatment could require a larger number of psychologists being educated than today, such extension needing to proceed, in this case, in step-wise fashion.

The problem is seen as that of providing evidence-based psychological treatment in which people ask for it to the same degree as they need it. Yet according to the Psychological Association the idea of not providing such treatment being due to a lack of psychologists represents a misunderstanding. A recent questionnaire investigation suggested the 2000 psychologists now in private practice to be able to provide their services to 44 000 more patients each year than at present. At the same time, this raises the issue of whether psychological health in Sweden is a matter of class. The Psychological Association argues that many patients seeking care are not admitted to psychological treatment since the counties responsible for care of the population have not employed or made agreements with a sufficient number of psychologists, seventy percent of health care centres in Sweden lacking such

services. Another reason for the lack of access to psychological treatment is seen to be that of evidence-based psychological treatment having developed much later than the use of drugs.

According to the National Board of Health and Welfare, 70% of those seeking care for depression and anxiety consult primary health care. However, it has been found that less than a tenth of the patients in primary health care with depression or anxiety are provided with specific psychological treatment of the sort recommended, i.e. with cognitive psychotherapy or cognitive behaviour therapy (CBT). It has also been found that 66% of the population prefers psychological treatment to drugs if given the possibilities of receiving it, only 9% selecting drugs first.

What are the lessons of this for psychology in the future? I consider it important to cooperate more closely with family physicians and general practitioners (GPs). Physicians should discuss with psychologists which patients with psychological problems should be referred to psychologists for more thorough psychological diagnosis and treatment. In the near future, most patients with psychological problems of a minor or moderate character will need to be handled by GPs, if only because of a lack of psychologists at these facilities. The Psychological Association argues that there should be a psychologist in every health care centre. An important initial aim should, in my opinion be that of having at least one psychologist in every five GPs and the counties responsible for the care provided seeing to it that such a system is established. I also believe it to be important for psychologists to not work in isolation at health care centres but to join together with one or more of their colleagues to ensure that none of them are overwhelmed by the psychological problems of their patients and that they have the opportunity to discuss with them thoroughly the problems they have at their workplace.

The frustration noted among representatives of the psychiatric profession of having psychologists available on the first line in primary health care centres can be understood as a question of "who knows most", which is ultimately a question of power. It could easily be argued that having psychologists with their education and emphasis on coping and prevention and their skills in assessment and measurement available at the primary health care centres would result in more appropriate diagnoses, so that persons with minor or moderate problems would be differentiated more adequately from those with more serious problems. The resistance of ►



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representatives of the psychiatric profession to having psychologists as health care workers is evident in many countries. In the US, for example, the resistance of psychiatric associations to the quest of psychologists for the right to prescribe psychopharmacological drugs has been extreme. Nevertheless, such rights are now a reality in various US states, many of the other states also being on the verge of passing laws providing psychologists who have been given advanced psychopharmacological training such prescription rights. It is highly important that psychologists be knowledgeable of basic psychopharmacology so as to be able to discuss medication and side-effects of medication with their patients and also that they have the right to "un-prescribe" inappropriate medication when this is indicated. The rights of psychologists to prescribe psychopharmacological drugs can be thought to ultimately result in a parity of psychologists with physicians in terms of reimbursement and professional opportunities in this area, a development that should be encouraged in the European countries as well. Psychologists in the Netherlands, for example, are seeking prescription rights through their professional organization. Last year (2008), 22 Dutch psychologists selected the psychopharmacological training program presently available in New Mexico, the Prescribing Authority Act there providing properly trained psychologists prescriptive authority (see Tablet: Newsletter of the Division 55 of the American Psychological Association: [www.division55.org/TabletOnline.htm](http://www.division55.org/TabletOnline.htm)).

For psychologists in primary health care, more than simply mental problems of patients should be taken into consideration. Appraisals and coping are involved in many other illness and diseases, such as diabetes, cardiovascular disease and cancer, not to mention the so-called fashionable diseases, such as fibromyalgia and chronic fatigue syndrome. One problem involved in illnesses of as well as in the treatment of other groups in the population, such as the elderly, is that of extensive drug use. At a health care centre the individual should be able to gain contact with a person who acts in his or her interest. This person can be a physician, a psychologist, a nurse, an employment counsellor, or an insurance administrator. When a person has a variety of problems, there is a much better chance of finding a satisfactory solution if those with the ability to help work together. Integrating psychologists within the work of primary health care units would be an excellent and, I believe, necessary means of furthering public health and research. In Sweden, as in many other European countries, the training of professional psychologists at institutions of higher learning is primarily geared to the basic

diagnosis of problems and to systematic psychotherapeutic work. Students of both medicine and psychology, in fact, are confronted with far too few "ordinary" patients. The health care training of psychologists should include experience in dealing with primary health care patients rather than simply that of working with patients typical at somatic and psychiatric clinics that represents a far more selective clientele. The tendency in medical education to gradually adopt a problem-oriented rather than an organ-oriented perspective has brought about an increase in inter-disciplinary collaboration between general practice and psychology. To foster such developments, which are in the interest of both individual and public health, considerable educational and organizational efforts are needed. Concerted European efforts are urgently called for to establish a coordinated form of health and psychological education of psychologists involving a broad focus, one that includes basic somatic and psychopharmacological knowledge. Here, organizations such as the European Union, the European Health Psychology Society and the European Federation of Psychologists' Associations (EFPA) each have an important role in achieving this.