[received by email]

Dear Commissioners,

I am writing in haste from overseas (Dubai, UAE), as I understand that you are currently finalizing the Productivity Commission's Position Paper on the Australian Health Workforce. I am a clinical psychologist who, between 2001 and late 2004, worked intensively on government trials of the efficacy of collaborative care between clinical psychologists and GPs in the primary care setting. We developed a clinically- and cost-effective model of mental health service delivery for the high prevalence/"common mental disorders" of depression and anxiety which contributed significantly to the support of GPs in their onerous role as primary care mental health service providers. As a consequence, we formulated a training and workforce development model provided through Divisions of General Practice which our research indicated was the optimal way of providing these services in the community (see attached proposal sent to the Minister for Health prior to formulation of the 2004 Health Budget; together with support documents from GP and research papers outlining the model and its efficacy).

At the end of Phase 1, I transferred the Commonwealth Project to colleagues in the Department of General Practice at Monash who are currently finalizing manuals for the training of Clinical Psychology Registrars (with GPs in the primary care setting) in preparation for articulation of the model across Australia. (I have moved temporarily overseas for family reasons, but remain closely involved with the vision of developing an optimal, early intervention mental health service delivery model through primary care, working closely with General Practitioners.)

It has become apparent, through the recent Mental Health Council of Australia's Report: ***"Not for Service: Experiences of injustice and despair in mental health care in Australia"***, that recent gains in mental health care have not yet been articulated into sustainable frameworks across the country. Most people with mental health conditions **still** do not receive appropriate treatment at the optimal time. Whilst the BOMHC (Better Outcomes in Mental Health Care) Initiative has resulted in significant improvements (there are now 104 Divisions of General Practice operating trials of varying models of "allied health" - 90% of these are psychological - service delivery across the country), these are still at "trial project".

What is required is the establishment of a **sustainable** (ie. permanent) **model of Primary Care Psychology Services** that:

a) is evidence-based (ie. provides intervention techniques that have been proved to work);
b) emphasizes early intervention and prevention (thereby minimizing damage and misery to individual sufferers and their families);
c) prevents stigma (General Practice is a "socially acceptable" setting in which treatments of all kinds are provided);
d) includes collaboration between the key primary care provider (ie. the GP) and the specialist mental health professional, thereby supporting the GP with their onerous mental health work load;
e) is known (and predictably available) to patients, enabling them to seek appropriate treatment early when suffering from a mental health condition;
f) averts the current "medicalisation of unhappiness" which frequently renders patients dependent and demoralised rather than responsible, autonomous and resilient;
g) is "accountable" (ie. provides **short-term** - six sessions, plus a further six if needed (not "open-ended") - effective treatment);
h) is a permanent part of primary care (ie. not an ad hoc series of continuing trials/projects requiring time-consuming annual applications for precarious repeat funding);
i) diminishes current inequities in availability of publicly-funded specialist mental health services.

The model outlined in the attached Submission includes all of the above as well as addressing**:**

a) **a number of the key issues highlighted by the recent MHCA Report:** eg. "the need for a model to be developed and agreed to…..based on collaboration, integration, community need, accountability, flexibility and innovation". As indicated, it's not the answer to everything but a solid component in the complex solutions needed;

b) **the existing inequity in mental health service delivery in Australia:** John Glover's (University of Adelaide) recent analysis of postcodes of psychiatrists practising under Medicare has found (depressingly) that only 4% of psychiatrists practice in rural areas; the **majority** of the remaining 96% practise in the upper-middle class suburbs of Melbourne, Sydney and Adelaide! (from billing postcodes of practices). Analysis of patient postcodes has also found that the majority of patients seeing psychiatrists under Medicare come from similar locations/socioeconomic levels (ie. middle-upper middle class) and are sometimes seen weekly for years. (These research findings are **deeply distressing** since psychiatry is the only consistently publicly-funded mental health specialty in Australia, providing the **only** consistently subsidised care available (or not available!) to the less-well-off and/or rurally located. Our model of publicly-funded Primary Care Psychology Services would redress some of this inequity (stats. indicate that psychologists are spread pretty much like the rest of the population: 20-30% in the country/rural areas).

I realize that your Position Paper is close to completion but, having only just been alerted to the call for contributions, I would be grateful if, at this very late stage, you would consider inclusion of our proposed model of primary care mental health service delivery. It's cost-effective, optimal/early intervention, collaborative approach needs to be included as part of the Public Health Framework in Australia on a **sustainable** basis.

Please let me know if you need further information.

Yours sincerely,

Robyn Vines

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Thursday 20th November, 2003

The Honourable Tony Abbott MP
The Federal Minister for Health and Ageing
Parliament House
Canberra 2600

Dear Minister,

MENTAL HEALTH NEEDS TO BE AUSTRALIA'S "NUMBER 1" HEALTH PRIORITY
CAN YOU AS HEALTH MINISTER MAKE A DIFFERENCE?

A PROPOSAL:
Clinical Psychology in Primary Care:
An Early Intervention and Prevention Approach to
Common Mental Disorders in General Practice
(Evidence-Based Best Practice in Mental Health Service Delivery)

There is an urgent requirement to address the mental health needs of the people of Australia:

- The burden of disease due to mental disorders/mental health problems is high and rising;
- The escalating cost of pharmaceutical benefits in treating mental disorders is unsustainable.

There are effective psychological treatments of mental disorders that empower patients and ensure more positive health outcomes. Cost savings can be made by the Commonwealth Government in medical and pharmaceutical benefits, if appropriate planning is undertaken for the provision of early psychological intervention for patients with Common Mental Disorders at the Primary Care level.

We are writing to propose:

- The articulation of a training framework for Clinical Psychology Registrars across Australia working with General Practitioners in Primary Care;
- The establishment of a "Psychology in Primary Care Research, Training and Development Centre" to coordinate and facilitate a national training framework for clinical psychology in Primary Care and to continue the development of the generic model of mental health service delivery involving collaboration between GPs and psychologists (similar to the GPET model for GP training);
- The development of a specialist mental health workforce under the public health system involving clinical psychology in Primary Care, as is the case in Britain.

Since early 1998, with Commonwealth Government support from January 2001, we have trialled the provision of psychological services in Primary Care for high prevalence anxiety and depressive disorders (see Appendix for a summary of the early intervention model and relevant research). Using a six session treatment framework, the approach to intervention is evidence-based, time-limited, accountable and short. Patients, many of whom have been on medication for years and frequently disempowered by the "medicalisation of their unhappiness", have responded extremely positively to treatment. Psychological intervention has entailed the development of new strategies in patients (cognitive, behavioural and interpersonal) to cope with and change their current, often exceedingly complex life situations and ways of responding to them (of which illness can be an expression).

Early intervention objectives include autonomy/resilience-building and, importantly, prevention/diminution of dependency on the health system. Mental health sequellae/parallels of chronic illnesses such as cardiovascular disease, arthritis, Parkinson's disease, diabetes etc are also addressed using psychological treatments which enhance patients' self management strategies.

GPs involved with this collaborative model have found it invaluable. The shared care approach which this model facilitates has relieved the stress frequently associated with treating patients with mental disorders and enhanced the capacity of GPs to respond better to the mental health needs of their patients.

Given that:

- depression alone, amongst the Common Mental Disorders, is predicted to be the greatest burden of disease worldwide by 2020;
- use of antidepressants has more than doubled in the past ten years;
- Australia has a rapidly declining and ageing mental health workforce;

we strongly recommend that a workforce development approach to clinical psychology – similar and parallel to that provided for General Practice/GP Registrars - be considered. This would entail a centrally coordinated programme of training for a Commonwealth annual target/number of stipended Clinical Psychology Registrarships/internships (already provided successfully through a number of Divisions of General Practice). These placements, for which best practice guidelines are currently being written, would ensure a training and service delivery framework within targeted General Practices across Australia, each internship involving the treatment of 20-30 patients with high prevalence mental health disorders. A further funding framework, using a systematic population health approach, would also need to be put in place for workforce outcomes from this training model, employing fully-trained psychologists with appropriate clinical skills as a permanent part of the specialist mental health workforce, located in Primary Care.

Research evidence suggests that huge cost savings:

a) directly from:

- the Pharmaceutical Benefits Scheme (currently government expenditure on anti-depressants alone is $400 million per annum and escalating);
- current over-use of Medicare-funded GP consults (renowned amongst patients with mental health disorders);
- prevention of the need for treatment of more severe disorders (ie. more serious conditions which often evolve if mental health difficulties remain unresolved; patients who previously might have needed hospitalisation, eg. for depression and severe agoraphobic/panic disorders, would be treated early and effectively in the Primary Care setting);

b) indirectly through:

- saved work days off, often consequent upon mental health difficulties; and
- overall social capital (whole families are frequently severely affected, both in the short and long term, by unresolved/inadequately treated mental health disorders)

would be achieved if proactive, centrally driven development of this specialist mental health workforce were undertaken, as in Britain.

We believe that, for a **fraction** of the amount currently allocated to: the training of General Practitioners in Australia; Medicare expenditure on psychiatrists (a similar sized profession of approximately 2000 FTEs) and PBS costs on antidepressant medication alone, a new and innovative framework for:

- national psychological service delivery providing equitably available, early intervention and prevention for patients with Common Mental Disorders in Primary Care;
- collaborative service delivery between GPs and psychologists with appropriate clinical skills;
- specialist mental health workforce training and development, similar to that provided in Britain;
- support and up-skilling of GPs in relation to mental disorders;

could be implemented.

Cost savings resulting from being adequately prepared for the escalating prevalence/envisaged epidemic of depression and other Common Mental Disorders, by having appropriate training and early intervention frameworks in place, would more than pay for the proactive investment in this new, best practice collaborative approach. Early intervention and prevention is critical when we look at the increasing burden of disease clearly

emerging in the mental health area. Australians need to be empowered rather than rendered dependent (and frequently demoralised) by their treatment. We believe the model we are advocating meets these objectives.

Attached is a more detailed overview of the issues raised and a framework for taking these ideas further. We look forward to discussing this proposal with you.

Yours sincerely,

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cc. Ms. Julia Gillard MP, Shadow Health Minister
The Honourable John Anderson,: Deputy Prime Minister
Mr. John Murphy MP
Mr. Dermot Casey: Assistant Secretary, Mental Health Branch, AGDHA

THE PROPOSAL

CLINICAL PSYCHOLOGY IN PRIMARY CARE: AN EARLY INTERVENTION AND PREVENTION APPROACH TO THE PRESENTATION OF COMMON MENTAL DISORDERS IN GENERAL PRACTICE

OVERVIEW

Burden of Disease:

It is well known that the burden of mental health problems and mental disorders in Australia is high and rising. The World Health Organisation estimates that worldwide, depression alone will constitute one of the greatest health problems by 2020 (**without** taking into account other high and low prevalence mental health disorders such as the anxiety and schizophrenia/bipolar disorders respectively). The WHO has concluded that, if level of disability (ie. YLDs: "years lived with a disability" or DALYs: "disability-adjusted life years") are taken into account as an important component of the "burden of disease" rather than just "leading causes of death", mental health and neurological conditions are predicted to show a larger proportionate increase than any other condition in the next 20 years.

In Australia, figures from the 1997 National Survey of Mental Health and Well Being indicate that currently approximately 23% of Australians (and more than one-quarter of 18 to 24 year olds) have at least one mental health disorder in a 12 month period (14% of those interviewed manifested a disorder at the time of interview). Other epidemiological research suggests that one in five people experience serious disruption to their mental well being during their lifetime. Estimates vary in relation to prevalence of particular disorders, the National Survey suggesting prevalence of anxiety, depression and substance use/abuse as 9.7%, 5.8% and 7.7% respectively, with high comorbidity of mental health and substance use disorders. Comorbidity with physiological conditions such as cardiovascular disease, diabetes, asthma and arthritis is also known to be high, mental health issues frequently needing to be addressed if successful intervention for these conditions is to take place.

Patterns of Care:

Approximately 95% of people with mental illness are now being cared for in the community. As is well known, General Practitioners bear the brunt of the treatment load, having emerged as the key primary care service providers and the gatekeepers to secondary care. Recent findings indicate that 85% of the Australian population visit a GP at least once in any year and 90% in any two year period. Of those presenting in the General Practice setting, conservative estimates suggest that somewhere between 19% and 40% of patients have mental health disorders. Estimates are higher if comorbidities with physiological conditions are taken into account. Approximately 30-50% of these patients manifest sufficient psychological distress to warrant further assessment and treatment. In relation to depression: the National Survey suggested that at least 40% of people suffering with depression consult with a GP within the first year of onset of the condition. Of these, only 6.2% are referred on to and see a psychologist, only 8.4% a psychiatrist. The remainder are managed purely in the primary care setting, often not receiving recommended best practice treatment (see below).

Detection and Treatment: The detection of psychological symptoms and the use of early, appropriate intervention at the primary care level is extremely important due to the fact that, apart from the obvious quality of life issues for patients, **use of medical services is far higher amongst those with psychological disorders than for those without.** The resultant cost burden and likelihood of inappropriate use of the health system by those whose psychological difficulties remain unresolved is an enormous cause of concern. It has been found that, despite high prevalence of psychological disorders in primary care, accurate detection by GPs remains low. A detection rate of approximately 30% of those with such conditions is consistently reported, with a range between 20-74%. Low detection of the high prevalence disorders of depression and anxiety has been found to be due to a number of factors including:

- common comorbidity with (and disguise by) physiological conditions such as hypertension, back complaints, diabetes, sleep disturbance, etc.which then become the focus of consultation and treatment;
- patients' perception of the GP's role as focusing on physiological conditions; and
- GPs' attitudes to mental illness and reluctance to diagnose appropriately due to perceived:
  - -possible stigma associated with labelling;
  - -minimal likelihood of appropriate treatment being available due to lack of appropriate treatment resources. Some findings suggest that GPs therefore focus on more "treatable conditions".

Current Primary Care Practice: The single greatest increase in public health expenditure over the last ten years has been under the Pharmaceutical Benefits Scheme. In the area of mental health, use of antidepressant medication alone has sky rocketed - doubling between 1994 and 2000 and continuing to rise. Government statistics on anti-depressant prescriptions showed a 40 per cent increase between 1998 and 2000, with 7.4 million scripts being written in the year to 2000 - up from 5.2 million two years earlier. At an average cost to government of about $50 per script, this implies an annual national antidepressant bill of $400million. The figures show that most of the increase in the use of newer drugs (such as Aropax, Zoloft and Prozac) is for new patients, in contrast to the widely held view that they are and should be replacing the older tricyclic antidepressants (the "TCA"s) which have more serious side-effects. Health Insurance Commission statistics indicate that use of these older drugs has in fact remained static, declining by only 2 per cent during the two years studied, to 2.25 million scripts.

The evidence in favour of drug therapy is not as robust as has been assumed. About two-thirds of people respond positively to antidepressants, but research findings suggest about 40 per cent of these respond positively to placebo, leaving a gap of just 25 per cent who do better on an actual drug. Some experts estimate that about 20-30% of people prescribed an antidepressant do not need it and that "the medicalisation of unhappiness" and the encouragement of people to see their distress as an illness is more in the interests of drug companies than the patients themselves. Many people do much better on appropriate psychological intervention, when it is available.

Best Practice:

Mental health consumers continue to have limited access to effective psychological treatments, despite the fact that current conclusive research evidence suggests that **'focused' psychological interventions** are demonstrably at least as effective, or more, than psychotropic medication in treating most anxiety and depressive disorders. They are **definitely** the treatment of choice for most childhood disorders. The research also suggests that **severe** anxiety and depressive disorders are probably most effectively treated with both pharmacological and psychological treatments, long-term outcomes indicating that focused psychological treatments alone tend to be more effective than medication, because people receiving medication only are more likely to relapse after the medication is discontinued. Given the relatively high cost of current psychotropic medications, focused psychological treatments are demonstrably, both clinically and economically, viable and preferable treatments. Cost-effective, evidence-based psychological/behavioural interventions are available for a broad range of health problems including both mental health disorders (eg. depression/suicide, anxiety/stress, antisocial behaviour, etc) and physical health disorders, for which changing behaviours such as smoking, eating, drinking alcohol and inadequate exercise, reduce risk factors (eg. for heart attacks and stroke, cancer , diabetes, asthma, etc)

Presently within Australia, there is a clear **"Efficacy-Effectiveness Gap"** in terms of best practice interventions for mental disorders. There is substantial research evidence from randomised control trials that highlights the findings above. However, there has, as yet, been a poor systematic uptake in our health services of evidence-based intervention packages, particularly in the psychosocial area where there is not a profit to be made (**except** in terms of government/public health savings on other expensive, sometimes ineffective interventions). Pharmaceutical treatments, on the contrary, have been taken up "big time", presumably due to the huge profits to be made in this area.

Funding Models for Psychological Interventions in Primary Care

It is hard to get a sense of trends in relative distribution of public health funding in Australia, particularly those relevant to mental health service delivery (including psychological services in Primary Care). In 2000-2001, "Allied Health and Other" (of which psychological services are merely a part) formed less than 1% of government expenditure on health, whilst pharmaceutical expenditure composed 11% of gross government outlay. In 1999-2000, the latter (ie. expenditure on the PBS) cost government alone (without consumer contributions) $3.5 billion (of which, as mentioned above, ~$400 million was spent on antidepressants). This continues to rise.

Figures from 1999-2000 indicate that non-institutional health expenditure was approximately $17 billion, with approximately $8 billion spent on Medicare. Of this, approximately $3.1 billion funded GPs in Primary Care; approximately $4 - 5 billion provided Medicare funding for Medical Specialists. Accountabilities to government required of GPs are high (including, for example, the following parameters: health problem/patient reason for referral/classification of consult; management outcomes; performance indicators; conformity to Practice Standards; notification of infectious disease; prescription for antibiotics; pathology/imaging ordered; number of patients bulk-billed; consultation with indigenous population, etc). In contrast, performance parameters required of Medical Specialists such as psychiatry by CDHA/AGDHA and HIC are relatively absent.

Over recent years (since 1999) there have been a number of **Government Initiatives** to increase and facilitate better consumer access to publicly funded, mental health services in Primary Care, including the following programmes:

Enhanced Primary Care: This arose as a 1999/2000 budget initiative and involved $8.1 million of additional MBS Items for GPs for health assessments, care plans and case conferencing. The aim was to encourage collaboration by GPs with other primary care providers (eg psychologists). Up-take was relatively good, 74% of GPs claiming at least one EPC item in the first two years. However, funding for Case Conferencing was provided for GPs alone, creating a disincentive for "Allied Health" (including psychologists) to participate, particularly since many are, of necessity, located in the private sector.

More Allied Health Services (MAHS): A four year programme commencing in 2000 and now currently under review, MAHS aimed to improve access to Allied Health Services in rural and remote parts of Australia. It enabled 66 eligible, rurally-based Divisions of General Practice to support funding of and access to psychologists, dieticians, podiatrists, social workers, physiotherapists and specialist nurses. $49.5 million was allocated over four years. Accountability requirements were not clear and it was not focused specifically on Mental Health Services. However, many Divisions chose to use it as a funding base for psychological services as their community-based needs assessments indicated that mental health was a high priority.

Better Outcomes in Mental Health Care Initiative (BOMHCI): was one of five Commonwealth General Practice Chronic Disease Initiatives - including diabetes, asthma, cervical screening, practice nurses and mental health - funded for four years under the 2001-2002 Federal Budget. It included five major components: incentive payments for GPs; education and training for GPs; MBS items for GP-provided "focussed psychological strategies" (FPS); access to allied health services; and access to psychiatrist support (case conferencing and emergency telephone support).

The Access to Allied Health Initiative: provided an initial $22.7m (ie an average of ~$5.68 mil. per annum) of the total $120.4million over 4 years to facilitate access to "Allied Health"professionals with "appropriate mental health competencies". 71 Allied Health projects have now been funded with assurances given that all Divisions who wish to participate will be included by 2004-5. Most projects have employed psychologists, different models being used around the country.

The figures above highlight a growing commitment to collaborative care for mental health disorders in Primary Care. This is an extremely positive development facilitating, in many locations, the use of best practice interventions involving psychologists with appropriate clinical skills. However, several issues emerge from these latest funding mechanisms for psychological intervention for high prevalence mental health disorders:

- the actual quantum of service delivery dollar allocated is **tiny** in comparison to allocations within the medical and pharmaceutical sectors. To provide an adequate complement to medical treatment approaches, a permanent, larger investment needs to be made and committed to;
- there is, in some places, an "ad hocery" about the models being supported under MAHS and BOMHC. Some have arisen primarily in response to the availability of "new" money being allocated through Divisions of General Practice, rather than out of best practice models and experience;
- a particular and continuing emphasis needs to be placed on providing incentives to build equitable service delivery frameworks for outlying metropolitan as well as rural areas (see section below).

<u>Rurality and Equity: A Snapshot of Some Rural Mental Health Issues:</u>

Given the overall reliance of Australia on the productivity of our rural regions, the mental health needs of those located on the outskirts of and/or outside the metropolis is crucial to the overall wellbeing and survival of the country.

Australia is a densely urbanised continent with approximately 1% of the continent containing 84% of the population. National trends have consistently highlighted the shift of people and services from rural to metropolitan areas. In 1911, 43% of Australians lived in rural areas. In 1976, 14% of the population was in rural areas. Current figures show a further decrease in rural population as a proportion of total population. The exact proportion varies from State to State. In NSW, the most populous state of Australia, there is a sizeable proportion of people (1,427,335 – ie 22.4% of total population) in rural areas (excluding the regional centres of the Hunter and Illawarra).

Particular risk factors and needs of rural people: People living in regional communities have particular risk factors and mental health needs associated with isolation and exposure to environmental hazards such as drought, flood and fire. The impact of drought alone has been found to lead to anxiety, depression, family breakdown, grief and anger. In addition, rural environments are often characterised by distance, specific occupational hazards, sparse infrastructure (including lack of health services) and risk-taking attitudes to health, illness and behaviour. These factors are associated with lower socio-economic status, hardship and risk exposure in early life, high levels of stress and job insecurity, low social support, ill health, addictive behaviours,

unhealthy food choices and other risky behaviours (eg dangerous driving practices). On average, Australian rural people are poorer and attain lower levels of education than people in urban areas. 56% of rural households fall into the two lower income quintiles, compared to 36% of capital city households and 45% of "other urban" households. (In rural and remote communities the cost of basic food is frequently up to 10% higher than metro and regional centres, giving a "double deprivation": lower levels of income combined with higher basic costs). Lower levels of education and higher levels of poverty are reflected in both physical and mental health status. Research findings suggest that rural and remote women are more exposed to violence in personal relationships than urban women; many are isolated without public transport. Physical and sexual violence against women are well documented as determinants of poor mental health. Compared to metro, rural/remote area males and females aged 20-29 are twice as likely to consume alcohol in hazardous or harmful quantities. Alcohol has been implicated in up to 50% of all suicides in Australia.. There is also a high level of gun ownership in rural areas. The factors outlined above combine to create what is termed ***'Social Exclusion'*** within a community, a shorthand term to describe what can happen when people or areas suffer from a combination of linked problems such as unemployment, poor skills, low incomes, poor housing, high crime, bad health and family breakdown. Social Exclusion disadvantages communities in many ways and rural communities are considered to be the most socially disadvantaged in relation to this global index. **Equity of access to services:** As is well known, recruitment to and retention of health professionals in small communities in regional, rural and remote Australia is a major challenge. Access to appropriate specialist mental health professionals is extremely limited once one moves beyond the main metropolitan centres. The establishment of a network of University Departments of Rural Health as well as Rural Clinical Schools across Australia has been one of a number of initiatives to assist the remedying of this imbalance. However, on the ground, availability of appropriately qualified and skilled personnel and services remains woefully inadequate.

Mental health specialties: Professions such as Psychiatry, Psychology, and even General Practice are largely absent in many rural and remote parts of the country. Base figures on the availability of appropriate mental health specialists are as follows:

a) Psychiatry: Most psychiatrists practising under Medicare are located in the "leafy" (ie well to do) suburbs of Sydney, Melbourne and Adelaide. Patients accessing these services are similarly concentrated in the higher socioeconomic level areas of metropolitan centres. This pattern is disturbing in light of psychiatry being the only mental health specialty publicly funded under Medicare.

Pychiatry in rural areas: It is hard to produce accurate data on the rural psychiatry workforce as numbers continually change. In 2000, it was estimated that approximately 4% of the nation's 2,000 psychiatrists lived and practiced in rural areas. The ratio of Psychiatrists to population in, for example, rural NSW is 1:10,000. The recommended number of available psychiatrists in rural NSW is 143. The actual number is 41. Data from South Australia suggests that there is only 1 rural resident Psychiatrist living outside a metropolitan area and Tasmania has 3 rural resident psychiatrists based at Burnie, with 3 vacant positions previously occupied by psychiatrists. Data from other States is not readily available although current information suggests distributions similar to NSW with the vast majority of psychiatrists living in metropolitan areas. There is a considerable number of outreach psychiatrists who provide services to rural areas in NSW, as well as in other States, some of these having the majority of their case load in rural areas whilst still living in a metropolitan area. Rural people often indicate that the "fly in/fly out" model of service delivery is inadequate, as there is little understanding of local issues and needs, frequent lack of availability and inadequate service continuity.

b) Psychology: In 2000, the estimated psychologist workforce in NSW consisted of 4,785.4 FTE (full time equivalents). 85.3% of psychologists were found to be located in Metropolitan Area Health Services, with Rural Area Health Services being the main job location for only 14.2% ie approximately 680. Current figures from the Australian Psychological Society (the peak professional body for psychologists) indicate that of a total membership of 12,635, 22% (ie 2,790) are located in regional, rural and remote areas. Of the nine specialist Colleges, 23% (ie 887) of the total of 2,981 members were found to be located in rural areas. Of those most relevant to mental health (the Colleges of Clinical, Clinical Neuro, Health, Counselling and Forensic) 24.9% of the total membership of 2,549 is indicated to be in rural areas.

In both rural and metropolitan areas, there are very few publicly-funded positions available for practising psychologists. The majority are to be found in academic positions, other institutions/environments and private practice. Access to psychological services is therefore skewed towards those who can afford to pay. This issue is not unique to rural areas alone. Throughout Australia, psychological services are not publicly funded under Medicare. Access is therefore exceedingly limited and inequitably available. Given that people in rural areas are both more prone to mental health risk factors and more likely to be in the lower socio-economic levels, this lack of appropriate, publicly funded services is of great concern.

c) General Practice In real terms, Community Mental Health Teams and GPs receive the brunt of formal mental health presentations in rural areas. However, waiting lists are long and costs for patients can be prohibitive as many GPs in rural areas do not bulk bill. Approximately 20% of GPs practice and live in rural areas. However, when one considers that, in rural NSW for example, there are 1.9 persons per sq. km. compared

to the NSW urban average of 96.1 persons per sq. km., service delivery issues and equity of access remain clearly unaddressed, despite the relative representation of GPs. Further, referral criteria for mental health interventions often focus on more acute and extreme mental health conditions leaving people with high prevalence disorders of depression, anxiety, stress and substance use frequently slipping through the net, their needs remaining unmet. (The latter issue is not unique to rural areas alone).

The Situation in Britain

In contrast to the situation here, the approach to mental health service delivery involving the collaboration between GPs and psychologists with appropriate clinical skills in Primary Care, has worked effectively in the U.K for nearly 30 years. As a consequence of the Trethowan Report in the mid 1970's, which advocated that clinical psychology be funded as a profession parallel to psychiatry under the National Health Service, clinical psychologists have worked extremely effectively with GPs in the Primary Care setting since that time, most recently under Primary Health Care Trusts.

Possible Future Directions in Australia:

Recent evidence also gives strong support to the model's efficacy in the Australian context, indicating that it provides an early intervention and prevention approach to ongoing mental disorders. We believe that serious consideration needs to be given to proactively resourcing a coherent, systematically implemented, collaborative workforce development model of clinical psychology in Primary Care. Funding of clinical psychology as part of the public health sector would augment the currently inadequate size of the psychiatric workforce. Many GPs also indicate that evidence-based, best practice clinical psychology provides a better collaborative complement to their work with patients with mental disorders and/or psychological difficulties, than another medical specialty which may, in some ways, duplicate what they already do.

Public funding of clinical psychology could either be via salaried positions located in, for example, Divisions of General Practice servicing a number of General Practices, or directly within the Practices themselves, (with a full career structure parallel to psychiatry, as in Britain) or through time-limited, accountable Medicare funding for evidence-based, short-term interventions (six, plus six if needed, sessions). We believe the latter could be provided **without** cost blowouts, if similar accountabilities for time-limited, effective treatment were implemented for other mental health specialists currently funded under Medicare.

What is needed is a consistent funding framework for the systematic roll out of a generic, collaborative model that works - with clear, best practice guidelines and central quality control mechanisms in place to ensure the early intervention and prevention approach to mental health disorders has the best treatment outcomes possible.

PROPOSAL:

In light of the issues outlined above, we request that the 2004 Health Budget provide resourcing for the collaborative model of Mental Health Service Delivery in Primary Care involving psychologists with appropriate clinical skills working collaboratively with GPs to treat high prevalence mental health disorders. Serious consideration needs to be given to articulation of this training and workforce development framework across the country, involving short-term, focused psychological interventions for mental health disorders and psychological dysfunction parallelling/resulting from chronic illness. The approach provides an early intervention and prevention framework focused on empowering people in the face of the increasing stress and dysfunction of daily life and escalating incidence of Common Mental Disorders.

This is not a "cost blowout" proposal. It is envisaged that the savings inherent in the approach (eg. from decreased PBS dependence, decreased use of GP medical consults, prevention of more serious disorders requiring hospitalisation) would more than pay for this new specialist service delivery framework. It is also suggested that, if similar accountabilities for short-term, outcome-oriented interventions were required of other mental health specialists, then cost shifting would facilitate at least a break even model.

PROPOSAL FRAMEWORK:

1) **Training Model: Articulated training framework for Clinical Psychology Registrars across the country: Total Cost per annum = $2,085,000 per annum**
2) **Psychology and Primary Care Research, Training and Development Centre: Charles Sturt University: Cost per annum: $860,480.14**
3) **Workforce Development Model for fully qualified Psychologists with appropriate clinical skills employed within Divisions of General Practice throughout Australia: Cost per annum: $18,603,000**

(Costs are done on a per annum basis. It is suggested, **to ensure service continuity at Primary Care level, that the funding framework initially be for a five year period** (renewable if evaluation indicates positive health outcomes are achieved, as in line with current research).

1) TRAINING MODEL:
(similar to that provided by GPET for GP Registrars)

a) Training and Registrar Service Delivery Framework

180 Clinical Psychology Registrars to be trained per annum in Mental Health Service Delivery in Primary Care

- 30 training University provide post-graduate training in Clinical Psychology (MPsych/Dpsych) with (on average) ~10-15 students per annum graduating per University (total enrolled students=~ 620);
- 6 stipended internships for Clinical Psychology Registrars would be provided (via fund holding in local Divisions of General Practice) per University (ie total of 180);
- Number of patients treated per placement: 20 (MPsych) – 30 (DPsych): using the 6 (plus 6 if needed) session treatment framework (total no. of patients treated= ~3600);
- Stipends are currently funded at $150 per day: ie $5,250 per 7 week (full-time) placement (Internships can also be done part-time over 12 or 18 weeks);
- Provision of incentives for rural primary care placements are required (eg. $7,000 per placement): Assume 30% of placements;

Total cost of stipends across the country (if full up-take is achieved) = $1,050,000
Number of students trained in best practice Primary Care Mental Health Service Delivery: 180 per annum
Total number of patients treated (assuming 20 pts. per placement) = 3,600
Cost per patient = $292 (for a six (plus six if needed) session treatment framework)

b) Supervision Framework:

- Supervision payment (via fund holding at Divisions of GPs) = $34,500 per University to cover the 50 hours face to face supervision for each of the 6 stipended students required by APS College of Clinical Psychologists Supervision Guidelines (ie 300 hours face to face, plus large administrative component in getting placement arrangements underway)
- **Total cost = $1,035,000**
- This will be an interim cost for the first two years whilst workforce development initiatives are implemented (see below).
- Adjusted cost per patient = $579.50 (including supervision costs) – again for the six (plus six if needed) session treatment framework.

Supervision will eventually be undertaken by psychologists with appropriate clinical skills employed in Divisions of General Practice to work clinically in Primary Care and to coordinate training and service delivery at Division level (see Section 3: Workforce Development Model). Hence cost savings on supervision will be factored in after the first two years.
NB. Uptake at Universities may be "staggered" (ie it is unlikely that all 30 training institutions will "come on board" by the first year).

TOTAL COST OF TRAINING FRAMEWORK = $2,085,000 per annum
(inclusive of Supervision Framework which will become redundant once workforce development is underway – see below).

2) PSYCHOLOGY AND PRIMARY CARE RESEARCH, TRAINING AND DEVELOPMENT CENTRE:

CHARLES STURT UNIVERSITY

(similar to that provided by GPET for GPs)

The proposed Centre would coordinate and facilitate a national training framework for Clinical Psychology Registrars through Divisions of General Practice across Australia. Involving the 30 training Universities currently running post-graduate training in Clinical Psychology, the Centre would provide best practice guidelines for the training and supervision of Clinical Psychology Registrars undertaking psychological service delivery in General Practice. The Centre would establish cumulative, national data sets in relation to psychological interventions with high prevalence disorders and develop treatment modules relevant to the presentation of specific mental disorders and chronic diseases with psychological sequelae in the Primary Care setting.

The aim of The Centre would be to:

- Coordinate research and evaluation data from across the country on an ongoing basis;
- Evaluate the collaborative model in terms of patient outcomes (pre and post results relevant to interventions);
- Assess GPs' mental health training/service delivery needs; their attitude to the model, requirement for case conferencing, further supervision etc;
- Develop generic treatment modules/frameworks specific to different patient mental health needs and required GP areas of need/expertise in mental health service delivery (eg; anxiety, depression, comorbidity, personality disorders, ageing and mental health needs, chronic disease and associated psychological conditions, assessment as well as evidence-based practice, focused psychological interventions etc);
- Provide training frameworks for Divisions of General Practice, GPs and Universities for the development/implementation of the collaborative model;
- Prevent each new location/Division of General Practice to which the framework is articulated having to "reinvent the wheel";
- Ensure cumulative "Knowledge Capital" is accrued re: this early intervention and prevention approach to mental health disorders, rather than be "frittered away" through lack of central integration;
- Ensure that an integrated, systematic framework (with sensitivity/responsiveness to local needs) for the national development of a Psychology in Primary Care Model for the treatment of Common Mental Disorders is facilitated.

Total Cost = $ per annum

Staff:		
Director		$130,554
Professorial Consultant re: research & model development		$52,221.60
Senior Lecturer (Training/Module Development)		$97,055
Senior Lecturer (Research)		$97,055
Research Assistant/Data Analyst		$66,869
Administrative Assistant		$59,989
(All salary costs inclusive of 25.8% "on costs")		
	Total:	**$503,743.60**
Consultancy Fees:		
Health Economist		$30,000
International Experts		$25,000
	Total:	**$55,000**
Administrative:		
Accommodation/rental:		$30,000
Travel:		$85,000
(to cover training in DGPs across the country)		
Administrative Expenses:		$51,500
Promotion/PR/Printing:		$23,000
	Total:	**$189,500**
		$748,243.60
University Infrastructure Levy		$112,236.54
TOTAL:		**$860,480.14**

3) WORK FORCE DEVELOPMENT MODEL

This of course would be facilitated by the appropriate professional organisations: Australian Divisions of General Practice in close consultation/collaboration with the Psychologists' Registration Boards and the Australian Psychological Society.

One Clinical Psychologist/Psychologist with appropriate clinical skills employed per Division of GPs across Australia. In the larger 50% of Divisions of General Practice where there are a large number of General Practices/GPs to service, two salaried psychologists are needed.

These positions will provide:

- pro bono service delivery/patient assessment and treatment in a number of key General Practices within the Division's region;
- supervision for trainee Clinical Psychology Registrars undertaking placements/providing service delivery within additional General Practices within the region
- supervision, case conferencing and educational frameworks for local GPs around "focused psychological interventions";
- group treatment programmes, where appropriate, for high prevalence disorders.

Salary average: $95,400 per annum (inclusive of 25% on costs); average based on Senior Psychologist (range: Basic Grade to Consultant Clinical Psychologist as in Britain.)

COST:
$12,402,000 per annum to employ one psychologist with appropriate clinical skills per Division
$6,201,000 to employ an additional psychologist in 50% of the larger Divisions
TOTAL: $$18,603,000

CONCLUSION:
Currently, mental health service delivery in Australia is fragmented between both Federal and State systems with little systematic integration across jurisdictions. Considerable fragmentation/lack of integration also occurs at State levels where few systematic frameworks are in place to ensure equitable access to early intervention and prevention appropriate to patients' needs.

The current proposal suggests that Primary Care and General Practice (the venue through which the vast majority of the population seek and receive general health care) should be the framework through which a **systematic approach to mental health service delivery** takes place. Current research evidence suggests that best practice psychological interventions are the treatment of choice for early intervention and prevention of Common Mental Health Disorders. The proposal above outlines an integrated framework by which this approach could be implemented.

If undertaken in advance of current projections of escalating incidence of mental disorders in our population, this model would place Australia at the forefront, with a number of other currently more advanced countries, of best practice mental health service delivery at Primary Care level in the world.

R.F. Vines
D.M. Thomson

(20th November, 2003)

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****We are exceedingly grateful to the Australian Psychological Society for their generous permission to quote and paraphrase a number of recent APS documents on mental health service delivery in Australia. Particular thanks are due to Dr. Lyn Littlefield, Chief Executive Officer and Mr. David Stokes, Manager, Professional Practice for their assistance.**

NSW Central West
Division of General Practice Ltd
ABN 41 062 949 553

Wednesday 10th December, 2003

The Honourable Tony Abbott MP
The Federal Minister for Health and Ageing
Parliament House
Canberra 2600

Dear Minister,

Clinical Psychology in Primary Care:
An Early Intervention and Prevention Approach to
Common Mental Disorders in General Practice

We are writing to offer our fervent support for the Proposal sent to you by Ms. Robyn Vines, Clinical Psychologist, and Professor Don Thomson on Thursday 20th November. Their proposal outlines a way of expanding, on a national level, the model of mental health service delivery which has worked extremely effectively in Bathurst and in a number of other regions for several years.

Since 1998, Ms. Vines has worked jointly with the NSW Central West Division of General Practice to develop a collaborative model of mental health service delivery that is able to genuinely assist general practitioners (GPs) to meet the needs of their patients. Routine surveys of our Members over the last few years have constantly highlighted that probably the greatest challenge for GPs in our region is effectively dealing with the huge number of patients presenting to them with mental health problems. This problem, of course, reflects current estimates that mental disorders such as depression are on the increase and are expected to be the greatest burden of disease worldwide by 2020. However, in our rural region, these patient demands simply cannot be met by the almost non-existent mental health services available in country NSW. In a desperate attempt to assist GPs to manage this demand, Ms. Vines has worked with the Central West Division to develop a collaborative model of care that brings together GPs and Clinical Psychologists/supervised trainee Clinical Psychologists to provide high quality, evidence-based, cost-efficient care to patients presenting with common mental health disorders.

An explanation for our passionate enthusiasm for the collaborative model is warranted. Clinical research literature overwhelmingly indicates that for most depression and anxiety disorders, psychological treatments are as effective as medication and more effective in the long term (Australian Psychological Society, 2000). Moreover, a number of psychological treatments have been shown to be effective in the treatment of depression, anxiety and substance abuse in adults, and disruptive behaviour disorders, anxiety disorders and depression in children and adolescents (APS, 2000). Unfortunately, these treatments are rarely available to most Australians, and particularly those living in rural regions such as the Central West. It seemed to us, therefore, that best practice in the treatment of the common mental health problems presenting to our GPs, would be to ensure that GPs could work jointly with clinicians skilled in the delivery of evidence-based psychological treatments in the primary care setting. Such a model recognises the efficacy of GPs in dealing with less complex mental health presentations but provides the expertise required for managing more complex presentations that cannot be effectively dealt with in the busy working day of the average GP.

We believe that our collaborative approach to the provision of mental health service has been highly successful. Empirically, we have shown that the collaborative model of care has a significant and positive impact on patients' mental health and well-being (Vines, Thomson, Richards, Brechman-Toussaint, & Vesely, 2003). GPs report that the model of intervention has helped them move forward with many of their

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most difficult clients and develop a collaborative team approach (sometimes including the patient) in doing so. We have attached a letter that was written to the Department of Health and Ageing by one of our Central West GPs (Dr Coral Morris) in response to the reduced funding of the AAHS pilot projects in the second and third year of the programs. The letter typifies the sort of "working day" experienced by many rural GPs, and no doubt many urban GPs, who struggle with the enormous mental health demands that present to their practice. As Dr Morris points out:

> It is essential that GPs … continue to have the backup of the current number of psychologists. If anything, these services should be increased. To curtail our ability to refer appropriately to local psychologists will do immense harm to patients, families and the social fabric. It will make medical practice difficult and in some respects impossible. It will unnecessarily impose an economic burden on us, as those who with appropriate psychological support might be working, remain unemployed.

Dr Morris' latter point is an important one as the economic burden of failing to provide adequate psychological services to Australians can only worsen if the Commonwealth fails to act on improving mental health services. Financial savings can be made not only in terms of restoring the health to people who are functioning poorly in society due to their psychological ill health, but also in terms of a reduced burden on the health system. Our GPs report that many of their patients who are seen by psychologists in the general practice setting require GP services far less frequently following psychological treatment. Indeed, patients report extremely high levels of satisfaction with the service; they appreciate the team approach to their care and the ease/reduced stigma of receiving treatment in the GP Practice.

It is also important to point out that the Central West Division currently provides psychological services to general practice under both the Commonwealth-funded More Allied Health Services (MAHS) and the Access to Allied Health Services (AAHS) (a Better Outcomes in Mental Health Care Initiative) programs. The collaborative model of service outlined in Ms. Vines Proposal is in fact based on the *Clinical Psychologists in General Practice* model that forms one component of our AAHS pilot project. Although both the MAHS and AAHS projects have been successful in providing general practice with increased access to psychological services, their implementation has been fragmented across Australia and of greater concern, is the lack of quality control and poor risk management that currently exists in most of these program. Ms. Vines' proposal will address these pitfalls by providing a standard model across that nation that has a high level of clinical supervision and risk management built in to the model.

We strongly support the recommendation in Ms. Vines' Proposal that this collaborative model of treatment of mental disorders be articulated across the country, providing equitable access to psychological services (particularly in country areas where access to specialist help is so badly needed). We would also welcome an opportunity to discuss the model with you and hope that you may be able to visit the Division in the near future to see how it works.

Please don't hesitate to contact us if you need further information.

Yours sincerely,

Dr Louise Roufeil PhD, MAPS
Program Director

Ms Sandra Christensen
CEO

CC. The Honourable John Anderson MP, Deputy Prime Minister
The Honourable Julia Gillard MP, Shadow Minister for Health and Ageing
The Honourable John Murphy MP
Mr. Dermot Casey, Assistant Secretary, Health Services Improvement Division

Dr Coral Morris,
Bowenfells Medical Practice,
7 Colonel Drew Drive,
Lithgow, 2790,
N.S.W.
14th October, 2003.

Dr Stephen Castle,
Director, Partnerships in Service Reform Section,
Mental Health and Suicide Prevention Branch,
Department of Health and Aging,
GPO Box 9848,
Canberra.

Dear Dr Castle,

re: Availability of Psychological Support Services in Central West NSW

I am a rural GP registrar. My husband has urged me to write this letter to you. I had thought when I planned to write a submission to you, that I would have all my usual passion and energy for this subject that is so close to my heart, but instead I find myself flat and dejected. I feel that the subject is so enormous that I don't know where to start describing the problem.
I have very recently found out that the funding for the Central West Division of General Practice pilot scheme for the 3 step mental health process has been drastically reduced because money could not be 'rolled over' from one financial year to the next. Consequently we are going from five psychologists to whom we could refer patients over several days a week, to one psychologist one day a week. I am told that she will be able to see a maximum of 5 clients a day.
On Monday I saw 10 patients. Seven of them were mental health patients with whom I spent 40 minutes or more each. Here are the profiles of these patients:
- One seriously stressed and out of control father.
- His very depressed and angry son followed.
- One raped, and possibly psychotic,16 year old girl.
- One victim of serious physical, mental and emotional domestic violence with social phobia and depression.
- One depressed and hopeless young woman about to enter a marriage she doesn't want, to have children she is not ready for, because her self esteem is so low that she doesn't see any alternatives for herself.
- One case of depression and obsessive-compulsive disorder who is about to walk out on her husband and family, and is contemplating ending her life.

Clearly many of these problems require urgent and ongoing attention.
During the day I was consulted by a colleague on the best course of action to take for a patient whose ex-husband is a policeman who regularly returns to the family home to beat her up, and has threatened that things will get much worse for her if she reports him because his police colleagues will support him, and she will have no one to protect her from him.

I spent the last 2 hours of my working day writing 5 referrals to a paediatrician for the five children in a family with severe behavioural problems, which include ADHD, oppositional-defiant disorder and depression. Their mother has depression, anxiety and post-traumatic stress disorder, and problems with control of impulsivity and anger. Their father has recently declared himself to be homosexual, and after a brief stint away from home, is now back with his family and trying to find a way to cope with it all.
This is the psychological coalface of Lithgow.
How does the withdrawal of psychological services affect our patients? Even with 5 psychologists available, patients were reporting a wait of several weeks before getting an appointment.
However the good news is that the system really works.
- Take the widow of a volunteer bush fireman, her soul-mate, killed in last years fires, who has received regular counseling and support, and who rates it as the most valuable factor in helping her to cope with her grief at the same time as continuing to raise her now fatherless baby.
- Then there is the 18 year old with depression and self-harming behaviour, who managed to get her HSC, and with improved self-esteem via cognitive behavioural therapy was able to obtain work in a solicitor's office where she is a great success and will shortly be promoted.
- How about the young husband with anti-social personality disorder and un-diagnosed ADHD who is now learning how to communicate with his wife other than by beating her. They have been back together 5 months with none of the weekly beatings she received prior to psychological intervention. He has also managed to get a job and hold it.
- Or the depressed, socially-phobic woman who has gone back to work for the first time in years.
- The young woman with a history of depression and childhood sexual abuse who has started a car-detailing business.

The intervention and support we were able to offer our patients were immeasurably valuable to both the patients and society - so clearly the fence at the top of the cliff.
How has the reduced funding affected me as a rural GP?
I feel abandoned. In good faith, with the understanding that there would be psychologist back-up, I undertook the necessary training to be able to diagnose and treat psycho-social problems. I have been overwhelmed by referrals from my GP colleagues, allied health workers, and from patients who have heard on the grapevine that I'm one to see for psychological and emotional problems.
I recently formed an arrangement with a local primary school headmaster, to assess problem children threatened with expulsion following multiple suspensions, with their parents consent, so that they can be referred for paediatric, psychiatric and psychological intervention. This would clearly be extremely useful in attempting to avert disaster for the children, their families and society. But there are many children in this situation, and too few psychologists employed by the Department of Education to deal with these numbers. I enclose a letter from one 8 year old who we were able to offer intervention to, who was about to be expelled. This would have meant leaving the safety of his grandparents home, to return to live with his violent, personality- disordered father. With support and psychological strategies, he is attempting to change his behaviour.

Sometimes I long for a working day of coughs, tummy pains, ankle sprains and vaccinations, but here's how it is: An urgent appointment request - this lady has been loosing hair for a couple of months. A careful examination – no obvious abnormality, reassurance follows –" This is probably a simple, self-resolving case of telogen effluvium" I say.
" Or perhaps it's just the stress." says the patient.
Response 1] "Could be stress," says I.
" Come back in 6 weeks if the hair is still falling."
Response 2] " Tell me about the stress……"
Anyway, back to the coalface, I've just checked my appointments for tomorrow:
9.00 Anxiety disorder
9.10 Depression and panic attacks
9.30 Relationship problems
10.00 Childhood sexual abuse/alcoholic father
10.10 Anorexia, depression, PTSD
10.40 ???????????? A sore throat???????????
11.10 Depressed child
11.20 Ovarian cancer counseling
11.40 Bipolar disorder, PTSD, childhood sexual abuse
12.10 Depressed mother of the 5 behaviourally challenged children previously mentioned.
12.30 Depressed, chronic pain, childhood sexual abuse……
I'm a female GP, I'm needed in the country, but if I'm not to turn into a sort of pseudo-psychologist, and if I am to be able to exercise my GENERAL medical skills, then I need adequate [as I define it] back up, because I'll never be able to NOT ask the question "Tell me about the stress……"
I believe it is essential that GPs in my area continue to have the backup of the current number of psychologists. If anything, these services should be increased. To curtail our ability to refer appropriately to local psychologists will do immense harm to patients, families and social fabric. It will make medical practice difficult and in some respects impossible. It will unnecessarily impose an economic burden on us as those who with appropriate psychological support might be working remain unemployed.

Thankyou for reading and considering my submission.

Yours sincerely,

Dr Coral Morris
MB ChB, DRACOG

Copies: Louise Roufeil, Central West Division of General Practice, NSW

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11 December 2003

The Honourable Tony Abbott MP
The Federal Minister for Health and Ageing
Parliament House
CANBERRA 2600

Dear Minister

Clinical psychology in primary care:
An early intervention and prevention approach to
Common mental disorders in general practice

We are writing in strong support of the proposal sent to you by Clinical Psychologist, Ms Robyn Vines and Professor Don Thomson on Thursday 20th November. In it, they outline a way of articulating the model of mental health service delivery which has worked extremely effectively in our Region, and in a number of other Regions across Australia, since its trial commenced in January 2001. The model has in fact worked well in Bathurst since 1998, was formally launched here in 1999 by the Honourable John Anderson (we participated with enthusiasm in the ceremony!), and has grown considerably since that time.

The involvement of our Practice has been primarily in hosting a number of Clinical Psychology Registrarships (a total of five now) and in liaising with Ms Vines in developing the collaborative model of mental health service delivery which we and the patients have found to be both beneficial and effective. All five registrars have been excellent:enthusiastic and keen, extremely nice young people and, above all, expert and "evidence-based" in their application of psychological techniques in treating patients in our practice. Each internship has entailed the assessment and treatment of approximately 20 patrients (a considerable undertaking within a short-term internship) and working closely with us to ensure best patient treatment outcomes. This has enabled ongoing support on our part for the patient once the Registrars' involvement has ceased. We have been pleasantly surprised at how helpful we have found the collaborative model. The large majority of patients (nearly 100 now) have found the therapy to be of considerable and permanent benefit. We, of course, as GPs continue to see these patients (often much less frequently once these treatments have been undertaken) and we have observed that the positive outcomes in relation to their mental health issues are frequently sustained without further specific intervention.

From our own point of view as busy country GPs, the collaborative approach has been invaluable. Mental disorders/mental health issues form a large part of our extremely pressured practice (either on their own or in conjunction with chronic disease or other physiological illness) and the presence of appropriately qualified psychologists on our team and working within our Practice has enabled us to provide best practice treatment for patients presenting with these conditions (either prior to use of prescription medication or as a necessary adjunct to medication). These patients are often our most difficult and time consuming and to have ways of dealing more effectively with them has been a huge help. They are also, at times, our most demoralising clients, as their conditions often seem intractable. This new model of intervention has helped us move forward with some of our most difficult clients and develop a collaborative team approach (sometimes including the patient) in doing so.

We strongly support the recommendation that this collaborative model of treatment of mental disorders be articulated across the country, providing equitable access to psychological services (particularly in country areas where access to specialist help is so badly needed). We would also welcome an opportunity to

discuss the model with you and hope that you may be able to visit Bathurst in the near future to see how it works.

Please don't hesitate to contact us if you need further information.

Yours sincerely

Dr Ross Wilson
Senior Partner
George Street Medical Practice
RACGP GP of the Year (2003)

Dr Debbie McClure
Senior Partner
George Street Medical Practice

RUSSELL STREET MEDICAL CENTRE

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An Accredited General Practice

5th December 2003

The Honorable Tony Abbott
Minister for Health and Aging
Parliament House
CANBERRA NSW 2600

Dear Sir,

Submission: Clinical Psychology in Primary Care, An Early Intervention and Prevention Approach to Common Mental Disorders in General Practice.

I am writing to support Ms Robyn Vine's proposal for a model of using Clinical Psychologist in General Practice in order to lessen the burden of mental illness in our communities. I have had the privilege of being able to develop this model over the past 5 years with Ms Vines and the Dept of Psychology at Charles Sturt University. After 5 years of working with the model I feel that:

1. The brief intervention clinical session model (6 + 6) speeds recovery and reduces the need for medication in anxiety and depression disorders.
2. Working collaboratively with clinical psychologists helps enormously in my understanding of mental health issues.
3. It is well received by our patients who generally feel that they benefit from the model.

The use of psychology registrars has been highly successful. I find them to be highly motivated and skilled professionals who add to our team during their stay. The patients like the fact that they are seeing the psychologist in a familiar and non-threatening setting and treat them like another doctor in the practice. They also like the system of being offered an alternative therapy to medication then being introduced to the psychologist by their doctor and their problem briefly explained to the psychologist.

A system for ongoing funding of the present scheme and expansion of the scheme to other practices is essential. The registrars must be adequately remunerated to retain the high quality practitioners that we have had.

Yours faithfully

Dr Colin Jamieson

RUSSELL STREET MEDICAL CENTRE

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An Accredited General Practice

5th December 2003

The Honorable Tony Abbott
Minister for Health and Aging
Parliament House
CANBERRA NSW 2600

Dear Sir,

Submission: Clinical Psychology in Primary Care, An Early Intervention and Prevention Approach to Common Mental Disorders in General Practice.

We are writing this letter in strong support of the articulation of government supported clinical psychological services throughout Australia.

We are rural General Practitioners who have been living and working in the Bathurst community for many years. During this time we have become increasingly involved in the delivery of Mental Health services to our patients for a number of reasons. Over this time the population has increased significantly. The number of Mental Health problems seen by us in clinical practice has also increased proportionately. We have only one psychiatrist and a small Mental Health Team to manage a population of over 23,000 people. They are overworked and over-stretched as they deal with more severe and chronic mental health issues such as Schizophrenia, Bipolar Disorder, Self-harming and suicidal patients. Their practices are limited to these conditions and do not entail the short term, focussed intervention needed by most patients.

The vast majority of Mental Health issues dealt with in the community are the more acute reactive problems such as anxiety, depression, post-natal depression, panic disorder, school and social phobias to name a few. Statistics (ABS 2001) show that 18% of all Australians suffer from at least one mental illness in a one year period, and that up to 20% of all Australians will have one severely disruptive episode of mental illness in their lifetime. This is reflected day in, day out in our practice where it is not uncommon to have days where up to at least one in three consultations are related to a Mental Health problem. The pressures in rural areas are worse with factors such as unemployment, drought and family and social isolation coming into play.

Over the last few years, encouraged by the Federal Government, we have undertaken further training in the Mental Health area so that we can access the Psychology in General Practice services. Since 1998 this has been provided by the Clinical Psychology in General Practice Project and latterly under

the Better Outcomes in Mental Health Care Initiative. This has proved invaluable to our patients who are able to be identified early in the course of their “dysfunction”. They are managed with timely intervention through prompt referral to a psychologist for appropriate assessment and time-limited therapy. There is always the expectation of a return to an improved level of functioning in a specific given time, usually less than 3 months. The patient is managed in a respectful and confidential manner and feels a great sense of relief and optimism as he/she is supported by a “team” approach. The vast majority of patients are not in a socio-economic position to pay for these services themselves.

The ongoing support by the Federal Government of the Better Outcomes in Mental Health Initiative and Psychology in General Practice Project is vital! As practitioners working at the “coal-face” we know that this initiative works. It is cost-effective and it reduces the long-term burden on the health dollar. This is to say nothing of the sense of relief felt by already over-pressured rural GPs as they feel supported and remunerated by an empathetic and caring Federal Government!

Yours faithfully

Dr Bernadette Droulers _____

Dr John Sandra _____

Dr Colin Jamieson _____

Dr Ian Thong _____

c.c.: The Honourable John Anderson MP
The Honourable Julia Gillard MP
The Honourable John Murphy MP
Mr Dermot Casey

THE CLINICAL PSYCHOLOGY IN GENERAL PRACTICE PROJECT:

Developing a new Collaborative Model of Mental Health Service Delivery involving Clinical Psychologists in the General Practice setting.

Vines, R.F., Thomson, D.M., Richards, J.C., Brechman-Toussaint, M. and Vesely, L.

Thanks are due to the Commonwealth Department of Health and Ageing for their generous support of this project over four years: 2001-2005

OVERVIEW:

The Clinical Psychology in General Practice Project is developing a Collaborative Model of Mental Health Service Delivery involving the placement of Clinical Psychologists in the General Practice setting. The Project involves Clinical Psychologists/Clinical Psychology Registrars from Charles Sturt University (CSU), Ballarat University, the University of New England and University of Newcastle piloting the provision of psychological services in a number of General Practices in three regional areas of NSW and Victoria.

During the two-year course of Phase 1 of the Project, 19 Clinical Psychology Registrars have been trained in the primary care setting. Their placements have entailed:

- observation of General Practitioners, sessions with patients;
- assessing, diagnosing and treating approximately 20-30 patients each in the primary care setting;
- analysing patient pre and post treatment results;
- making qualitative observations of the Model and of the General Practice setting during the course of the placement.

HISTORY of the PROJECT

The Project originally began in late 1998. Initial observations by a Senior Clinical Psychologist (R.V.) of two General Practitioners in Bathurst indicated that between 40-60% of patients presenting in random sessions had some psychological dysfunction. It was decided to pilot the co-location of Clinical Psychology services in the General Practice in an attempt both to treat adequately the patients' conditions and to relieve some of the pressure on GPs in dealing with patients' mental health difficultie . Service delivery was established one morning per week by the Senior Clinical Psychologist, and an initial placement was carried out by a Senior Academic at CSU.

The Project was formally launched in 1999 by the Honourable John Anderson, then Minister for Transport and Regional Services. Commonwealth Department of Health and Aged Care (DHAC) funding of Phase 1 of the Project commenced during 2001 with the placement of four Clinical Psychology Registrars in two Bathurst Medical Practices. It was decided also to trial the model in a rural, single doctor practice township (Rylstone). One of the Clinical Psychology interns from CSU completed placement requirements at Rylstone and now provides ongoing psychological services to the townships of Rylstone and Kandos under the More Allied Health Services (MAHS) funding.

Additionally, with the approval of DHAC (now CDHA), a trial of the concept in a remote location using video conferencing facilities was established. A CSU intern has completed an out-reach placement to Trundle and Tullamore, and the NSW Central West Division of GPs (CWDGP) is now supporting ongoing psychological service provision, again under MAHS funding.

In parallel with the rural and remote placements established by CSU and the CWDGP, trials in Ballarat and Armidale commenced in 2002.

Further funding under the Better Outcomes in Mental Health Care (BOMHC) Allied Health Initiative has enabled the trial of four different funding models for psychological services found to be feasible in the Clinical Psychology in General Practice Project:

- Clinical Psychology Registrar stipends;
- Salaried positions within Divisions of GPs;
- Patient voucher systems;
- Direct funding for group treatment programs.

Psychological services are now being provided to Forbes and Parkes, Oberon, Lithgow and Orange, as well as further services in Bathurst. In the Central West of NSW, nine rural towns now have access to publicly funded psychological services under BOMHC and MAHS, with similar services being provided in Ballarat, Victoria and Armidale, NSW. From extremely small beginnings in 1998, quite wide articulation of this model of collaborative mental health service delivery has occurred.

AIMS of the PROJECT are to:

- Service patient needs in rural locations where access to specialist help is often limited;
- Facilitate early intervention, thereby preventing both the development of greater severity of the preventing condition and greater frequency of use of medical services;
- Support GPs with the diagnosis, management and treatment of patients presenting with:

a) psychological issues;
b) physiological issues with a psychological dimension;

- Support ongoing Continuing Medical Education for GPs 'in situ' by providing learning outcomes for GPs whilst working collaboratively with the profession of Clinical Psychology;
- Develop appropriate funding models to facilitate ongoing provision of this method of service delivery in locations where fee paying may not be a viable source of monetary support;
- Provide an innovative generic model of mental health service delivery which can be articulated nationally;
- Offer training opportunities for post graduate students in Clinical Psychology.

THE COLLABORATIVE MODEL:

- Provides Clinical Psychology services in the Medical General Practice setting, preventing the need for articulation of treatment to another specialist setting, thereby minimising patient attrition.
- Enables "in-house" referral of patients whom the General Practitioner feels could benefit f om psychological intervention.
- Entails an initial joint session between the patient, General Practitioner and Clinical Psychologist at the commencement of the psychological assessment and treatment.
- The Clinical Psychology Registrar provides pro bono services within the General Practice. The first session is Medicare rebateable enabling payment of the GP.
- A six (plus six if needed) session treatment model applicable to high prevalence disorders of anxiety and depression.
- Ongoing face-to-face consultation between GPs and Clinical Psychology Registrars on both an informal and formal basis. Informal consultation is facilitated by co-location on the same premises.
- Formal Case Conferencing using new EPC (Enhanced Primary Care) items.
- Ongoing feedback to the doctor.

THE CLINICAL PSYCHOLOGY IN GENERAL PRACTICE PROJECT

RESULTS

TREATMENT PATIENTS.

276 patients have received treatment through the Clinical Psychology in General Practice Project (74% (206) female, 26% (70) male). 66% of patients (181) completed all pre- and post-intervention measures: the Depression Anxiety and Stress Scale (DASS), General Health Questionnaire (GHQ) and General Well-Being Index (GWBI) (73% (133) female, 27% (58) male).

At the time of initial assessment:

- 48.7% (88) scored within the extremely severe (36.5%) or severe (12.2%) range for anxiety;
- 49.2% (89) scored within these ranges (32.6% and 16.6%) for depression;
- 42.5% (77) scored within these ranges (20.4% and 22.1%) for stress.

(There is a degree of comorbidity within these disorders.)

- 29.8% of patients (54) scored within the normal range for anxiety, 21.5% (39) for depression, and 24.3% (44) for stress, suggesting either an unnecessarily high referral rate by GPs, or that the measures were not picking up on conditions that GPs assessed clinically.

After treatment, average scores significantly decreased on all DASS measures and the GHQ, and increased on the GWBI from pre- to post-intervention, indicating a positive change for patients (see Table 1).

Table 1. Pre and Post-Test Comparisons for Treatment Participants.
NB. This includes only those participants who completed both pre and post-test measures.

		Pre	Post			
	n	Mean (SD)	Mean (SD)	Dif.*	t	p
DASS Depression	176	20.38 (12.03)	7.30 (9.49)	13.08	14.57	<.001
DASS Anxiety	177	15.03 (10.95)	6.40 (8.04)	8.63	12.20	<.001
DASS Stress	177	22.71 (10.86)	10.56 (10.12)	12.15	14.63	<.001
GHQ (Total)	173	39.35 (17.05)	17.54 (14.12)	21.81	16.71	<.001
GWBI	178	36.27 (15.93)	59.12 (16.56)	-22.85	-16.34	<.001

*** Difference Score ; SD Standard Deviation.**

Summary Findings:

•The post-treatment measures were significantly different on all scales (at the 0.01 level or greatest). This difference indicated a positive change in the Mental Health of the patients.

The percentage of patients scoring in the extremely severe/severe ranges decreased from 49.2% to 10% (89pts/18pts) for depression, 48.7% to 12.2% (88pts/22pts) for anxiety, and 42.5% to 10% (77pts/18pts) for stress. The number of patients scoring in the normal range increased to: 76.7% (138) for depression, 69.6% (126) for anxiety, and 74.4% (134) for stress.

CONTROL PARTICIPANTS.

A control sample was recruited through the same General Practices by asking patients who were not referred by their GP if they would complete the same measures as those receiving the treatment. They were then requested to repeat the measures eight weeks later (approximately the time interval for those receiving the therapeutic intervention). Due to the usual difficulties associated with postal surveys and control recruitment, this sample is smaller than the treatment population, with a total of 198 participants. Of these, 66% (129) were female, 34% (69) were male. Of these, 49% (97) completed both pre- and post-interval measures (69% (67) female, 31% (30) male).

Obviously, recruiting controls was an extremely difficult procedure, and ethically presented us with a limitation. Any participant recruited for the control condition who scored extremely highly on the measures was immediately referred to a Registrar for treatment. This ethical obligation resulted in a control group whose average pre-scores differed significantly from those of the treatment group. The vast majority of participants in the control condition scored in the normal range on the DASS Depression, Anxiety, and Stress scales (70.0% (63), 67.0% (61), and 70.3% (64) respectively). (See Tables 2 and 3.)

COMPARISON BETWEEN TREATMENT AND CONTROL PARTICIPANTS AVERAGE SCORES.

Table 2. Comparisons between Pre-Test Results of All Control and Treatment Participants.
NB. This includes those who did not complete the post-measures.

	Control		Treatment				
	n	Mean (SD)	n	Mean (SD)	Dif.*	t	p
DASS Depression	192	8.72 (10.24)	275	21.19 (12.17)	-12.47	-11.97	<.001
DASS Anxiety	192	7.11 (8.91)	275	15.81 (11.03)	-8.70	-9.40	<.001
DASS Stress	192	11.81 (9.81)	274	23.22 (10.97)	-11.41	-11.53	<.001
GHQ	193	23.31 (14.58)	271	39.86 (16.97)	-16.55	-11.25	<.001
GWB	191	55.29 (18.11)	273	35.89 (16.21)	19.39	11.85	<.001

*** Difference Score; SD Standard Deviation.**

Table 3. Comparisons between Post-Test Results for Control and Treatment Participants.

	Control		Treatment				
	n	Mean (SD)	n	Mean (SD)	Dif.*	t	p
DASS Depression	98	6.37 (8.41)	180	7.30 (9.39)	-.93	-.85	.398
DASS Anxiety	98	5.14 (7.41)	181	6.41 (7.97)	-1.27	-1.34	.183
DASS Stress	98	9.40 (8.57)	181	10.49 (10.02)	-1.09	-.95	.341
GHQ	98	20.03 (14.69)	178	17.46 (14.05)	2.57	1.41	.160
GWB	96	59.27 (16.07)	180	59.25 (16.60)	.03	.01	.989

*** Difference Score; SD Standard Deviation.**

Summary Findings:

• Encouragingly, the control and treatment participants' average scores do not differ significantly from each other on any of the post-test measures (see Table 3).

The impact of the intervention, however, cannot be judged by this analysis alone. Inspection of the pre and post-interval measures for the control participants also shows a significant decrease across all DASS scales and the GHQ, and a significant increase in the GWBI (see Table 4). This suggests that time and/or GP intervention alone is having an impact, the degree of which is difficult to judge.

Table 4. Pre and Post-Test Comparisons for All Control Participants.

		Pre	Post			
	n	Mean (SD)	Mean (SD)	Dif.*	t	p
DASS Depression	97	7.46 (9.06)	6.02 (7.72)	1.44	2.11	.037
DASS Anxiety	97	6.51 (9.03)	4.86 (6.92)	1.65	3.09	.003
DASS Stress	97	10.21 (9.10)	9.10 (8.10)	1.11	1.87	.065
GHQ (Total)	95	22.07 (13.86)	18.95 (12.10)	3.13	2.39	.019
GWBI	93	56.78 (18.81)	59.45 (16.01)	-2.67	-1.98	.051

*** Difference Score; SD Standard Deviation.**

To overcome this issue, the participants' scores were reviewed and 94 participants were selected from both groups within the study to produce a new subset of 47 matched pairs. Paired-samples t-tests indicate that the matching is adequate, with no significant differences between the treatment and control participants' pre-test scores on any of the scales (see Table 5).

MATCHED PAIR COMPARISON BETWEEN TREATMENT AND CONTROL GROUPS.

Table 5. Comparison between control and treatment participants pre and post-test scores for paired data sets.

			Control		Treatment				
		n	M	SD	M	SD	Dif.*	t	p
DASS Dep	Pre	47	11.49	10.13	11.74	10.19	-.026	-0.903	0.37
	Post	47	9.04	8.74	3.02	3.97	6.02	4.474	<.001
DASS Anx	Pre	47	8.43	9.98	8.81	9.46	-0.38	-1.454	0.15
	Post	47	6.60	3.71	3.34	3.71	3.26	2.819	.01
DASS Stress	Pre	47	15.18	9.02	15.17	9.13	0.01	0.043	0.97
	Post	47	12.54	9.05	5.79	4.85	6.75	4.870	<.001
GHQ (total)	Pre	45	26.82	14.31	28.18	14.32	-1.36	-0.734	0.47
	Post	46	21.76	13.03	11.87	8.98	9.89	4.158	<.001
GWB	Pre	47	49.52	17.28	48.65	14.89	0.88	0.422	0.68
	Post	46	53.25	15.03	65.85	13.57	-12.59	-4.340	<.001

*** Difference Score; M Mean; SD Standard Deviation.**

Analysis of the post-test scores reveals a highly significant difference between the controls' and the treatment participants' scores on all scales.

CONCLUSION

Comparison of the pre and post test scores for the treatment and controls in the paired analysis, in addition to the reduction in average scores shown for all treatment participants, supports the conclusion that the therapeutic intervention in the collaborative model of mental health service delivery is having a significant and positive impact on patients' mental health and well being.

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ARTICLES

Clinical Psychology in Rural General Practice:

*A PILOT OF A COLLABORATIVE MODEL OF MENTAL HEALTH SERVICE DELIVERY**

Vines, R.F., Hurley, B.M. and Thomson, D.M.

Prevalence of Mental Disorders in Australia

It is well known that the burden of mental health problems and mental disorders is high and rising. Murray and Lopez in their 1996 comprehensive assessment of the global burden of disease: a World Bank Project done by the Harvard School of Public Health and the WHO in Geneva, estimate that depression alone will constitute one of the greatest health problems worldwide by 2020. The WHO (World Health Organisation, 2000) estimates that approximately 1.5 billion people worldwide suffer some kind of mental illness. Until recently, according to Teeson and Burns (2001), Australia was reliant on United States studies for epidemiological data on mental health. In 1997 however, the National Survey of Mental Health and Well Being was undertaken by the Mental Health and Special Programs Branch of the Commonwealth Department of Health and Aged Care. This surveyed a representative sample of 10,641 Australians, providing the first national Australian data on the prevalence and patterns of mental disorders in the Australian population. According to Teeson and Burns (2001), the survey was designed to answer three main questions:

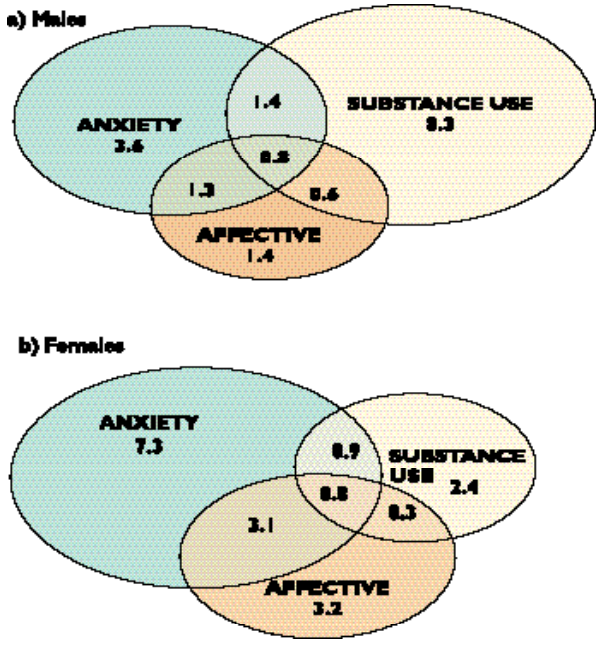
- how many Australians have which mental disorders?
- how disabled are they by these disorders?
- what services have they used for these disorders?

*A project funded by the Partnerships in Service Reform Section, Mental Health and Special Programs Branch of the Commonwealth Department of Health and Age Care.

The survey suggested that approximately 18%, or up to 4.7 million Australians, are affected by at least one mental disorder in a 12-month period (DHAC, 1997). Recent reanalysis of the figures suggest a figure of 23% reporting at least one disorder in the past 12 months and 14% a current disorder (Andrews, Henderson and Hall, 2001). Young adults were found to be particularly affected, with more than one-quarter of Australians aged 18 to 24 years suffering from at least one mental disorder over a 12-month period. Other epidemiological research in Australia suggests that one in five people experience serious disruption to their mental well being in their lifetime (Aloizos, Harris, Hickie & Penrose-Wall, 1998).

Estimates vary across studies in relation to prevalence of particular disorders, one estimate suggesting that 12.6% of the population suffer an anxiety disorder, 9.5% an affective disorder, 9.5% substance abuse and .5% schizophrenia (Clarke, Drake, Mellsop, Stedman & Yellowlees, 1997). Results of the 1997 National Survey suggest that the prevalence of anxiety, depression and substance use disorders is 9.7%, 5.8% and 7.7% respectively, and shows gender differences as follows:

FIGURE 1:



(from Teeson M., & Burns, L. (2001). National Comorbidity Project (NDARC). National Drug Strategy and National Mental Health Strategy)

These figures show that comorbidity in mental health and substance use disorders, or co-occurrence of more than one mental disorder, is highly prevalent but remains largely un-addressed. The high rates of comorbidity have a number of implications for treatment and management.

For older adults, the prevalence of mental disorders drops to 6% among those aged 65 years and over, although an additional 6.1% are estimated to have dementia, which is strongly age-related and increases in incidence significantly with age after this time from 1.6% of 65 to 70 year-olds, to 39% of 90-94 year-olds (see National Action Plan for Promotion, Prevention and Early Intervention for Mental Health, 2000; Sawyer, Arney, Baghurst, Clark, Graetz, Kosky, Nurcombe, Patton, Prior, Raphael, Rey, Whaites, & Zubrick, (2000).

Patterns of Care

It has been estimated that approximately 95% of people with a mental illness are now being cared for in the community, either by their General Practitioner (GP), psychiatrist and/or community mental health team (Creed, Gask and Sibbald,1997, and Altson, Hustig, Keks, Sacks & Tanaghow, 1998). As is well known, GPs have emerged as the key primary care service providers and the gatekeeper to secondary care (Creed et al., 1997). The BEACH study ("Bettering the Evaluation and Care of Health"), conducted by Sydney University and the Australian Institute of Health and Welfare in late 1999, in which 1000 GPs from metropolitan, regional and rural areas of Australia were interviewed and 98,400 patient consultations were covered, found that 85% of the Australian population visits a GP at least once in any year and 90% in any two-year period (Bhasale, Britt, Charles, Horn, McGeechan, Miller, Sayer & Scahill, 1999). Of those presenting in the primary care setting it has been estimated that between 19% and 40% of patients have mental disorders (Aloizos, Harris, Hickie, & Penrose-Wall, 1998; Bhasale et al., 1999; Chamberlin, Jackson & Kroenke, 1999; Creed et al., 1997; Goldberg, 1984; Hennrikus & Sanson-Fisher, 1988; Hickie, 1999; Robinson & Roter, 1999). Of these, between 31% and 46% present with significant psychological distress that warrants further assessment (Hickie, 1999; Robinson & Roter, 1999). The results from the National Survey of Mental Health and Well Being suggest that at least 40% of people with depression consult with a GP within the first year of onset of the condition. Of these, only 6.2% are referred to and see a psychologist, 8.4% a psychiatrist. Overall, less than half of the adults (38%) and less than a third of children (29%) with mental disorders in Australia receive professional help for those disorders (Sawyer et al, 2000).

The detection of psychological symptoms in primary care patients

The detection of psychological symptoms in primary care patients and the use of early appropriate intervention at the primary care level has received much attention recently (Aloizos et al., 1998; Hennrikus & Sanson-Fisher, 1988; Hickie, 1999), This is largely due to the fact that use of medical services is far higher amongst those with psychological disorders than for those without such problems (Brugha, Smith & Wing, 1989; Chamberlin et al., 1999; Franco, 1991; Hennrikus & Sanson-Fisher, 1988; Hickie, 1999). The resultant cost burden and likelihood of inappropriate use of the health system by those with these difficulties continues to be a cause of concern.

It has been found that, despite a high prevalence of psychological disorders in the primary care environment, accurate detection by GPs of patients with a psychological disorder has been quite low. A detection rate of approximately 30% is consistently reported with a range of between 20% and 74% (Andrews, Brodaty & Kehoe, 1982; Andrews, Chancellor & Mant, 1977; Bowers, Harris, Henderson & Jorm, 1990; Franco, 1991; Gordon, Hennrikus, Redman, Sanson-Fisher & Webb, 1991; Hennrikus & Sanson-Fisher, 1988; Hickie, 1999; Ormel, Simon & Tiemens, 1996; Robinson & Roter, 1999). A number of hypotheses have been proposed to explain the consistently low detection rate of psychological disorders by GPs, including the common co-morbidity of psychological symptoms with physical illnesses (Bhasale et al., 1999; Creed et al., 1997; Galassi, Schanberg & Ware, 1992; Goldberg, 1984). The BEACH report highlighted hypertension, back complaints, menopausal complaints, diabetes and sleep disturbance, as commonly co-occurring with a depressive disorder (Bhasale et al., 1999), frequently making it difficult for the GP to disentangle the physical and psychosocial symptoms in order to make an accurate diagnosis.

The low detection of psychological symptoms in primary care patients has also been attributed to the GP's attitude towards mental illness and to patients' perception of the GP's role. It has been found that General Practitioners have been reluctant to diagnose mental illness due to:

- the possible stigma associated with such a label (Aloizos et al., 1998; Hennrikus & Sanson-Fisher, 1988); and
- the perceived likelihood that recognition of the condition does not improve treatment outcomes (Chamberlin et al., 1999; Hennrikus & Sanson-Fisher, 1988; Ormel et al., 1996). Many GPs do not feel confident to treat mental disorders, and mental health facilities are often difficult to access if a mental disorder is diagnosed. It is hypothesised therefore that, in these circumstances, "treatable conditions" are more readily focused upon.

Patient perceptions that the role of their GP is to attend to physical rather than psychological symptoms have also been found to inhibit the likelihood of detection, (Andrews, Chancellor, & Mant, 1977; Bridges & Goldberg, 1984). In one study (Robinson and Roter, 1999) it was found that 83% of patients opted not to disclose psychological symptoms to their GP. Similarly, Andrews and colleagues (1977) determined that patients suffering anxiety and depression were generally reluctant to disclose their emotional needs to their GP, preferring to present physical symptoms such as prolonged fatigue and sleep disturbance, as more appropriate. Patients' choice to present physical rather than psychological symptoms has therefore contributed to the low detection rate of psychological disturbance in patients.

Recent Health Policy

Despite these difficulties in accurately assessing mental disorders in the primary care setting, and despite GPs already having a huge work load carrying the patients and diagnostic presentations that they currently do, recent Commonwealth health policy has been fostering a continuing shift towards GPs becoming more involved in managing patients with these conditions (see Australian Psychological Society Fact Sheet: "How Can Clinical Psychology contribute to Primary Mental Health Care" 2000a, and the recent budgetary allocation of $100 million to GPs for treatment of mental health). As increased emphasis is placed on the mental health intervention capability of GPs, it is clear that there are a number of problems associated with this:

- limited and variable access to specialist support where and when required, and
- variability in GP psychological/psychiatric disorder assessment and diagnostic skills.

Best Practice

As outlined in the recent Australian Psychological Society Fact Sheet (2000): "The Role of Psychological Treatments in Managing High Prevalence Mental Health Disorders", the clinical research literature overwhelmingly indicates that for most depression and anxiety disorders, psychological treatments are as effective as medication and more effective in the longer term. Individuals receiving medication only are more likely to relapse after the medication is discontinued. There are a number of well defined psychological treatments that are effective in the treatment of depression, anxiety and substance use disorders in adults; and disruptive behaviour disorders, anxiety disorders and depression in children and adolescents (APS, 2000). "These focused psychological treatments are demonstrably as effective as psychotropic medication in treating most anxiety and depressive disorders. However, severe anxiety and depressive disorders are probably most effectively treated with both pharmacological and psychological treatments. Current best practice in the treatment of all serious mental disorders requires integrated pharmacological and psychosocial interventions. This means that for best practice, ie. empirically supported interventions in the primary care setting to occur, increasing access to effective non-drug treatments, or focused psychological interventions such as cognitive-behavioural therapies, is essential. Currently, health consumers in Australia have very little access to effective psychological treatment. By contrast, (according to the Productivity Commission's figures in March 2000) the prescribing of psychotropic medications such as antidepressants has doubled over the past six years. This situation is now out of step with the evidence from the scientific literature on effective treatments for mental disorders" (APS, 2000).

One of the points made in the APS Fact Sheet is that, whilst support needs to be given to the focus on upgrading the mental health assessment and intervention skills of GPs, there are significant practical limitations to the capacity of the GP workforce to both develop the necessary psychological expertise and to carry the number of patients who require more in-depth psychological treatment. Beyond learning supportive counselling and basic cognitive-behavioural intervention skills, extensive training is required to become proficient in the delivery of specialised psychological therapies (APS, 2000). Also, existing practice-operating demands on already busy GPs, and their varying skill and interest levels in the mental health area, all mitigate against the primary care sector developing the needed psychological intervention capacity required to deliver all specialised mental health services.

It has been suggested (APS, 2000) that patients with mental health disorders can be classified conceptually at different levels of complexity, requiring three different levels of skill to adequately treat them. Whilst GPs are both practically and professionally capable of carrying out psychological assessment and treatment at levels 1 & 2 with a large range of patients presenting with mental health disorders, more specialised input is desirable with patients presenting with more complex mental health difficulties (APS, 2000).

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The "GP Project"

Vines, R.F. and Thomson, D.M.

The current project aims to address a number of the issues outlined above, including the limited and variable access that both GPs and patients have to specialist support. The project involves the implementation of a collaborative model of mental health service delivery in a number of rural settings in which there are limited mental health resources. The model is being evaluated through a two-year trial which is expected to sample approximately four hundred patients with matched controls, and is located at Charles Sturt University (see Vines, (2000); Vines & Thomson, (2001); Vines & Thomson, (2001). The project is being articulated to the University of Ballarat and an additional regional University in the second year. Both fully qualified and trainee/intern Clinical Psychologists (known as Clinical Psychology Registrars) are involved in the service provision. The research has been supported and funded by the Partnerships in Service Reform Section of the Mental Health and Special Programs Branch of the Commonwealth Department of Health and Aged Care.

The Aims of the Project are to:

- service patient needs in rural locations where access to specialist help is often limited;
- facilitate/enable early intervention with mental health conditions and some physical conditions with either a psychological cause or psychological sequelae, thereby preventing both the development of greater severity of the preventing condition and greater frequency of use medical services;
- support GPs with the diagnosis, management and treatment of patients presenting with:
  a) psychological issues;
  b) physiological issues with a psychological dimension;
- support ongoing Continuing Medical Education for GPs 'in situ' by providing learning outcomes for General Practitioners whilst working collaboratively with the profession of Clinical Psychology;
- provide an effective way of supporting rural GPs to more adequately meet their patients' mental health needs, particularly in the current context of lack of adequate and accessible mental health services in rural areas;
- develop appropriate funding models suitable to GPs and psychologists to facilitate ongoing provision of this method of service delivery in locations where fee paying may not be a viable source of monetary support;
- provide an innovative generic model of mental health service delivery which can be articulated nationally;
- offer training opportunities for post graduate students in Clinical Psychology (in the Doctoral and Masters in Clinical Psychology training programme at Charles Sturt University in the first year and two additional regional universities in the second year).

The model of collaborative service delivery consists of:

- the provision of Clinical Psychology services in the Medical General Practice setting, preventing the need for articulation of assessment/treatment to another specialist setting as is usually required (either a public facility: such as Community Health or private practice setting). Patient attrition, which often occurs at this point, is therefore minimised.
- "in-house" referral of patients whom the General Practitioner feels could benefit from psychological intervention for either:

a) psychological issues, or

b) physiological issues with a psychological dimension. Most referrals within the project are envisaged to be cases of high prevalence disorders of depression and anxiety.

- an initial joint session between the patient, General Practitioner and Clinical Psychologist at the commencement of the psychological assessment to facilitate:

  a) establishment of rapport between the psychologist and patient through endorsement by the GP whom the patient frequently knows well;

  b) opportunity for the patient to communicate to both professionals their own perception of the presenting problem/condition and its background;

  c) opportunity for both professions to provide a formulation of the patient's condition and to explain treatment options;

  d) communication between the GP and psychologist about the patient's condition, presenting issues/problems and background;

  e) obtaining of patient consent for cross-professional communication to continue whilst the patient is in psychological treatment and access to medical notes by the psychologist;

  f) appreciation by both professions of their alternative and complementary ways of formulating patient difficulties/presenting conditions.

Currently, there is very little funding available for clinical psychological/psychotherapeutic services. This necessitates patients paying fees to private practitioners, which essentially means that service provision is skewed towards those who can pay. As a result, the model at present requires fee for service delivery with participating practitioners who are fully trained. The Clinical Psychology Registrars, however, provide pro bono services within their designated General Practice.

The first session is Medicare rebateable. In the current project the rebate remains with the General Practice for payment of GP time. Collaborative treatment does not necessarily entail continuing joint consultations. However, the GP and Clinical Psychologist may occasionally see the patient jointly. Most frequently, GP and psychologist sessions continue in tandem, with the GP needing to see the patient less frequently to monitor medication for both mental health and other health issues.

Ongoing treatment sessions using a six-session treatment model with a total of up to ten sessions, including follow-up sessions. This model is applicable to "straightforward" high prevalence disorders of anxiety and depression treated in this study, but may not be feasible with more complex cases of dual diagnosis and/or co-existence of DSM IV Axis II Disturbance/Personality Disorders.

- Ongoing face-to-face consultation between the professions on both an informal and formal basis: all consultations by the Clinical Psychologist with the General Practitioner entails use of the Case Register Form which facilitates easy scanning of patients referred by the particular doctor, and rapid summary of number of sessions seen, etc. Informal consultation is facilitated by co-location on the same premises: through attendance at morning tea, lunch etc.

- Formal Case Conferencing using new EPC (Enhanced Primary Care) items is arranged where patients have contact with more than two professionals (eg General Practitioner, Clinical Psychologist, Physiotherapist, Nurse etc.) or very occasionally when more than one doctor is involved in different aspects of the case. Case conferencing is particularly useful for patients referred for assistance with treatment compliance with physiological problems such as diabetes, high blood pressure, asthma, etc; or complex presentations such as Borderline Personality Disorder where a treatment team (doctors, nurses, psychologists and mental health team) is often required. However, it is also useful in relation to the high prevalence disorders of depression and anxiety seen within this study, facilitating discussion of medication (type, dose, and time and method of withdrawal), and complimentary treatment approaches between the two professions, etc.

- Formal written feedback/letters to the referring doctor:

  a) after the assessment session;

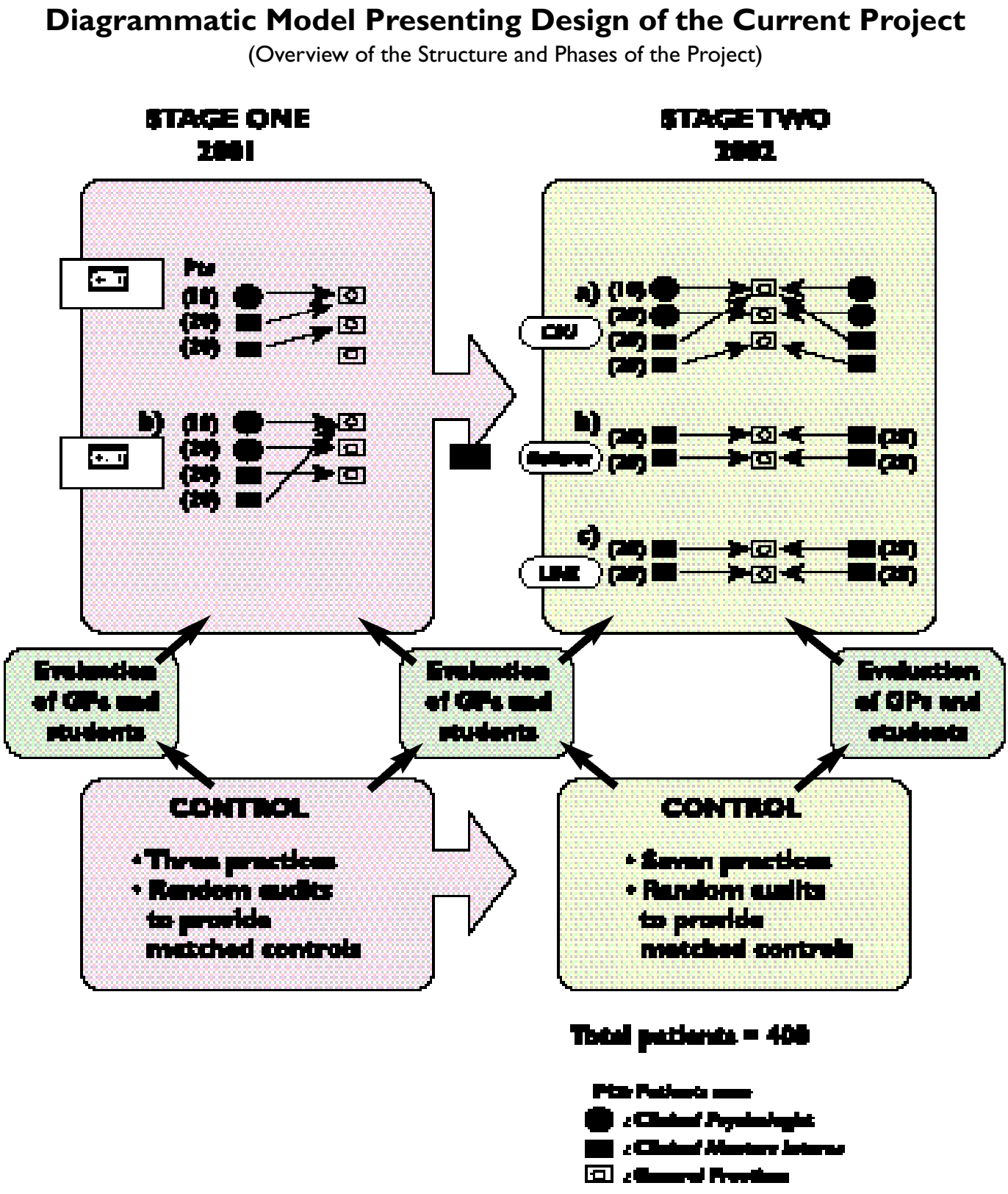
  b) at conclusion of treatment: summarising gains made both on objective indices and patient-generated problem list.

Brief summary statements are placed in the ongoing medical notes indicating to the GP that the patient has seen the clinical psychologist since their previous medical consultation (patient consent for the psychologist's access to their medical notes is obtained in the first session). In addition, a Clinical Psychology Form including Treatment Plan and Discharge Summary is filed at the back of the notes, to provide the GP with an overview of the psychological treatment undertaken.

Methodological Design Of The Research Project:

The research design uses both quantitative and qualitative techniques and methodologies. The general framework being used is as follows:

FIGURE 2:



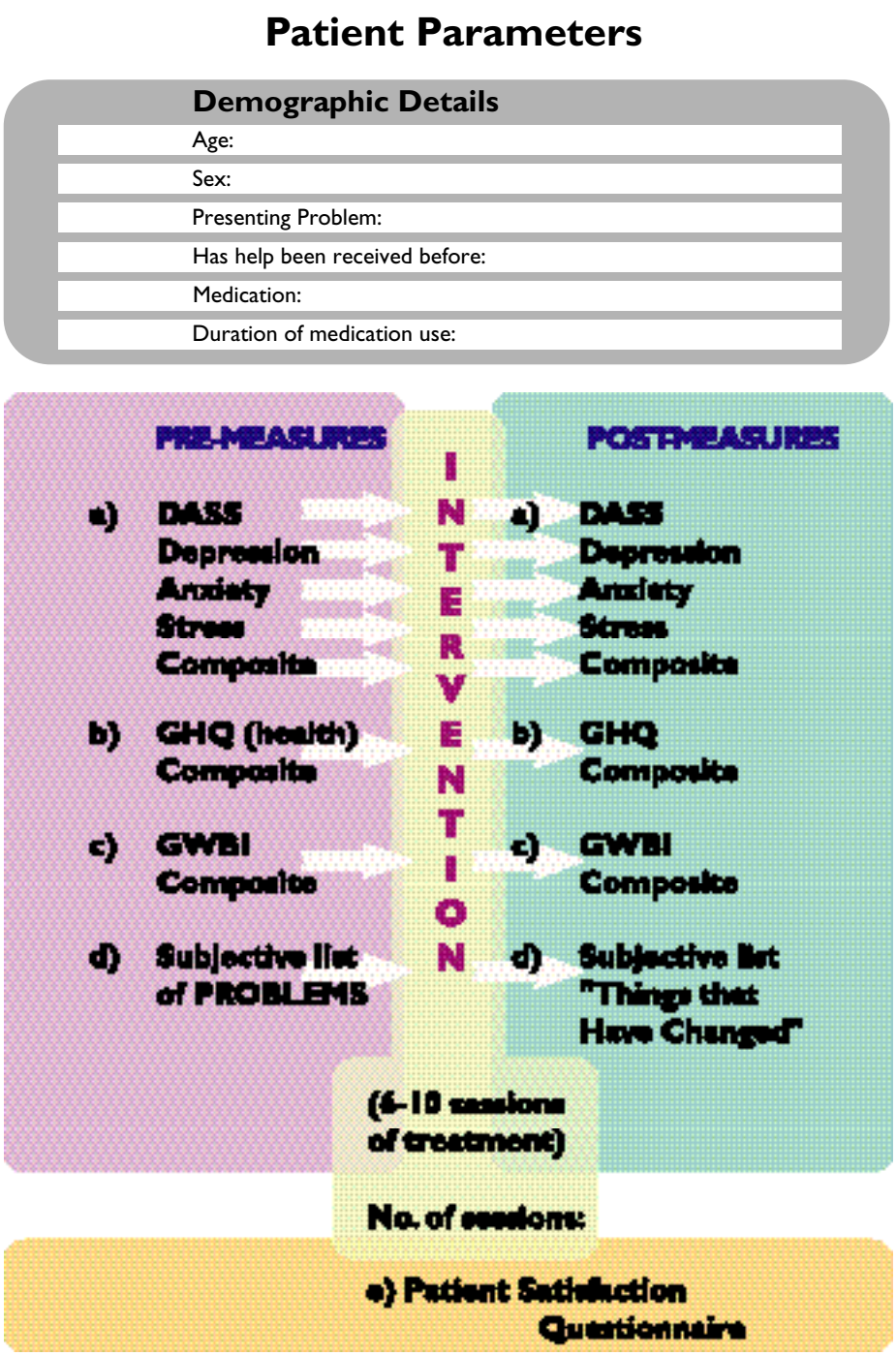
It is envisaged that a total of approximately four hundred patients will be treated over the two year project, with pre- and post-measures being taken on patients, GP and Clinical Psychology Registrars to assess effectiveness of treatment interventions, effectiveness of collaborative model in assisting mental health service delivery, and effectiveness in providing worthwhile clinical placements.

Preliminary Protocols For Student Placements

Students are provided with the opportunity to observe 2 (+) random sessions of General Practitioners in the practice to which they are allocated. This entails attendance at ward rounds at the local Base Hospital, and observations of primary care sessions (both assessment and continuing sessions). This provides an orientation to the General Practice setting, and enables an evaluation both on the part of the Clinical Psychology Registrar and the

FIGURE 3:

For each patient a number of quantitative and qualitative measures are being used as follows:



General Practitioner of the incidence of psychological problems presenting in the General Practice setting.

Students then attend a number of sessions (for booked in patients) with the Senior/Supervising Clinical Psychologist, observing her/his model of assessment, diagnosis/formulation and treatment. The aim of this is to enable them to have a sense of what is required once patients are referred to them in the General Practice setting.

Twenty patients are referred to the Clinical Psychology Registrar whilst on placement at the specific General Practice. GPs are encouraged to use the service to a maximum, as it enables full treatment (using a six-ten session treatment framework) of twenty patients on a pro-bono basis by the Registrars. Since the General Practitioners feel that most of their patients are not in a position to afford to pay fees, this is a service that they are exceedingly pleased to access.

For each patient a number of quantitative and qualitative measures are used (please refer to table 3). Patients are requested to fill out the DASS (Depression, Anxiety and Stress Scale), GHQ (General Health Questionnaire) and the GWBI (General Well Being Index) prior to the initial assessment session, although on occasion when this is impossible they fill it out after their first session. The latter is not ideal as it may reflect some initial improvement after the initial assessment session. However, the reality of patient referral means that some do not fill the forms out prior to being seen. This may diminish the effect size of any change consequent on therapy.

Between the first and second sessions the patient is required to fill out a subjective list of problems experienced, to enhance the assessment devices already used. All of these indices provide pre-measures of the patient's situation, prior to the intervention. Post-measures are taken on the same indices.

Students are required to assess and treat patients using the specified pre- and post-parameters (see figure 3). Before, during and after their internship as a Clinical Psychology Registrar, the students are required to fill out placement assessment forms, which indicate their attitude to the placement and the collaborative model of mental health service delivery used.

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Clinical Psychology in Rural General Practice:

SOME INITIAL OBSERVATIONS

Guthrie, D., Peckham, J. and Read, L.

The 'Clinical Psychology in Rural General Practice Project' is described previously in this article. One component of The Project is the utilisation of Clinical Masters students to undertake a course-related placement within The Project. During 2001, three students from Charles Sturt University's Masters of Clinical Psychology training program undertook the placement within two General Practice settings in Bathurst, NSW. Both were multiple GP practices and the students saw patients within the practice. Each student had a caseload of at least 20 patients, all of whom were referred by a GP in the practice. The NSW Psychologists Registration Board approved the title of Clinical Psychology Registrar (Registrar) to be used for students in recognised Primary Care Placements. The Charles Sturt University (CSU) Masters course requires that four placements of seven weeks full-time (or equivalent part-time duration) be completed. This required length of time fitted well with The Project's desire to provide short-term focused psychological treatment for the high prevalence disorders of anxiety and depression.

The Project is being evaluated empirically at the conclusion of the two-year trial, by which time it is hoped to have a sample of approximately 400 patients and matched controls. The purpose of this paper is to describe the preliminary observations from the three Registrars who have undertaken the placement so far.

Location of Psychological Services within the Practice setting

Many patients reported having little previous knowledge of psychological services and counselling. A number of patients indicated some wariness about seeing a Psychologist, but were willing to follow their GP's advice. As part of The Project the GP attended part of the first session to introduce the patient. Each patient who had a GP attending reported this as helpful, with some patients commenting that they felt the GP could better articulate their symptoms than they could. Having the GP attend a joint consultation greatly enhanced the rapid development of rapport and confidence in the Registrar, as the joint consultation was seen as a strong endorsement of the Psychologist by the GP. It also provided an opportunity to seek the consent from the patient for the Psychologist and GP to have ongoing communication about the patients' treatment and for the Registrar to access their medical files. This proved to be very useful.

Medical Files for each patient were provided for each session and we were required to make short notes on each session during treatment. At the completion of treatment a summary letter was also provided for the GP to file in the patients' notes. The files provided us with the opportunity of developing a history and enabled us to see if the patient had been to their GP between sessions. Particularly gratifying to us was the regular comment made by a GP in the patient notes after a session, or series of sessions with the Registrar: *"patient seems much improved after seeing Psychologist"*.

Being seen by the Registrar at the Practice was perceived differently by different patients. A large number found it gave a 'cover' for seeking psychological help in a setting they were already familiar and comfortable with. This seems particularly useful when dealing with depression and anxiety disorders where motivation (or courage) to attend a new setting may be low. Preliminary results on the Patient Satisfaction Survey suggest that around 90% strongly agreed/agreed (30%/60%) that they felt more comfortable meeting at the Doctor's surgery. The remaining 10% were neutral (neither agreeing nor disagreeing). One of the psychology interns reported, however, that some patients disliked having to return to the surgery feeling that *"were always at the Doctor's"*. The Project was responsive to both groups as a number of patients were later seen in consulting rooms at CSU for their third and subsequent appointments. This also freed up the limited appointment times at the surgery for new patients and joint consultations.

A beneficial aspect of the placement for us as students was the ability to work within a GP surgery and to develop a deeper understanding of the constraints and demands upon them and the best ways to contact and liaise with them. One Practice had a policy of having a common confidential morning tea session for the GPs that included the Registrar. This was particularly beneficial in feeling part of the team and enabled the Registrar to talk to the GPs about their patients' progress or any issues that were arising within psychotherapy that the GP needed to know about.

The Project specified a maximum of six-ten sessions for any patient. Whilst the ratio of sessions varied for each Registrar, across our sample approximately 50% utilised either five or six sessions. Others reported significant change in less than six sessions and treatment concluded. Of these between 15% and 24% attended four sessions. The percentage of patients who did not take up the initial session was less than 10% across this sample. Overall there was a less than 10% attrition rate. This is not to say the issue of attendance was without frustration. A number of the patients who were experiencing concurrent physical illnesses required frequent postponements, making it difficult to complete treatment for some individuals in the time constraints of the placement.

Patient Features

One of the most pleasing features to us as Registrars was the growing sense we had that The Project was providing early intervention strategies for some patients, and accessing others with more chronic symptoms who would not have sought psychological help otherwise. Of the patients seen by the female Registrars, 80% were female. The male Registrar (who was situated in another surgery) had a ratio of 60% (female) to 40% (male). Most if not all patients referred were of Anglo-Saxon background. This would seem to reflect, by and large, the nature of the practices serviced. Ages ranged from 16 – 78 years of age, with the average age being 39.

Approximately 50% of those referred were diagnosed with depression, 25% with anxiety/panic attacks, 10% with primarily relational problems, 10% with PTSD and 10% with "complex" problems. Some had more than one diagnosis and the majority had significant life stressors that had precipitated the depression and/or anxiety. One GP had an interest in alcohol and other drugs and referred some patients with complex/co-morbid problems that included depression. The six-session program, whilst beneficial for these patients was not sufficient to effect long term change.

The patients completed a Patient Satisfaction Survey. This instrument asked them to rate statements such as *"I am pleased my Doctor referred me to a Clinical Psychologist"* on a 5 point scale (from Strongly Agree to Strongly Disagree). On this particular question all patients responded with; 'strongly agree' (90%) or 'agree' (10%).

One of the strongest responses on the Patient Satisfaction Survey reflected the inability of patients to personally pay for the psychological treatment. Ninety percent of patients referred reported that they would not have been in a position to pay a fee (in the vicinity of $100 per session) to see a Clinical Psychologist. This may have been a result of the availability of the Registrars offering the service at no cost which allowed the GPs to refer patients who could otherwise not afford to pay for psychological services. However, it is just as likely that very few people who need the service are in a position to easily pay for it themselves, particularly in a regional/rural area.

Of the patients referred 75% were taking SSRI antidepressant or anti-anxiety medication before initial presentation. Others were referred specifically because they were reluctant to take medication. One Registrar reported that 30% of those who were taking medication ceased taking it before the conclusion of therapy. These patients had this as a goal of therapy and were keen to not only reduce their medication but, to discontinue it completely. These patients also had a GP who supported them in this process. The other Registrars did not report such significant levels of medication reduction although many patients had reduced dosage levels.

A key factor was the individual GP's attitude to medication cessation with some GPs encouraging patients to continue the medication for a number of months, even years, post improvement, whilst others were willing to discontinue medication more rapidly. Another factor was the fact that many patients had only just been prescribed medication when referred, so attempted withdrawal within the six-ten session framework would have been contrary to appropriate usage.

Whilst the results of the interventions will be presented empirically at the conclusion of The Project, we were impressed with the dramatic improvement over the course of four to six sessions for the majority of patients. We often commented that we could see a physical change and improvement over the course of treatment. In addition to their psychological symptoms some patients had medical complaints such as migraine, gastric reflux, nausea or irritable bowel syndrome. Almost all reported these symptoms had largely disappeared by the end of the psychotherapy sessions.

The results seem to be due to the intensive nature of the treatment program which includes an expectation that a significant amount of homework be completed between sessions.

Homework included prescribed reading, an emphasis on cognitive and behavioural tasks and various record keeping activities. Homework was well monitored and almost all patients were compliant with homework and actively engaged in behavioural strategies at home. Pre and post measures included Depression, Anxiety and Stress Scale (DASS), the General Health Questionnaire (GHQ 28), the General Wellbeing Index (GWBI) and the Patient Satisfaction survey.

Factors regarding the GPs

Each of us appreciated the doctors' warmth and willingness to work collegially with us. As part of our orientation we had the privilege of being able to observe several GPs half-day session of patient consultations. Our observations were that in approximately 60% of cases there were either psychological problems, or physical with psychological sequelae. Each of us was impressed with the relational skills of the GP's we observed. Each took time with patients who needed to talk about psychological and emotional concerns such as work stress, carers' issues and the like. It was also noted that there are costs both financially and time-wise in providing such a service. We noted that GP's have large workloads and time pressures that mitigate against the type of therapy that the Registrar was able to provide.

Being rural Practices the GPs often had long associations with their patients. There was usually a high level of trust and regard for the GP by the patient. The GPs and the Registrars adopted a "team" approach to the patients' care which was effective for the patient and both professionals. We were impressed with the accuracy of the doctors' psychological diagnosis and appropriateness of the referrals. The GPs clearly seemed able to determine when the patients could be assisted by the interventions of a Psychologist and who the best 'Specialist' was for their patient. We noticed that the practices that agreed to have us as Registrars were 'psychology friendly' and believe they had also benefited from the association with The Project's director Robyn Vines who had provided treatment with patients and consultation with Doctors over the preceding two years.

Whilst the referral rates of the GPs prior to the advent of The Project are unknown, we noticed that referrals to us as Registrars increased over the time we were in the Practice setting. This supports the common sense view that GPs are more likely to refer to a Psychologist whom they have regular professional contact with. The registrar could also see the patients quickly after the referral had been made (for example, the GP would ask the patient to make the appointment at the conclusion of their consultation and the patient was generally seen within the same week if not sooner). We believe that the GPs were impressed both with how quickly their patients were seen, and also how many of them rapidly improved.

Supervision

As well as being a very interesting project to participate in, The Project also served as one of four Placements required for the Masters of Clinical Psychology at CSU. As the Director of The Project, Ms Robyn Vines provided clinical supervision to each of us individually and conjointly. As Registrars we found the placement to be a very supportive environment both personally and professionally. As many of our supervision sessions were done conjointly this allowed us to learn about each others' patients in terms of diagnosis and treatment strategies. As a team, we also provided each other with relevant materials and articles and discussed cases on an informal basis.

As part of the placement requirements we observed Robyn Vines conducting some sessions with patients. This was an invaluable experience for all three Registrars as it enabled us to better understand the nature of The Project and in particular the need to conduct relatively intense, focused sessions. Robyn encouraged us to utilise an integrationist format with a cognitive behavioural approach informed by aspects of the psychodynamic tradition. This approach lent itself to short-term, in-depth psychotherapy, and intensive homework seemed to allow a more rapid patient response to their issues. Our supervisor also offered us a range of printed patient resources and activities as homework tasks that she has developed over a number of years that proved very beneficial.

The completion of such tasks by patients outside the psychotherapy sessions enabled efficient use of session time in and also served as a good means of gathering, for example, patient histories to enable further hypothesis forming.

Some Concluding Thoughts

Clearly, the idea of psychological services being located within a General Practice is a sensible one. If such a model was adopted within a General Practice it is likely to be cost effective, given the time limited and intensive nature of the therapy. It could also be cost effective for the GPs in that they can refer patients who need psychological assistance to the resident Psychologist and be free to see patients who only need medical care. This is potentially both time efficient and cost effective as it reduces the patients' time spent at appointments with their GP. In a large number of patients, that as their psychological symptoms improved, it was noticed that they needed to see their GP less frequently. These are value-added benefits of a collaborative approach with the GPs. A combined approach effectively addresses both the physical and mental aspects of health and well-being in a setting that is familiar and conducive to treatment. At a time when depression and anxiety are acknowledged as very high prevalence disorders, this is particularly important.

This type of short-term focused evidence-based therapy is one that is highly suited to both the GP setting and is demonstrated to be of benefit to the majority of patients referred. The outstanding

question remains: how to fund the provision of such services, as the majority of people referred to the Registrars indicated an inability to pay fees? This remains the most significant issue to be resolved.

This question aside, we found it a rewarding and exciting placement for us as Registrars, and are committed to finding ways of better integrating clinical psychology into rural general practice.

The three authors are all Registered Psychologists and mature aged students enrolled in the Masters of Clinical Psychology program at Charles Sturt University Bathurst. This Masters program is offered part-time externally over four years. David Guthrey and Lindy Read are both final year students and Janine Peckham is a first year student in this program who is concurrently completing a PhD in Psychology through Adelaide University.

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PRIMARY MENTAL HEALTH CARE
PARC
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PARCupdate

SPECIAL ISSUE: Access to Allied Health Services Projects

September 2003 Issue 7

Inside this issue:

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Editorial: Introducing Carmel McCarthy, new PARC Research Officer

Eleanor Jackson Bowers
Research Librarian, PARC

Welcome to the seventh edition of PARC Update and this is a very full issue. This edition focuses on the Access to Allied Health Services Projects funded as part of the Better Outcomes in Mental Health Initiative. We have articles from some of the initial round of pilot projects, and feature articles by Joan Foster from the Association of Counsellors and Psychologists in Primary Care in the UK, and Robyn Vines on the Clinical Psychology Services projects in NSW. Jane Pirkis writes in this issue on the evaluation of the Allied Health Services projects and we also have articles from Duncan Steed on knowledge management, and Shirley Anastasi on the Partners in Mind website.

The grapevine discussion is that the Access to Allied Health projects have been almost too successful with the major issue arising being the management of demand. It seems that the projects are meeting a real need in the community for counselling at no or negligible cost to the consumer.

The information available about the Pilot programs is, at this stage mainly descriptive and there are many questions which are as yet unanswered. A few Divisions have asked for co-payment from clients and we don't yet know how successful this has been or what the implications have been. A few have used central booking agents. How has this worked? Has the location of the counsellor either in the GP surgery or in their own rooms made a difference, and what are the relative advantages or disadvantages in using a voucher system over direct employment of the counsellor by the Division? What supervision and support arrangements are in place and how does this contribute to the success of the different models? What issues have arisen during the reporting relationship between the counsellor and the GP and how have different Division handled this? Where are records kept and what are the implications of this on patient confidentiality? Although some of the Divisions projects highlighted in this newsletter comment on how well aspects of their individual programs have worked, for answers to these, and other unanticipated questions, we await the report from the Program Evaluation Unit of the School of Population Health at the University of Melbourne, who are currently working on a report focusing on the lessons learnt by the first round of Allied Health Pilot projects.

PARC have is about to move into a new phase of knowledge management for the Divisions of General Practice. We have put a lot of thought into the management of Divisions knowledge in one area- mental health. Gathering reports onto a database hasn't worked. The intellectual property complications made this system unworkable. Strategy number two metamorphosised into a dreaded 'proforma' and became confused with more tedious repetitive reporting. So we are moving to a knowledge harvesting and story gathering approach to integrate with and supplement the existing, strongly supported, networking culture which we acknowledge as being vitally important for the diffusion of experiential knowledge.

In order to achieve this PARC have received funding to employ our new Research Officer Carmel McCarthy who comes to us with a health education background and research experience in education and organisational

(Continued on page 2)

"... over the next year Carmel will be contacting Divisions to talk about your mental health programs, what you are doing and how, what works and what doesn't, what you are interested in and what your support needs are. Our findings will be fed back to Divisions in a digested form in a way that will be as useful as we can make if to support Divisions ongoing mental health work ..."

(Continued from page 1)

learning. Over the next year Carmel will be contacting Divisions to talk about your mental health programs, what you are doing and how, what works and what doesn't, what you are interested in and what your support needs are. Our findings will be fed back to Divisions in a digested form in a way that will be as useful as we can make if to support Divisions ongoing mental health work. At the same time our other resources and information service will support Divisions to be responsive to future developments. It is NOT reporting and the primary stakeholders are YOU, the mental health project officers. You tell us what you need to know and it will be given to you to in a form that is easily usable to inform your future project work. This will not disappear into a bureaucratic black hole.

So much knowledge is being lost through staff turnover, lack of documentation and reporting requirements which don't meet Divisions learning needs. In fact PARC approached one Division recently for a newsletter article about a big project involving hospitals, a university and community organisations only to discover that there was nobody left who knew anything about it. The project finished nine months ago. We at PARC will do our best to see that the experience gained from projects such as these is no longer lost but is available to inform future projects.

Welcome Carmel, we don't know how we have managed for so long without you.

Evaluation of the Access to Allied Health Projects

Jane Pirkis, Belinda Morley, Fay Kohn

Program Evaluation Unit, School of Population Health, University of Melbourne

"... the Program Evaluation Unit of the School of Population Health at the University of Melbourne were recently commissioned to provide support to Divisions that are conducting Access to Allied Health Services projects ..."

The Better Outcomes in Mental Health Care initiative has a strong commitment to evaluation, and as a consequence we were recently commissioned to provide support to Divisions that are conducting Access to Allied Health Services projects.

We are based in Victoria, within the Program Evaluation Unit of the School of Population Health at the University of Melbourne, but our support role is national. We bring considerable expertise to the tasks at hand, as we and our colleagues in the Program Evaluation Unit have conducted local, state and national evaluations of both mental health and general practice initiatives, usually adopting a model of capacity-building.

Our support role recognises that Divisions have varying levels of evaluation expertise, may be using internal or external evaluators, and are employing different evaluation designs.

In the main, this support has taken the form of individual contact with project and evaluation staff, but we are planning a series of newsletters that address key evaluation issues, and will shortly have a website available.

We have also been involved in trailing a minimum dataset, which will soon be available to Divisions. The minimum dataset has been developed by Strategic Data and is designed to capture de-identified consumer-level information, which will be invaluable for describing who is accessing allied health care as a result of these projects, as well as for providing a broad overview of the care these people are receiving.

Periodically, we will be drawing together information from the local evaluations and the minimum dataset to provide ongoing information about how the Access to Allied Health Services projects are going, and whether specific models of service delivery seem to be particularly effective in given circumstances. We are working on the first of a series of national evaluation reports at the moment. This one will focus on the lessons learnt by the original pilot projects.

Our other task is to develop an overall national evaluation framework for the entire Better Outcomes in Mental Health Care initiative, considering not only the Access to Allied Health Services component, but also its other components (Education and Training for GPs; the 3 Step Mental Health Process; Focused Psychological Strategies; and Access to Psychiatrist Support).

Divisions requiring evaluation support should feel free to contact us.

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Clinical Psychology in General Practice: a collaborative model of mental health service delivery

Robyn Vines

Centre for Rural and Remote Mental Health, University of Newcastle

Since 2001, the provision of clinical psychology services in a number of regional and rural General Practices has been trialled through the government-funded "Clinical Psychology in General Practice Project". The project has entailed the implementation of a collaborative model of mental health service delivery in a number of primary care settings in which there is limited access, both by GPs and patients, to specialist mental health support. The model is being evaluated through an ongoing trial in which treated patients' pre and post measures on a number of mental health indices are compared to those of a matched control group of equivalent patients. Initially located at Charles Sturt University, Bathurst the project articulated to the Universities of New England and Ballarat and has also entailed a number of placements from the University of Newcastle. Fully qualified and trainee/ intern Clinical Psychologists (known as Clinical Psychology Registrars) are involved in the service provision. The research has been supported and funded by the Partnerships in Service Reform Section of the Mental Health and Special Programs Branch, Commonwealth Department of Health and Ageing, to whom we are grateful for their generous assistance with developing this new model of collaborative care.

Context:

It is well known that the burden of mental health problems and mental disorders is high and rising. For a detailed discussion of the overall context in which the model arose (eg. estimates of prevalence of mental disorders in Australia, patterns of care for patients with these conditions, etc.) see Vines, Hurley and Thomson, 2002.

History of the project:

The Project originally began in late 1998. Initial observations by a Senior Clinical Psychologist (RV) of two General Practitioners in Bathurst indicated that between 40-60% of patients presenting in random sessions had some psychological dysfunction. It was decided to pilot the co-location of Clinical Psychology services in the General Practice in an attempt both to treat adequately the patients' conditions and to relieve some of the pressure on GPs in dealing with patients' mental health difficulties. Service delivery was established one morning per week by the Senior Clinical Psychologist, and an initial placement was undertaken by a Senior Academic at Charles Sturt University.

The Project was formally launched by the Honourable John Anderson, then Minister for Transport and Regional Services. Commonwealth Department of Health and Aged Care (DHAC) funding of Phase 1 of the Project commenced during 2001 with the placement of four Clinical Psychology Registrars in two Bathurst Medical Practices. It was decided also to trial the model in a rural, single doctor practice township (Rylstone). One of the Clinical Psychology interns from CSU completed placement requirements at Rylstone and now provides ongoing psychological services to the townships of Rylstone and Kandos under the More Allied Health Services (MAHS) funding.

Additionally, with the approval of DHAC (now DoHA), a trial of the concept in a remote location using video-conferencing facilities was established. A CSU intern has completed an out-reach placement to Trundle and Tullamore, and the NSW Central West Division of GPs (CWDGP) is now supporting ongoing psychological service delivery, again under MAHS funding.

In parallel with the rural and remote placements established by CSU and the CWDGP, trials in Ballarat and Armidale commenced in 2002.

Further funding under the Better Outcomes in Mental Health Care (BOMHC) Access to Allied Health Initiative has enabled the trial, via the CWDGP, of four different funding models for psychological services found to be feasible in the Clinical Psychology in General Practice Project:

- Clinical Psychology Registrar stipends;
- Salaried positions within Divisions of GPs;
- Patient voucher systems;
- Direct funding for group treatment programs.

Psychological services are now being provided to Forbes and Parkes, Oberon, Lithgow and Orange, as well as further services in Bathurst. In the Central West of NSW, nine rural towns now have access to publicly funded psychological services under BOMHC and MAHS, with similar services provided in Ballarat, Victoria and Armidale, NSW. From extremely small beginnings in 1998, quite wide articulation of this model of

(Continued on page 4)

"... The project has entailed the implementation of a collaborative model of mental health service delivery in a number of primary care settings in which there is limited access, both by GPs and patients, to specialist mental health support ..."

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About PARC

The Primary Mental Health Care Australian Resource Centre (PARC) is an Information Service in Primary Mental Health Care, to support Australian professionals with their mental health activities.

(Continued from page 3)

collaborative mental health service delivery has occurred.

The model of collaborative service delivery consists of:

- the provision of Clinical Psychology services in the Medical General Practice setting, preventing the need for articulation of assessment and treatment to other specialist settings as is usually required. Patient attrition, which often occurs at this point, is thereby minimised;
- "in-house" referral of patients whom the General Practitioner feels could benefit from psychological intervention;
- an initial joint session between the patient, General Practitioner and Clinical Psychologist at the commencement of the psychological assessment to facilitate rapport, to obtain patient consent for a team approach to treatment and access by the psychologist to the patient's medical notes. The joint consultation also facilitates appreciation by both professions of their alternative and complementary ways of formulating patient difficulties and presenting conditions.
- Collaborative treatment occasionally entailing some joint consultations in which the GP and Clinical Psychologist see the patient together. Most frequently, GP and psychologist sessions continue in tandem, with the GP needing to see the patient less frequently to monitor medication for both mental health and other health issues.
- Ongoing treatment sessions using a six (plus six if needed) session treatment model with a total of up to twelve, including follow-up sessions. This model is most applicable to high prevalence disorders of anxiety and depression which have formed the majority of patients treated in this trial.
- Free psychological treatment, with the first joint session with the GP being Medicare rebateable.

The aims of the Project have been to:

- service patient needs in regional and rural locations where access to specialist help is often limited;
- facilitate/enable early intervention with mental health conditions and some physical conditions with either a psychological cause or psychological sequelae, thereby preventing both the development of greater severity of the preventing condition and greater frequency of use medical services;
- support GPs with the diagnosis, management and treatment of patients presenting with psychological issues;
- provide an effective way of supporting GPs to more adequately meet their patients' mental health needs, particularly in the current context of lack of adequate and accessible mental health services;
- provide learning outcomes for both Clinical Psychologists and General Practitioners whilst working collaboratively;
- develop appropriate funding models suitable to GPs and psychologists to facilitate ongoing provision of this method of service delivery in locations where fee paying may not be a viable source of monetary support;
- provide an innovative generic model of mental health service delivery which can be articulated nationally;
- offer training opportunities for post graduate students in Clinical Psychology (Doctoral and Masters interns in Clinical Psychology);
- develop a trained, specialist mental health workforce with experience in the provision of evidence-based, focused psychological techniques in the Primary Care Setting.

Interim results:

Comparison of pre and post test scores on treatment patients, as well as detailed paired analysis of the pre and post test scores for treatment and control patients, indicates that the therapeutic intervention in the collaborative model of mental health service delivery is having a significant and positive impact on patients' mental health and well being when compared to "treatment as usual" by GPs in the Primary Care Setting.

(For a detailed outline of these results see Vines et al (2003)).

Current developments:

The collaborative model has been highly successful with both patients and GPs and provides a valuable placement experience for Clinical Psychology Registrars.

In addition, the training framework in which the collaborative model has been trialled results in appropriate workforce development for specialist mental health service delivery in the Primary Care Setting. The model is now being funded in a number of further regional and rural locations under the new Commonwealth Government Better Outcomes in Mental Health Care Access to Allied Health Initiative, ensuring more widespread access to funded psychological services.

Written modules providing a clear framework for the collaborative model between GPs and Clinical Psychologists of treatment for patients with mental disorders are being developed by the Project Team with ongoing support from the Commonwealth Department of Health and Ageing.

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Primary Care Counsellors - the UK Experience

Joan Foster
Chair, Association of Counsellors and Psychotherapists in Primary Care (CPC)
Chair, PriMHE (a charity to promote Primary Care Mental Health and Education)

"... in the UK primary care counselling has developed rapidly over the past ten years to become what can be identified as a "distinct discipline"..."

What is Primary Care Counselling?

In the UK primary care counselling has developed rapidly over the past ten years to become what can be identified as a "distinct discipline". It is generalist, brief, focussed work. It is short term – six to eight one hour sessions, usually weekly. The counsellor will see a wide spectrum of presenting problems, such as:

Depression	Anxiety
Panic Attacks	Injury
Illness	Trauma
Bereavement	Life Crises
Stress	Abuse Issues
Loss	Relationship Issues

Referrals to secondary services will be for the more complex mental health problems such as:

Phobias	Eating Disorders
Obsessive Compulsive Disorder	
Psychosis	Schizophrenia
Manic Depression	Substance Abuse

Primary Care Counsellors usually see adults – aged 16 plus, and usually individuals rather than couples. There is a strong tradition in the UK of Couples Counselling usually provided by a voluntary organisation called Relate. There is a serious shortage of family therapists and child and adolescent therapists.

There has been dissention, over the past 5 – 10 years, as to whether Cognitive Behavioural Therapy (CBT) or Counselling should be the treatment of choice. It could be said that CBT sits more comfortably with the medical model, whereas counselling shifts the focus into new areas of thinking and approach. My view would be that CBT is appropriate for some patients, particularly in the areas of OCD and phobias. However, more generalist counselling can be highly effective for many clients in the mild to moderate spectrum of mental health problems.

Context:

The last four years have seen dramatic changes in the structures within the Health Service in the United Kingdom.

The current structure in England is:

Department of Health
(Sets national strategy and implements Government policy)
↓
28 Strategic Health Authorities
(Provide strategic overview for population of about 1.5 million)
↓
305 Primary Care Trusts
(Provide community and primary care and commission secondary care services)
↓
8000 General Practices (35,000 General Practitioners (GPs))
(On average 2000 patients per GP. GPs are self-employed & employ own staff)

To emphasise the speed of change, in 1999 there were 95 Health Authorities and 461 Primary Care Groups. Similar structures are being put in place in Wales and Scotland, but they are not as advanced as in England.

Policy for Mental Health has been set at national level with the publication of a "National Service Framework for Mental Health" in 1999. This sets seven standards, which all services are required to meet. The standards are:

- Standard 1: Mental Health Promotion
- Standards 2/3: Primary Care and Access to Services
- Standards 4/5: Older People with Severe Mental Illness
- Standard 6: Caring about Carers
- Standard 7: Preventing Suicide

Background:

The development of counselling in the NHS has been rapid. They first started working in general practices in the late 1960's, by 1992, 31% of English and Welsh practices had a counsellor. By 1999 this figure had risen to 51%. By 2001, 76% of Primary Care Trusts (PCTs) in England reported a primary care counselling service in place.

Primary Care Counsellors could be said to exemplify the tensions between primary and secondary care mental health services. Throughout the 1990's and sadly still today, there is tension between secondary and primary care mental health services. For years the focus has been Secondary Care Mental Health Services and Primary Care has been the poor relation. The National Service Framework for Mental Health stated that 9% of the population were referred to secondary services, with the other 91% only being seen in primary care. However, the funding

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PARC Services

Reference Service: help finding resources or information to support projects

Loans of educational materials to Divisions of General Practice

Free licensed copies of journal articles for Divisions of General Practice

Website and the PARC Electronic Library of Primary Mental Health Care Resources packed with information.

Contact PARC on 08 8204 5917 or email parc@flinders.edu.au Visit our website http://www.som.flinders.edu.au/FUSA/PARC

"... it is interesting to note that a particular benefit of the presence of a primary care counsellor in a general practice setting has been a contribution to the emotional well being of the practice staff ..."

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streams are probably reversed!

There is increasing awareness of the mind/body link, with estimates of the mental health component in presentations at the GP surgery varying from 30 – 60% or more. Skill in recognition and appropriate referral is essential. Research in the UK showed that GPs fail to recognise that 30 – 50% of people have a mental health problem.

Establishing equitable primary care counselling services across England has identified important areas that need to be considered before an effective service can be put in place. The issues that have had to be addressed are wide and varied:

1 Counsellors are not statutorily regulated therefore anyone can call himself or herself a counsellor.
2 In the 1990's, 60% of counsellors were self-employed, 30% employed and 10% were students or volunteers. As a result no service started from a clean slate, instead there were isolated counsellors, working to different standards, pay and conditions. Bringing these disparate counsellors together in some form of managed structure is on-going and challenging work!
3 There were (and still can be) issues between counsellors and psychologists as to status and control.
4 Counsellors found their ethos of confidentiality challenged when working within a statutory service where more open information sharing was the norm.
5 Counsellors bring a non-medical model of treatment into the NHS, which needs to find an accepted place.
6 There were few, if any, effective pathways of care between primary and secondary care.
7 Creating effective service structures in a constantly changing system can be difficult.
8 Counsellors as Managers are a new development, with little previous experience or training.

Benefits:

Having a counsellor as a member of the Primary Health Care Team (PHCT) is of great benefit to a practice. Once the counsellor becomes integrated as a member of the team, they can work closely with the referring GP for example, ensuring the patient receives appropriate physical and emotional care.

Patients may return for further counselling and a practice-based counsellor will have the same "cradle to grave" care as the general practitioner.

Placing a counsellor in general practice reduces the stigma of a mental health referral. The patient does not have to travel to a different building and meet a new set of staff.

It is interesting to note that a particular benefit of the presence of a primary care counsellor in a general practice setting has been a contribution to the emotional well being of the practice staff. This can be seen by an ability of the counsellor to contain anxiety. The opportunity for informal contact with a staff member who approaches the workplace from a psychological as opposed to a physiological perspective can result in a more "whole" approach to both staff and patient care.

Moving to the benefits of a co-ordinated managed service of primary care counsellors, with good referral pathways into secondary care. Once a team is in place, there can be cross-referrals when boundary issues might make it inappropriate for a counsellor to work with a husband and wife for example. Specialist skills can be brought into use – such as working with the abused, bereavement, stress management etc. A service approach also meets the needs of accountability and evidence based practice.

Conclusion:

The survival of primary care counselling in the UK is to be celebrated, as two years ago it was by no means a certainty. There can be reluctance at an institutional and culture level to accept the need for counselling. The British "stiff upper lip" has strong adherents and it can be seen as a sign of weakness to admit to emotional problems. Counselling is the treatment of choice for many people, aligned with a preference not to take pills. There has also been a resistance within the NHS to accept the role of counsellors. This is not only due to the difficulty there can be to accept change, but also due to the struggles for any new profession to establish itself.

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NEWS FLASH

Many of you will be aware of the work that PARC has been doing in lobbying for access to a range of academic databases, journal articles and library services for Divisions staff.

Unfortunately our submission to the Commonwealth for them to fund this for Divisions has been turned down on the grounds that access to the medical literature was not identified as a priority in the Review of Divisions.

Our next move will be decided by the Knowledge Management Action Group (KMAG) on September 15th 2003.

Partners in Mind

Shirley Anastasi

Development and Liaison Officer, QDGP

In June 2003, the Queensland Divisions of General Practice (QDGP) and Queensland Health launched www.partnersinmind.com.au. *Partnersinmind* has been developed to promote Mental Health Shared Care and to gather together project reports and resources from the General Practice and Psychiatry Partnerships (GPAPP) program.

The Mental Health Intersectoral Reference Group, a group consisting of members from QDGP, Queensland Health, the Commonwealth Department of Health and Ageing, the Queensland Alliance and Department of Veterans Affairs, identified the need for a centralised resource for information about mental health shared care. The establishment of the *Partnersinmind* website represents a unique collaboration of state level stakeholders from within the mental health sector.

The website provides:

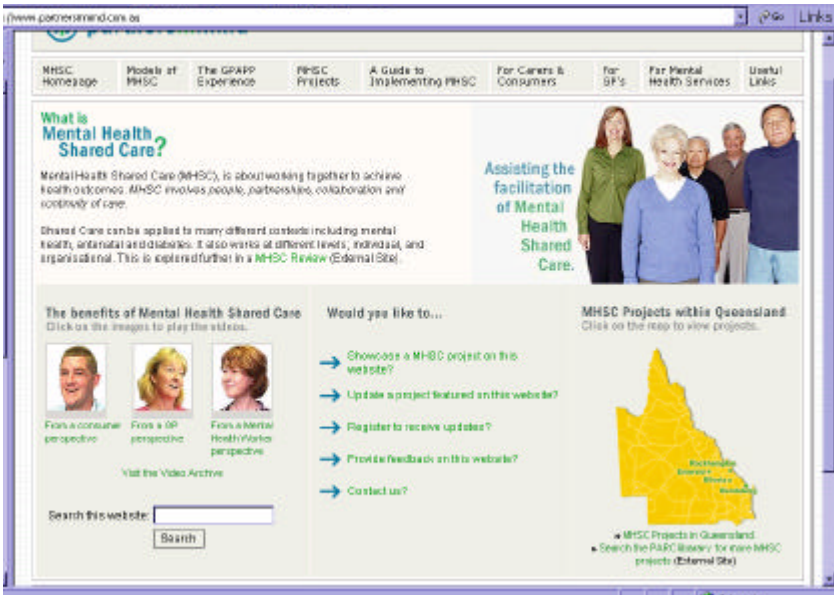
- Information on how to implement effective shared care at a local level
- A centralised location for resources
- Information and learning outcomes from various mental health shared care projects
- The benefits of mental health shared care from GP, consumer and mental health worker perspectives
- Links to other relevant websites

Significant consultation was conducted. A consumer and carer reference group provided input in to the development of the website to ensure that it is user-friendly, relevant and practical. There are sections tailored to provide information for specific groups, namely GPs, consumers & carers and other health service providers. The information contained is evidence based and practical and has the potential to enhance the services provided to people with mental illness. The website also has video snapshots that capture the real life experiences of a consumer, a General Practitioner and a mental health service worker. These experiences are powerful and encouraging and add to the uniqueness of this website.

An development has been that the website was recently awarded the 2003-2004 Golden Web Award. This award is part of the "International Association of Web Masters and Designers" and is awarded for excellence in web design, originality and content. This award means that the profile of mental health has been promoted in another part of the wider community and that this is very unique in itself.

The website is being maintained by QDGP and is in it's early days of development. The challenges include collecting and updating the resources with relevant information, maintaining the commitment and enthusiasm of those involved and sustainability in general.

"... *Partnersinmind* has been developed to promote Mental Health Shared Care and to gather together project reports and resources from the General Practice and Psychiatry Partnerships (GPAPP) program ..."



LOANS AVAILABLE

PARC has many educational resources available for loan to Divisions. Hot items are a range of University of Manchester videos developed by Andre Tylee and David Goldberg.

We also have EPPIC guides to psycho-education in early psychosis, a video and training manual for Enhancing Cultural Competency from the Transcultural Mental Health Centre, and much more.

Check the PARC website for a catalogue and contact PARC to arrange a loan.

Discussion paper: Knowledge Management - How do we reframe the concepts of KM into a paradigm easily understood by GPs?

Duncan Steed

Central Wheatbelt Division of General Practice

The simplest paradigm here may be to find examples relating to what is known about GP learning, experience and education and 'fit' this into the explicit/ implicit and tacit model. Many GPs may not understand the latest knowledge about GP learning but would have a pragmatic awareness about 'what works for them' and may well have some insight into 'what may be helpful for the likely future roles of the GP'.

There is much already known that would fit well into the KM model eg:

- Characteristics of adult learners
- Commitment to life-time learning
- Problem based learning principles
- The benefits of group learning.

As well as some interesting current initiatives eg:

- Computer-assisted learning
- On-line inter-active case reports
- GP peer support groups
- Ways of dealing with inexplicable health problems
- Activities linked to Better Outcomes in Mental Health Initiative.

The new paradigm for CME proposed by Karen Mann, and others, seems to capture much of the spirit of KM, it can be summarised as:

- Knowing what you do not know (not feeling bad about it) and knowing how to find out (or help others to find out)
- Learning from cradle to grave
- Legitimising uncertainty, learning by questioning
- Ability to question received wisdom
- Turning problems into questions and to find, appraise, store and act on experience and evidence to solve them
- Complementing experience with knowledge from research
- Problem and process based learning
- Professionals as members of collaborative teams.

Even if it is accepted that "GP LEARNING", is an appropriate paradigm for promoting the principles of KM there would need to be much work in developing the right language and tools for the job. A useful model that has worked in Divisional programs is "how does this information help the GP better manage (educate, treat or refer) the individual patient in front of them'.

What is different about applying KM principles in primary mental health care?

I have long been fascinated by the tendency of people at Mental Health Conferences to spend much of the conference debating definitions of 'mental health', 'mental illness', 'mental health promotion', 'mental health disease prevention, treatment, cure etc etc'.

Given this inherent uncertainty with definition, together with similar uncertainty as to the scope and relevance of psychiatry and allied disciplines it is hardly surprising that the clarification and measurement of outcomes in mental health remains elusive.

To further muddy the waters 'the evidence for interventions in primary care, whilst now just emerging from some of the research (Sphere, CLIP) is far from clear enough to inform the wide range of situations facing the GP

On the positive side, it seems to me that the Mental health area has been the one that has most clearly demonstrated the potential for Divisions as 'agents of health care reform', locally, and at State and National levels. An example in point being our local mental health services in the Central Wheatbelt. Ten years ago there was one mental health nurse for the entire area with little communication and woeful discharge planning. We now have greatly improved communication, discharge planning, shared care and numerous and diverse service providers, most of them at no cost to the patient. The challenge now seems to be to put in place the systems changes necessary to build the teams to provide primary mental health care and define the relative roles of the team members. Systems change in the many organizations will also be needed, hopefully moving towards the principles of 'learning organizations'.

The approaches I have supported in the past, given the enormous uncertainties around mental health (uncertainty is a thing most GPs are well used to) are pragmatic ones:

- Work with the GPs who want to work with you
- Develop local solutions with other mental health care providers who want to work with you
- Promote simple measuring tools that are relevant to GP and patient (eg K10)
- Design simple ways for GPs to evaluate the outcomes of their interventions
- Link CME to the above to highlight the 'learning' nature of the process rather than the 'academic' or bureaucratic'
- Link incentives into process.

The model of national, state and divisional staff all dedicated to an individual initiative (Immunisation, BOMHI) seems a very good one, though it is dependent on the selection and retention of high quality staff (though I suppose there is nothing too unusual in that), a strong policy initiative and funding support. These initiatives also seem to have a relatively short time line.

How do we develop a 'generosity of spirit' in the culture of Divisions to enable sharing of data, information and knowledge?

There is no doubt that Australian general practice has a ruggedly individual, isolated and competitive commercial basis, not so apparent in other health systems in which I have worked (NZ, UK) and that some unhelpful attitudes have transferred from general practice to Divisions.

Working for Divisions is, by and large, still not viewed as a 'valid form of work' and certainly accorded less importance than traditional GP work. The skills that

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a GP has to learn in making the transition to management (information management, facilitator skills, office management, accounting, program design and management etc) are, by and large not understood or greatly valued by GPs.

As in nearly all areas of the health system there is then a tendency for the loss of 'corporate knowledge' in Divisions, with a tendency for GPs with the knowledge to drift into other area of the health sector and little effective succession planning.

Along with these trends, and partly because of them, individual, group or program 'excellence' is rarely identified, supported or promoted. Although there have been outstanding individual divisional (and inter-divisional) programs people have usually only learned about them by ad hoc means. The benefits of inter-divisional programs (hard to get going) have not been identified or promoted.

Finally, the almost total absence of defined health policy at National and State levels over the last five years has led to great uncertainty among Divisions and Divisional staff. Good career structures for Divisional staff are rare indeed.

All this sounds a bit gloomy, so I will end this 'snapshot' by stating that I have had some of my greatest moments whilst working with Divisions, have met lots of lovely intelligent people, had my own abilities challenged many times, learned tomes and seen nearly all of the beauty of Australia in the process.

How then to proceed? A few suggestions?

1 Leadership must be a key to setting the 'climate' within organization. Leadership and management training programs for GPs and Divisional staff have been high quality, brief and rare (eg Deakin program c1996). Training, modeling and promotion of leadership qualities relating to vision, collaboration and facilitation are all needed.
2 Managed collaboration (as it was termed in the UK white paper) needs to be encouraged by Policy promoting integration and funding linked to the same.
3 Systems for identifying 'excellence' and 'innovation' need to be developed, together with methods for refining the knowledge and effective dissemination of the latter. This will require much stronger links between academic units and Divisions (necessary for a whole raft of reasons of their own)
4 Principles of 'learning organizations need to be implemented through the health sector (and not least the GP organizations representing General Practice)
5 Principles relating to the formation and maintenance of 'collaborative teams' require to be introduced to all levels of medical education. The benefits, individual and group, promoted widely. Why do GPs enjoy working in a Palliative Care Team?
6 GPs need to be taken from their comfort zones and stirred gently with others from whom they can learn (including patients and good GP role models) within a environment conducive to learning.
7 A philosophy promoting positivity and generosity of spirit needs to be encouraged. Altruism is not psychopathology, and we are all working, by and large, with public funds for the common good.

"... individual, group or program 'excellence' is rarely identified, supported or promoted. Although there have been outstanding individual divisional (and inter-divisional) programs people have usually only learned about them by ad hoc means ..."

Aboriginal Mental Health Worker Program: working both ways

Sandy McConachy
Top End Division of General Practice

Background:

One of the factors contributing to the inequity in health service delivery for remote communities is the lack of professional allied health services which could support the work of General Practitioners. There was an identified need that local qualified Aboriginal Mental Health Workers are desperately required to work in collaboration with primary health care provision and that Indigenous people are the key stakeholders in the delivery of culturally appropriate services to remote communities.

There must be primary recognition that GPs are not psychiatrists and without support in the basic areas of culture, language and local knowledge from the Aboriginal Mental Health Workers, often struggle to provide informed and appropriate mental health care.

Aims:

To improve the health care of indigenous people within a remote community through the provision of effective and efficient allied health services that provide the optimum health outcomes in a cost effective manner. To provide to General Practitioners, the vital cultural link to knowledge, understanding and language of indigenous people around issues of mental health and well-being. To enhance the capacity of GPs in the accessing of Medicare Benefits Schedule Items. To value add to the Government initiative of retaining GPs in the bush.

Currently the program supports 17 AMHWs in eight remote communities which have a resident General Practitioner, across the Top End.

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Practice objectives:

- To build community capacity to address community issues.
- The development of a two ways partnership between GPs and AMHWs: to provide local solutions to local problems.
- To have a culturally sensitive program and service delivery that is community managed and directed and owned in each and every part of the process.
- To incorporate prevention and early intervention as part of the role.
- To be administratively economical, as workers become part of the existing service system.
- The Division remains as a broker between the AMHWs, the Councils and the GP in the development of remote area general practice in mental health care.
- The GPs and health centers remain autonomous relative to the Division therefore encouraging a model of consultative collaboration.

The underlying theme:

"*To provide local solutions to local problems***."** Each remote community has varying levels of mental health issues to address and a major factor for remote communities is the need for *community based services,* not visiting services which tend to provide infrequent support which is less likely to be culturally appropriate.

There stands an acknowledgment that Non-Indigenous people are unable to fully understand the intricate cultural and traditional ways of Indigenous people therefore indigenous staff are paramount in providing basic mental health intervention.

Support from the Top End Division:

TEDGP has two dedicated indigenous support staff to assist with the smooth implementation of the program into the communities. The support staff also provide a link to the Top End Division with ongoing mentoring, encouragement and brokerage support, if required, on personal or workplace issues.

Current funding:

The program is currently funded by the Commonwealth Government's, 'More Allied Health Services' and beyondblue Limited. Future funding is expected to be forthcoming from beyondblue via the Alcohol Rehabilitation Education Fund which will see the number of participating communities being increased and the AMHWs being trained in issues pertaining to alcohol and substance misuse.

PARTNERSHIP AGREEMENT UNDERPINS THE PROGRAM between:

- Top End Division Of General Practice (TEDGP)
- Batchelor Institute Of Indigenous Tertiary Education (BIITE)
- Top End Mental Health Services (TEMHS)
- Northern Territory University (NTU)

The Partnership Agreement intends to foster a cooperative partnership between the above organisations to support Aboriginal Mental Health Workers (AMHWs), General Practitioners and the visiting Mental Health Teams in addressing mental health needs in remote communities in a culturally appropriate and sensitive service delivery model.

For any further information on this program please contact:
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Top End Division of General Practice
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Referred Counselling Project (Access to Allied Health)

Katie Prince
Fremantle Regional Division of General Practice (GP Network)

Fremantle Regional GP *Network*'s Referred Counselling Project began in November 2002 as one of two Western Australian Access to Allied Health Pilot Projects, part of the Better Outcomes in Mental Health Care (BOiMHC) Initiative.

This Project involves General Practitioners and Allied Health Professionals (AHPs) working together to improve the access and equity of mental health care for consumers, leading to better health outcomes.

Consumers aged 16 years and over who present to the GP with a mental health problem, would benefit from short-term individual counselling, but are unable to access private psychological services, can be referred. Consumers are asked to pay a co-payment, determined by the GP.

Forty hour-long counselling sessions are available weekly. GP *Network* has contracted five Allied Health Professionals to deliver these services in nine general practices throughout the GP *Network* region.

General practitioners who are interested in referring patients to the Project, and are registered with the BOiMHC initiative, are given a GP Referral Kit, which outlines the roles and responsibilities of the GP, AHP and GP *Network*.

When referring a patient, the GP completes the Referral proforma and faxes it to GP *Network*. The original copy of this Referral is given to the patient to be taken to the first appointment with an AHP. At this time, the patient is asked to sign a Project consent form and is provided with a copy of the Service Information Sheet, which details the service. It is then the responsibility of the patient to phone the Booking Officer at GP *Network* to organize their first appointment.

Following the patient's first appointment, the GP is provided with an Initial Report from the AHP, outlining the patient's problems, strengths and a goal for counselling. A second written report is provided on completion of the final appointment. In addition, at this time, the AHP and GP are asked to complete a Progress Feedback Form regarding the effect of counselling on the patient.

The Project is now moving out of the pilot year and into Phase 2. Since commencement, the Project has undergone continuous review, which has resulted in processes, policies and resources being improved and streamlined.

For more information, please contact:
Katie Prince
Mental Health Project Officer
Fremantle Regional Division of General Practice (GP *Network*)

South East Access to Allied Health Project

Graham Fletcher
Dandenong District and Greater South Eastern Divisions of General Practice

These two Divisions have a combined membership of over 360 general practitioners, representing approximately 240 practices[1] in three complete and two partial local government areas in Melbourne's south east. The number of accredited practices is currently 106[2]. The principal project officer is located at Dandenong Division, with a support officer at Greater South Eastern Division.

The model:

Participating GPs receive serial numbered vouchers that entitle the patient to up to six sessions with a selected service provider. Comprehensive referral documentation has been based on the Victorian Department of Human Services/Primary Care Partnership Service Coordination Tools. These include*:

- Summary and Referral Form
- Patient (Consumer) Information Form
- Patient (Consumer) Consent Form

The DHS/PCP *Summary and Referral Form* has been adapted to incorporate the *Mental Health Assessment* and *Mental Health Plan* components of the 3 Step Mental Health Process. The Consent form enables transfer of information between health professionals as well as collection of de-identified data for evaluation purposes. GPs complete a data collection form outlining patient demographics and other information as required by the evaluation data set.

A 'Feedback Form', completed by the service provider, provides information back to the referring GP regarding assessment, treatment and outcomes/ recommendations. This is intended to inform the Review component of the 3 Step process.

Service providers are paid by the Division on receipt of a claim form (tax invoice) that also incorporates details of the service provided (dates and duration of sessions, brief description of intervention provided).

Service providers:

Service providers were selected following an initial invitation to participate and an interview process. Guiding principals in selecting providers included geographic spread to enhance access and choosing agency or larger group private practices, where there was likely to be flexibility in their capacity to provide relevant and timely services. Service Agreements ensure that providers are skilled and qualified in providing CBT and that providers comply with the professional and business requirements of the project. Payment schedules have been negotiated with providers on the basis of their existing business model, with session costs ranging from $60-$100. Providers had the option of requesting a patient contribution, although none have imposed this.

GP participation:

In the first eight months of the project 40 GPs have received a total of 300 vouchers. About 100 referrals were initiated according to project records. It is known that more have been undertaken, but data has not yet been forwarded to the Division.

Not all GPs who have requested vouchers have followed through with referrals, reportedly deterred either by the administrative requirements of the initiative or by lack of confidence in their skills to make appropriate assessments. However, a number of participating GPs have embraced the project and are making numerous and regular referrals, reporting high levels of satisfaction with the project mechanisms and patient outcomes.

While every effort has been made to promote the project through Division newsletters and regular communication with members, it appears that there are still numbers of GPs who are not aware that this is available. However, the project is gaining recognition among Division members through word-of-mouth, and an additional promotional event will be conducted involving presentations by service providers and participating GPs.

Evaluation:

Data collection processes have been implemented to gather key minimum data set information as required by the Department. Some gaps exist in this process but we are able to report that between October and May just under 100 vouchers were activated. That is, patients either commenced or completed a psychological intervention. Of the 100 vouchers, **61** were completed (ie invoice received and service provider paid). From the related documentation we are able to state that **337** individual sessions were attended (average number of sessions attended = 6; ranging from 1 session to 12). Expenditure on actual service purchase was **$28,340**, at an average cost of **$464.60** per patient.

Analysis of actual services provided is based on the brief description included by the service provider on the reimbursement claim form. To date all services have been provided for individuals (ie. no referrals to groups). Depression and anxiety disorders are the most commonly reported diagnoses, often combined. Based on the information available, CBT strategies provided include psycho-education, cognitive interventions (particularly cognitive analysis), relaxation strategies, skills training and interpersonal therapy.

A preliminary round of interviews was conducted with a sample of participating GPs in February. Generally, the project has been reviewed favourably with some reservation expressed about the complexity of the referral mechanisms.

Further local evaluation activities commence in August. This will be undertaken by the Melbourne University Centre for Program Evaluation, who will conduct more extensive interviews and focus groups with GPs and service providers. The evaluators will address a range of issues including identification of facilitative and inhibitive factors in the referral process, changes in the interface between general practice and psychologists, and an assessment of patient outcomes according the professional judgement of those practitioners.

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[1]DDDGP - 79, GSED - 161 w/in post code boundaries
[2]DDDGP - 62, GSED - 44 w/in post code boundaries
*Copies of these forms can be found on the Division web site

Allied Health Mentoring in Central West NSW

Helen Denovan
NSW Central West Division of General Practice

This is a pilot project to develop and trial a replicable model of mentoring for allied health practitioners providing service in small rural towns less than 5000 in Central West NSW. This project will be developed in partnership between Services for Rural and Remote Allied Health (SARRAH) and the NSW Central West Division of General Practice (CWDGP) and is funded by the Commonwealth Department of Health and Ageing, through the Regional Health Strategy.

Dr Louise Roufeil, Program Director for the NSW CWDGP is overseeing the project and Cas Ingham and Helen Denovan are the project officers. An advisory group which will be chaired by Robyn Adams from SARRAH and will include consumer, GP and allied health representation will be established.

About the pilot:

By December 2003 we will develop a mentorship model which will suit the central west and be applicable across professions and health sectors. The model will include training of mentors and will be trialled and evaluated by December 2004.

We are currently mapping the allied health workforce in the area and conducting a needs assessment of the workforce in regards to mentorship.

Who can be involved?

Professional groups can include: physiotherapy, occupational therapy, speech pathology, podiatry, psychology, orthoptics, social work, radiography, audiology, dietetics, and prosthetics/ orthotics.

Professionals providing services to towns of population less than 5000 will be targeted. Towns included are Portland, Oberon, Blayney, Molong, Cudal, Eugowra, Canowindra, Peak Hill, Grenfell, Condobolin, Lake Cargellico, Tottenham, Tullamore, Trundle, Kandos, Rylestone, Yeoval and Wallerawang

Professionals employed in the public, private and non government organisations will be eligible to be included. Service mapping will assist in determining who to include. Individual service providers will be invited to participate as mentors or mentees.

Recruitment and retention of allied health staff to small rural communities is difficult. The intention of this project is to develop an appropriate model of mentoring that might support allied health professionals in these communities.

We are interested in networking with any allied health professionals in the area.

Anyone interested in the project can contact Helen Denovan, Cas Ingham or Louise Roufeil at the NSW CWDGP on 02 6332 6646.

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Better Outcomes in Mental Health Care Initiative
Access to Allied Health Services - Integrate for Recovery

Fairlie McIllwraith
Program Coordinator. GP Connections - Toowoomba & District Division of General Practice

The program in its pilot stage was hugely successful for all stakeholders and we are now in the live stage.

Defining features of our model included small patient co-payments, treatment sessions held in general practitioners' (GPs) rooms, engagement of a central booking agent to handle referrals, the availability of a joint session with the patient, allied health professional (AHP), and GP, and engagement of sufficient AHPs to provide a range of different therapies and styles.

Our overriding concern at this stage is the low level of funding and the changes made to the pilot program are largely in response to a high uptake of the service and a reduced budget. In other words, we are grappling with how to conduct an expanding and highly successful program on a decreasing budget.

The measures we have taken do not alleviate the problem to any great extent but are our attempt at keeping operating costs to a minimum. Thus we have increased the amount of the patient co-payment but have retained the right for the GP to waiver the co-payment. We realise that the financial benefits of an increased patient co-payment may be cancelled out by an increase in the number of waivered co-payments.

We have dispensed with the services of the central booking agent and referrals will be directly from GPs to AHPs. The downside of this is that with a large number of contracted AHPs more time will be spent in acquiring information for ongoing monitoring and evaluation.

We continue to encourage treatment sessions to be conducted in GPs' rooms where appropriate. In practice what often happens is that the initial treatment session is held in the GP's rooms and subsequent sessions are held in the AHP's rooms if the patient is comfortable with this arrangement.

(Continued on page 13)

(Continued from page 12)

The joint session was highly valued by GPs, AHPs, and patients and this has been retained as a valuable component of the treatment program.

Our external evaluators, the Mental Health Education and Research Service at Toowoomba Health Service, concluded that:

> Evidence thus far suggests this service is offering early intervention and continuity of care for clients with mental illness. It also potentially reduces stigma and offers an affordable service to clients who may otherwise not be in receipt of treatment. There is global support from AHPs, GPs and clients for the continuation of this service.

There have also been a number of positive side affects such as increased appreciation by both GPs and AHPs of each other's roles. This understanding was further expanded at a meeting for participating GPs and AHPs that focused on the patient handover process between GP and AHP. The program included acted vignettes, a brainstorming session, workshop and final integration session. The meeting was videoed and those GPs and AHPs who did not attend are able to borrow the video.

Overall, the program has been an outstanding success but as one GP commented:

> The service is wonderful and the combined interview marvellous and very beneficial but I don't think there is any point in continuing if we are only going to be allowed a very limited number of referrals. Only being able to refer a few people is an enormous stress and it would be better not having a service at all.

This participating GP's comment underlines the present problem. GP Connections is making representation to obtain commitment to expand this initiative, otherwise it will surely die. We would be interested in hearing the views of other tender holders.

Sunshine Coast Allied Health Pilot

Deborah Hookham
Sunshine Coast Division of General Practice

The Sunshine Coast Allied Health Pilot was granted funding for 2002/2003 and began taking referrals from October 2002.

The Sunshine Coast has a mix of provincial and rural communities. The Division also has a MAHS program providing mental health services mostly in the Cooloola Shire.

Four allied health professionals (three psychologists and a social worker) are engaged to provide pilot services across the three local government areas of Noosa and Maroochy Shires and Caloundra City.

Two workers are located in GP surgeries, one in a community hospital's consultants rooms and another in a local counselling agency.

There are 1.4 (FTE) clinical providers, a 0.4 project manager and 0.3 receptionist directly employed by the Division.

This is supplemented by two AHPs contracted on a per session basis doing approximately two days per week. Contracted AHPs invoice the Division monthly. The Program funds professional supervision in group format that all AHP's can access.

There is no co-payment sought from the patient. Patients are identified by their GP as being of low income. Services are provided to those aged 14 years and over.

The Pilot has 77 GPs registered to participate with 85% of those making referrals to the service.

Between Oct 02 and June 03, 389 referrals were received with 287 patients contacting and making an appointment.

984 individual counselling sessions were conducted in the same nine-month period.

Groups were not popular particularly in the smaller rural communities. Increasing costs of rental accommodation in the coastal areas has forced those on lower incomes to live in the rural/hinterland areas where transport is either very expensive or non-existent.

In one area alone 50% of the referrals received came from the rural community while 100% of the non-contacts for an appointment came from the same community. The service is currently looking at ways of bringing services into these areas.

Referrals are faxed by GPs and notification is given to GPs of when their patients keep their first appointment and the name and contact numbers for the AHP; whether their patients fail to contact at all or if they drop out of the program before the expected number of sessions.

Referral and all other feedback forms to GPs have been standardised and apart from the final report to GPs about patient progress and outcomes all communication is via fax where possible.

GPs receive updates and information and are invited to give feedback on the service in general via monthly Pilot Faxes to participating GPs.

ACCESS TO ALLIED HEALTH SERVICES PROJECTS PROFORMAS & RESOURCES

Several people have indicated that they would like proformas and resources developed as part of the Access to Allied Health Services Projects to be available in a central place.

PARC have offered to provide this service on our Allied Health Services web page.

Could those Divisions who have developed resources please forward them to PARC and we can make them available on our web site.

Alternatively, if you want to retain them for your own web site, could you send PARC the link.

Email: parc@flinders.edu.au

Northern Wellbeing

Sherri Hodgekiss
Adelaide Northern Division of General Practice

Adelaide Northern Division of General Practice was the first division in South Australia to be successful in gaining funding to provide allied health services to their members.

They have been providing mental health programs to support general practice since 1993 providing an extensive shared care project. The ideas for the allied health project had been discussed with general practitioners, community mental health services and community health services to determine how the mental health needs of the community who are patients of general practitioners in the northern area would be met.

Northern Wellbeing offers assessment and intervention to Adelaide Northern Division of General Practice patients aged 14 years and above who report to their General Practitioner with psychological distress and are diagnoses as having an anxiety or depressive disorder.

Patients are excluded from the service if they have significant cognitive impairment, a primary substance abuse problem and/or are involved in medico-legal proceedings. The patient may have a co-morbid presentation, as long as the non-anxiety/depression problem (eg, psychosis, bipolar disorder) has been stabilised for a period of time.

The clinicians provide an assessment plus a maximum of five therapeutic sessions of cognitive behavioural therapy at the referring practice. The sessions last about an hour and cost the patient $10.00 or $5.00 for health care cardholders.

On completion, the clinician provides the referring general practitioner with an intervention summary report. The general practitioner can then conduct a mental health review with the patient.

Clinicians:

Six clinicians (psychologists and social workers) provide 2.5 full-time equivalent clinical input.

Recruitment of Consumers:

Twenty-eight GP's from 15 practices have made a total of 349 referrals until

31 July 2003. The first referral was received on 10 September 2002.

The number of referrals per month has remained high and constant. Two referrals have been inappropriate and two patients have been re-referred.

Therapeutic intervention commenced on 18 September 2002. When divided into practices, the average wait between the referral and first appointment ranges from 9 days to 29 days. These averages are a reflection of demand on the service, patient's availability to be seen on the allocated day, staffing, and GP room availability.

The large majority of patients were recognised to have problems with both anxiety and depression.

All patients were referred for assessment, education and therapy. Some patients were recognised by their GP as having interpersonal problems and a goal was to address this issue. Session notes are kept in the patient's file at their general practice (either on medical director or hard copy) and also in their file at Adelaide Northern Division of General Practice.

Positives of the service:

The feedback from GPs and patients has continued to be extremely positive and encouraging. Benefits highlighted by consumers included:

- Being seen at the GP practice (ie, familiarity - feeling 'safe' and 'protected'; accessibility - close to home)
- Having their first appointment organised for them (Adelaide Northern Division) contacts the patient for the first appointment)
- The 'token' payment (helped ensure motivation and value of the service)
- Being listened to, supported and not judged
- The usefulness of cognitive behavioural therapy approach.

GPs and clinicians also saw benefits of seeing patients at GP practices and keeping GPs abreast of the intervention (ie, session notes given to GPs).

Difficulties:

- Clinician's balancing their workload between client sessions and administrative tasks (i.e., case notes, closure reports). This was resolved in a number of ways. Arrangements were made with the practices regarding computer and printer access (included having lap tops for clinicians). Templates were developed for closure reports and case notes, which required minimal information. The remaining administrative tasks (e.g., letters to patients) were performed by the Division administration assistant.
- Evaluation. The lack of clarification and timing about the minimum requirements of the evaluation (including final report date and its format). Having an external evaluation team caused some difficulties insofar as additional consent forms were needed. Clinicians reported a conflict between balancing the requirements of the evaluation (eg, evaluation consent forms) and the clinical input.
- Seeing patients in some of the referring GP practices due to room availability, opening times and travelling times. For example one practice had a room available for an hour a week, while some solo practice surgeries close for part of the day limiting patient contact.
- Other services have continued to express an interest in accessing Northern Wellbeing. Adelaide Northern Division staff has been unable to provide them with the names of participating practices due to the privacy of GPs and have simply suggested practices where there are GPs with a mental health focus. It is hoped in the new financial year that the Division will seek participating GP consent to share their involvement with the program to people/services requesting this information.

Access to Allied Health Pilot Project: Mental Health Partnerships in Primary Care

Madonna Hirning
Bayside GP Division and Brisbane Inner South Division of General Practice

Proposed model:

In 2002, the Bayside GP Division and the Brisbane Inner South Division of General Practice (BISDIV) received joint funding to implement an Access to Allied Health Pilot Project. The proposed model included direct contracting of a range of Allied Health Service Providers (AHSPs) to whom the GPs involved could refer directly.

It was planned to charge patients a small co-payment that would be collected by the Division. The co-payment was set at $20.00, or $5.00 for Health Care Card Holders, with GPs having the capacity to waive this if the patient was unable to pay. There was provision for the Culturally and Linguistically Diverse (CALD) population to be referred to a bilingual AHSP as it was planned for a contract to be signed with the Queensland Transcultural Mental Health Service.

The AHSPs contracted to the Project had the option of providing individual or group treatment. In order to obtain clinical outcome measures, the Kessler-10 (K-10) and Global Assessment of Functioning (GAF) Scale were chosen as outcome measures to be administered by the GPs at the time of referral and following each block of treatment. A treatment block of 240 minutes was allocated for each patient, with the option of a second treatment block if required. The AHSP could utilise this time as it suited them best, for example, six forty minute sessions, or four one hour sessions. It was proposed that the evaluation would be completed internally.

Implementation:

Prior to accessing the project, GPs are required to attend a Project Information and GAF Scale Training Session. This session provides them with the necessary paperwork and processes for the Project, and also provides them with training in the use of the GAF Scale. The GPs are provided with a list of the AHSPs registered with the Project at this session. Prior to the referral being made the GP provides the patient with a Plain Language Statement and goes through the consent process with them if they are happy to participate. The referral process includes a one-page cover sheet containing demographic information and the outcome scores, which is printed in triplicate and individually numbered. A copy of this form is sent to the Project Coordinator, the AHSP, and a copy retained for the patient's file. A copy of the Mental Health Assessment and Plan (if completed) is also sent to the AHSP. Upon receiving a referral the AHSP contacts the patient and arranges the first appointment. Upon completion of each treatment block the AHSP is required to send the GP a standard feedback form outlining the progress made during treatment and any recommendations regarding the patients future treatment and management. Upon completion of each block of treatment the GP reviews the patient and forwards a form containing their outcome measures to the Division. In order to request a second treatment block, the GP forwards a copy of the Mental Health Review, or a letter providing details of the Review, requesting the AHSP commence a second block of treatment. The referral process commenced in early January 2003 and as of the end of August, 156 referrals have been made. To date, the process has worked well and no difficulties have been encountered.

The AHSPs complete a standard invoice for each session they complete and all information contained on the Referral Forms and Invoices is entered into a database to be used in the Evaluation and invoicing for the co-payments. After each treatment block, the patient is sent an invoice for the co-payment for that block. Upon completion of the final block the patient is also sent a survey.

Obstacles:

A few things haven't worked as anticipated. Due to contractual concerns, we were unable to offer patients direct referral to bilingual workers at the QLD Transcultural Mental Health Service, however were able to offer interpreting services. It is hoped that the original plan now may be able to be implemented when we enter the next funding period. In terms of the therapy being provided, groups have not yet been utilised by the AHSPs. They were all given the option of using a group approach if desired, however no AHSPs have elected to do so to date. Another obstacle in the delivery of the Project has been that of the Division collecting the co-payments. The process is working fine, however is very labour intensive, and also requires the Division to collect identifying patient information. It is considered that the best solution to this would be for the AHSPs to collect the co-payments at the time of the appointment.

Future directions:

Due to our late start, our funding period has been extended to the end of September. As we enter into the next round of funding several small changes will be made to achieve a more cost-effective and streamlined process. Due to funding issues, the number of referrals per GP will need to be capped to ensure the cost of treatment does not exceed available funds, and the number of GPs accessing the Project will need to be monitored.

Given the uptake of the Project in a relatively short period of time, and the feedback being received from all parties involved, it is evident the Project has been successful in providing GPs with a much needed treatment option for patients in need of psychological treatment and in encouraging a more structured referral and feedback process between GPs and Allied Health Providers.

We aim to build on the strengths of this model for the future, whilst balancing against the inherent challenges.

Gippsland Access to Allied Mental Health Project

Cecilia Martin
Gippsland Access to Allied Mental Health Project Coordinator

Mental Illness was responsible for about one seventh of the total burden of disease in Victoria in 1996 (Victorian Burden of Disease Study: Morbidity, Public Health Division, Department of Human Services, 1999). The Gippsland region covers most of eastern Victoria from the Latrobe Valley through to the border including the Bass coast, and nearly all the region falls within RRMA 4-7. Gippsland as a whole is estimated to expect a treatment rate for serious mental illness of approximately 77 cases per 10,000 persons (Health Status in East Gippsland, Hind & Hind, 1998). There are less than 0.1EFT private psychiatrists within the Gippsland region.

In 2001 when the Commonwealth Government announced the More Allied Health Services (MAHS) funding, each of the three divisions of general practice in Gippsland decided to use the funding to increase services by establishing mental health projects.

Later in 2001 the East Gippsland, South Gippsland and Central West Gippsland Divisions of General Practice joined forces to form the Gippsland Interdivisional Mental Health Initiative (GIMHI), a committee made up of GPs from each of the divisions and a coordinator. One of GIMHI's objectives was to attract additional mental health funding to the Gippsland region, thus in 2002 an application for funding for a Better Outcomes in Mental Health Care (BOiMHC) Access to Allied Health Pilot Project was made. The application was successful in the first round of funding

The Gippsland Access to Allied Mental Health Project model is based on the principle of maximum access for the people who need it. This has a number of ramifications. All GPs who have registered with the Health Insurance Committee to participate in the BOiMHC initiative are eligible to be a part of the project, so that the service is available through as many GPs as possible.

Similarly, all Allied Health Professionals who meet the necessary criteria (as set out by the Commonwealth Government in the Allied Health Pilots application guidelines) are able to join the project, thus giving the greatest level of choice of providers. Furthermore, there is no cost to the consumer for the service, ensuring that patients are not discouraged by co-payment requirements.

To best meet these criteria, a project coordinator was employed to establish the project across the three divisions using a voucher system. Eligible GPs are given the opportunity to obtain vouchers. They can then use these to refer patients with mental health disorders who have low incomes to local Allied Health Professionals, such as Psychologists in private practice, and the divisions will then use project funds to reimburse the Allied Health Professionals for their work at a set rate. The GPs (with their patients) choose the most appropriate Allied Health Provider out of those the divisions have established service provision contracts with. A voucher entitles patients to four therapy sessions, and the GP can choose to allocate up to three vouchers (ie 12 sessions) to each patient, providing they have a sufficient number of vouchers to do this.

As one of the original pilot projects, the Gippsland Access to Allied Mental Health Services Project has overcome a number of hurdles in its establishment. Shortages in the skilled workforce have been an issue, causing the project to change focus from contracting services from local agencies to focussing on the privately practicing workforce.

Although this adjustment temporarily slowed the progress of the project, it has proven an effective strategy to date. The eagerness of highly skilled and qualified local Allied Health Professionals in private practice has been a major boost, although some areas have still required special arrangements to ensure services could be provided. The project is still in the roll out phase, and townships are dealt with individually to ensure the best solution is found for each area.

The referral process obviously involves some additional paperwork by the GP, but every effort has been made to minimise this so only one "tick-a-box" page is required in addition to the normal referral letter. GPs have expressed greater difficulties with the completion of the "3 step mental health plan", as although they usually do the work required, they can find it time consuming to record this in the required format. The GPs in Gippsland have been very enthusiastic about gaining additional mental health services for their patients however, in fact Gippsland has had one of the highest rates of GP registrations for the BOiMHC initiative. This enthusiasm is a fantastic asset for the Gippsland community, although it means that the funding for the Allied Mental Health Project needs to be spread further, giving each GP fewer vouchers to use.

Another major task of the project has been to differentiate the service from others in the Gippsland region, including the More Allied Health Services counselling programs conducted by each of the divisions and the state funded Gippsland Primary Mental Health and Early Intervention (PMH&EI) Service recently established. To this end a referral flowchart, an information brochure and a mental health resource folder were developed collaboratively together with the PMH&EI team. Joint marketing activities have also been conducted.

The Gippsland Access to Allied Mental Health Project is in its implementation phase, but the feedback from the GPs who have had the opportunity to use the service has been very encouraging. Work is now being done to expand the project to more areas, and an external evaluation is planned to assess the success of the project, as well as opportunities for improvement.

For further information contact:
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PARC welcomes short articles about mental health projects for future issues of this newsletter.

9th NSW Rural Mental Health Conference
PAPER:
Clinical Psychology in General Practice Project: An early intervention approach to mental health service delivery in Rural Primary Care

Author: Robyn Vines MSc, FAPS

Affiliation: Clinical Psychologist;
Director, Clinical Psychology in General Practice Project;
Senior Research Fellow, Charles Sturt University.
Conjoint Senior Lecturer, Centre for Rural and Remote Mental Health
The University of Newcastle.

Since early 1998, with Commonwealth Government support from January 2001, the Clinical Psychology in General Practice Project has trialed a new model of collaborative care for common mental disorders, entailing provision of psychological services in the Primary Care setting. The development and trial of this model was initiated in response to the increasing burden of disease due to mental disorders, and the escalating and unsustainable cost of pharmaceutical benefits associated with treating these conditions in the Primary Care setting.

The Project has involved Clinical Psychologists and Clinical Psychology Registrars from various Universities practising in General Practices in regional and rural areas of NSW and Victoria. The Project's aim has been to provide evidence-based psychological treatments for high prevalence mental health difficulties (particularly anxiety and depression) that empower patients and ensure more positive health outcomes. Further Project objectives have included:

- the servicing of patient needs in rural locations where access to specialist help is often limited;
- facilitation of early intervention, thereby preventing both the development of greater severity of the preventing condition and greater frequency of use of medical services;
- support for GPs with the diagnosis, management and treatment of patients presenting with psychological issues or physiological issues with a psychological dimension;
- provision of ongoing Continuing Medical Education for GPs 'in situ' by providing learning outcomes for GPs whilst working collaboratively with the profession of Clinical Psychology;
- development of a new training opportunity in Primary Care for post-graduate Clinical Psychology Registrars.

The development of appropriate funding models to provide these services on an ongoing basis in locations where fee paying may not be a viable option has also been a significant focus. Equitable availability and accessibility of services has been a key priority of the Project team.

During the three year course of Phase 1 of the Project, 20 Clinical Psychology Registrars have been trained in the primary care setting. Their placements have entailed:
• observation of General Practitioners, sessions with patients;
• assessing, diagnosing and treating approximately 20-30 patients each in the primary care setting;
• analysing patient pre and post treatment results;
• making qualitative observations of the model of service delivery and of the General Practice setting, during the course of the placement.

Approximately 330 patients have been treated with matched controls being recruited via General Practice waiting rooms. Pre and post measures on the Depression, Anxiety and Stress Scale (DASS), General Health Questionnaire (GHQ 28) and General Well Being Index (GWBI) were obtained from both treatment and control groups to establish a basis for comparison between the two, to establish whether there was true "value added" from the shared care approach. Control trials indicate a highly significant positive change in the mental health status of patients as follows:

- post-treatment measures for patients in the collaborative treatment group showed a positive and significant (at the 0.01 level or greater) change in the Mental Health of the patients;
- the control group (ie "treatment as usual via GP") also showed, on average, a significant improvement on mental health indices;

- matched pair comparison between treatment and control groups indicated a highly significant difference between controls' and treatment participants' scores on all scales post treatment with the treatment group showing a greater improvement.

Overall, comparison of the pre- and post-test scores for the treatment and control patients in a paired analysis, as well as the reduction in average scores shown for all treatment participants, suggests that the collaborative model of mental health service delivery is having a significant and positive impact on patients' mental health and well being when compared to matched controls.

Continuing Developments:

In the Central West of NSW, further funding under the More Allied Health Services and the Better Outcomes in Mental Health Care (BOMHC) Allied Health Initiatives has enabled the trial of four different funding models for psychological services, found to be feasible in the Clinical Psychology in General Practice Project:

• Clinical Psychology Registrar stipends;
• Salaried positions within Divisions of GPs;
• Patient voucher systems;
• Direct funding for group treatment programs.

Findings relevant to the most cost efficient and flexible way of providing services are still being evaluated.

As a consequence of the original Project, psychological services are now being provided to Bathurst, Blayney, Canowindra, Condobolin, Cowra, Forbes, Lithgow, Molong, Parkes, Tullamore, Trundle, Rylestone and Kandos. In the Central West of NSW therefore, thirteen rural towns now have access to publicly-funded psychological services under BOMHC and MAHS. Similar continuing services, originally established under the "GP Project", are also being provided in Armidale, NSW under the Better Outcomes in Mental Health Care framework. From extremely small beginnings (i.e. one clinical psychologist in a Bathurst General Practice for one session per week in 1998) quite wide articulation of this model of collaborative mental health service delivery has occurred.

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