Perceptions of Psychology through the eyes of Government Mental Health policies

Dr. Jillian Horton-Hausknecht
Clinical Psychologist
Suite 35,
11 Cliff Street,
Fremantle WA 6009

Tel: 08 94871859
Email: jhorton@iprimus.com.au

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Introduction

During this presentation I will be raising and discussing 4 main points which show that the Federal Government policies:

1. Do not sufficiently recognize or support the importance of high standards of training for the delivery of psychological therapies to people with mental health problems.

2. Do not sufficiently recognize the competencies of Clinical and Counselling Psychologists.

3. Place an inappropriate focus on General Practitioners (GPs) as a centre point for primary care mental health services.
   and that they

4. Should consider more cost effective and relevant alternatives in their Mental Health policies.

There is certainly plenty of evidence to indicate that mental health problems, such as depression and anxiety, are rapidly becoming leading health issues in the Australian community. A survey for the Dept of Health and Aged Care, for a 12 month period in 1999, found the prevalence rate of psychological disorders in the adult population is as high as 11.6 % for depressive disorders and 19.1% for anxiety disorders (Commonwealth Department of Health and Aged Care, 1999). The projection by the World Health Organization suggests that depression in particular, will be second only to heart disease, as a major health concern in the near future. So not only are there significant levels of psychological distress present in individuals in the community, but there are also significant flow-on effects, such as increasing levels of family disintegration, significant productivity losses in employment and potentially higher levels of crime, and drug abuse in the community.

The Federal and State Governments, over the last few years have started to recognize the need to address mental health issues. This focus is welcomed and is long overdue.

Before I focus on my 4 points I will very briefly mention the National Mental Health Plan.

- **National Mental Health Plan 2003-2008**

  The National Mental Health Plan is the third Mental Health Plan run at a National level. The first National Mental Health Plan started in 1992 and was implemented over a five year period. It was the first attempt to co-ordinate mental health care reform through National initiatives and focused largely on severe and disabling, low-prevalence mental health illnesses, especially psychoses. At the end of 1997, a second 5 year National Mental Health Plan was endorsed by the Health Ministers, to further develop the original reforms and to create a new emphasis on high prevalence disorders such as depression and anxiety, and to focus on mental health promotion and prevention. The current Mental Health Plan aims to continue and extend these earlier initiatives, plus promote a further focus on population health. This means, examining how the diverse needs of different population groups, can receive appropriate input ranging from prevention, to early intervention, to treatment, to recovery and to relapse prevention.

  All National Mental Health Plans have developed policies, initiatives and programs supported by substantial funding. One initiative, which was developed under the second National Mental Health Plan and has received further funding in the current health budget is the Better Outcome in Mental Health initiative. I will use this initiative as the main example to illistrate my first 3 points, but the criticisms I raise could apply to many of the Federal Mental Health initiatives.

  Better Outcomes in Mental Health Initiative

  The BOMHI was started in 2001 with funding by the Federal Government to a level of $120.4 million over four years. It has three main aspects to it and these are:

1. Linking Psychiatrists in an advisory and supportive role with GPs, so that GPs can receive timely advice and assistance, especially when a patient presents in crisis or with a mental illness.

2. Linking Mental Health professionals (Psychologists included) to GP practices to develop a collaborative, shared care model of psychological health service delivery.

3. Providing short courses in mental health assessment and focused psychological therapies for General Practitioners (GPs) to then use with their patients.

It is this last part of the initiative which I will focus on now. When a GP decides to be involved in the BOMH training program they firstly have to register with the Health Insurance Commission. Then they can undertake Level One training, which lasts approximately 6 hours. This training teaches them how to conduct mental health assessments, mental health planning and a review process. They can then choose to do Level Two training, which lasts approximately 20 hours. Where what has been called "Focused Psychological Strategies" are learnt. These are most often Cognitive Behaviour Therapy skills and/or Inter-Personal Therapy skills.

I will show you a couple of examples taken from the RACGP website, of the Focused Psychological Therapy training programs which have been approved in 2005.

"Cognitive Behavioural Therapy Strategies for GPs"
provider: Educational Health Solutions

"The aim of the CBT program is to provide GPs with the confidence, knowledge and skills required to deliver cognitive behavioural therapy strategies to depressed and anxious patients in their practice, as well as those suffering from somatic illness"

"Psychological Skills for Health Professionals"
provider: Relationships Australia

" …………… GPs will also have an improved set of skills which include communication skills, problem solving skills, anger management skills, and an understanding of both the cognitive and behavioural aspects of CBT, as well as the practical methods of applying these therapeutic systems within the GP-patient environment" .

Once a GP has completed the 20 hour skill based course, they can then use the psychological therapies with their patients for a wide range of psychological problems. I will show you 2 OHs taken from Australian Divisions of General Practice Familiarisation Training Manual, 2003. The first one lists what GPs are supposed to be able to competently do once they have attended the FPS course. The second lists the type of patient problems they are allowed to work with.

Focussed Psychological Strategies

An element of the Better Outcomes in Mental Health Care Initiative is the introduction of MBS rebates for Focussed Psychological Strategies (FPS) that can be provided by GPs who satisfy the relevant education requirements set by the GPMHSC.

What are Focussed Psychological Strategies (FPS)?

FPS are specific mental health care treatment strategies, derived from evidence based psychological therapies. They have been shown to integrate the best research evidence of clinical effectiveness with general practice clinical expertise.

What is the remuneration for provision of FPS?

In recognition of the enhanced mental health care skills and expertise required for GPs to provide FPS, MBS rebate levels have been set at approximately 20% above the current Level C or D Attendance items and include two time bands:

- 30 to 40 minutes; and,
- longer than 40 minutes.

What strategies can be provided by GPs under the MBS item numbers for FPS?

The strategies and treatments that have been approved for use by GPs under the Better Outcomes in Mental Health Care Initiative are limited to:

1. **Psycho-education**
2. **Cognitive-behavioural therapy including:**
   - Behavioural interventions
     - Behaviour modification (especially for children, including behaviour analysis and contingency management)
     - Exposure techniques
     - Activity scheduling (including pleasant events, mastery and time management)
   - Cognitive interventions
     - Cognitive analysis, challenging and restructuring
     - Self-instructional training
     - Attention regulation
   - Relaxation strategies
     - Guided imagery, deep muscle and isometric relaxation
   - Skills training
     - Problem-solving skills training
     - Anger management
     - Stress management
     - Communication training
     - Social skills training
     - Parent management training
     - Motivational interviewing
3. **Interpersonal therapy (especially for depression)**

Hypnosis and family therapy have not been approved for use under the FPS item numbers. The major FPS that are shown to be evidence based for a number of psychological disorders are provided in Appendix I.

Eligibility

Which doctors are eligible to participate?

The doctors eligible to participate in the Better Outcomes in Mental Health Care Initiative are medical practitioners including GPs, but excluding specialists and consultant physicians. For the purposes of brevity, future references in this manual to GPs include Other Medical Practitioners (OMPs) unless otherwise specified. These doctors need also to have completed the relevant training requirements and to be working from a PIP or accredited practice to register for the initiative.

Which patients are eligible to participate?

Under the Better Outcomes in Mental Health Care Initiative the patient group eligible for care is:

> 'all patients with a mental health disorder, including those with co-morbidity, who present in the general practice setting.'

A mental health disorder has been defined as, 'a significant impairment of an individual's cognitive, affective and/or relational abilities which may require intervention and may be a recognised, medically diagnosable illness or disorder.' The ICD-10 PHC version informs this definition[1].

The following disorders, taken from the ICD-10 PHC version can be treated under this initiative:

- Alcohol use disorders
- Chronic psychotic disorders
- Bipolar disorder
- Phobic disorders
- Generalised anxiety
- Adjustment disorder
- Unexplained somatic complaints
- Eating disorders
- Sexual disorders
- Conduct disorder
- Bereavement disorders
- Drug use disorders
- Acute psychotic disorders
- Depression
- Panic disorder
- Mixed anxiety and depression
- Dissociative (conversion) disorder
- Neurasthenia
- Sleep problems
- Hyperkinetic (attention deficit) disorder
- Enuresis
- Mental disorder, not otherwise specified

Please note: dementia, delirium, tobacco use disorder and mental retardation are excluded.

Footnote:

1. World Health Organisation International Statistical Classification of Diseases and Related Health Problems: Chapter V, Classification of Mental and Behavioural Disorders: Primary Health Care Version.

What makes this initiative even more concerning than the already existing array of unregulated short courses in psychological therapy skills in the community, is that the Federal Government has endorsed this level of training in a specialist area, by providing GPs with significant Medicare rebates when they use the FPT skills with their patients. I will outline this in some detail shortly.

Some of the problems of this GP training initiative, which I will go though now, will illustrate my first point about poor standards of training.

1. Firstly, a 20 hour courses for GPs in psychological therapy *techniques*, is a considerable departure from the thorough and lengthy training considered important for the specialist area of psychological health care provision. Universities and Psychology Registration Boards in many states of Australia, have set 6 years of university training in psychology and 2 years professional supervision as a benchmark for providing high quality psychological therapy services. Therefore it is unclear why lower training standards are being accepted by many government health departments and community services. It could be readily argued, on the basis of Duty of Care for the consumer, that minimum training standards for the delivery of psychological therapy should be set in accordance with those which provide the best training (not the least) in psychological health care.

2. Not only is the training remarkably short, the content of the training programs are not scrutinized by University Psychology Departments or by our professional registration bodies. Instead committee called the General Practice, Mental Health Standards Collaboration (GPMHSC) committee, consisting of approx. 6 people, has the power to accredit the short training programs. This committee can also allow GPs to bypass both Level 1 and Level 2 courses, if they have done other training deemed acceptable to the committee. There is one APS representative on this committee, and in personal communications with her, she has indicated that she has raised on numerous occasions that this training is not long enough or thorough enough for the practice of psychotherapy, but her voice has been largely ignored.

3. There are no objective or independent examinations or assessments to evaluate the GPs level of knowledge and competency in the assessment and therapy skills. There are also no appropriate levels of clinical supervision required to ensure that competency in assessment and therapy have been achieved.

4. If a member of the public does not benefit from the psychological therapy provided by the GP, the consumer may well conclude that the treatment is not effective, which can then decrease the likelihood that they will seek other psychological assistance in the future. Or, they will have to use multiple

services in order to get proper assistance, driving cost higher in the health budget.

Finally the Australian Psychological Societies, Standards Advisory Group, wrote a discussion paper in 1996 titled “Competencies for Psychologists to ensure an effective, skilled and professional discipline”. They outlined the range of knowledge and skills that should be possessed by a Psychologist who has completed 6 years of university training and is about to enter the profession. The Advisory Group listed 8 competencies and due to time constraints, I will only very briefly highlight the first one as it relates to this section of the presentation.

COMPETENCY 1: DISCIPLINE KNOWLEDGE

This set of competencies is concerned with the knowledge base in the discipline of psychology and is achieved after the completion of a 3 year Degree in Psychology. It includes the possession of knowledge of psychological theories and models, empirical evidence for them, and the major methods of psychological enquiry. What I wish to highlight about this competency, as stated by the APS Advisory Group is that: **It is the foundation upon which the other competencies depend.** This clearly indicates that the undergraduate Degree in Psychology is highly relevant and essential, should not be done away with, in favour of just teaching psychology therapy skills.

This GP training initiative is a strong example supporting my first criticism that the standards of training required for the delivery of psychological therapy training are not high enough and appear to be not well understood by decision makers, governments and indeed some professional groups. I would argue that high standards of training and competency are necessary for any specialist when treating members of the general public. The public should be able to trust and expect that whomever the Federal Government funds to provide these services must have the highest training and competency levels available.

2. Competencies of six year trained Psychologists are not sufficiently recognized.

My second point is that the competencies of Clinical and Counselling Psychologists are not sufficiently recognized by the Federal Government and its agencies.

It is certainly clear that we have a wide range of skills and competencies as indicated by the last slide. So what evidence is there that these skills and

competencies are not being properly recognized? The following table will illustrates this.

Comparison of the financial support provided by the Federal Government for the provision of Psychological therapy from General Practitioners Vs Psychologists.

Comparison Item	GPs	Psychologists
Health Insurance Commission Incentive payment.	**$150**	**Nothing**
Government rebates for Psychological therapy	**$ 61.45** (session lasting 30-40mins.) **$ 87.95** (session lasting longer than 40 mins.)	**$ 44.00** (based on a 20 min. session) No option of more rebate for a longer session
Service Incentive Payment - received when a review of psychological therapy occurs	**$150** ***per patient*** per review ($10,000 cap ***per GP per year***)	**Nothing**
Number of psychological therapy sessions supported per year, per client	**12**	**5** (For all "Allied Health")

There is **clearly no equity** in the levels of rebates provided, nor in the number of sessions rebated between, GPs and private Psychologists. The public is without doubt influenced by cost factors. The funding in this initiative would therefore readily influence people to choose the least expensive option, especially when they are led to believe they are getting the same care. From a fair trade practicing point of view, the **profession which is more highly qualified in psychotherapy, is greatly disadvantaged in the marketplace**. Perhaps this is something the ACCC should look at?

3. My third point raises the view that the Focus on General Practitioners (GPs) as a centre of primary mental health care is not well placed.

I will show you some quotes taken from several government documents as examples of the GP focus that is very evident in a wide range of mental health policies.

For example, the glossary of terms and definitions on page 36 of the current National Mental Health Plan defines "Private Sector Mental Health Services" as:

"Specialized health services that are specifically designed for people with a mental health problem or mental disorder seeking treatment in the private sector. In Australia, private sector mental health services include the range of mental health care and services provided by psychiatrists in private practice, and those in-patient and day only services provided by private hospitals, for which private health insurance funds pay benefits. Private sector services may also include services provided in general hospital settings and services provided by General Practitioners and by other ***allied health professionals***."

The only two professional groups clearly identified are psychiatrists and GPs. I assume the services provided by private Psychologists comes under the last 3 words "allied health professionals".

A second example comes from a discussion paper written for the Department of Health and Aging, titled "Pathways of recovery: Preventing Relapse", (2004). It dedicates a section to the role of general practice and states:

"Most mental health care is delivered through general practice and other primary care services. An established and ongoing relationship with a health practitioner is a vital tool for relapse prevention, and the role of general practice needs to be more fully explored and supported…………… GPs need to be skilled in providing mental health care, and they vary in their ability, training and interest to do so. Two major initiatives have recognized the role of general practice in mental health care: the National Primary Mental Health Care Initiative which came into effect in June 1999, and the Better Outcomes in Mental Health Care Initiative in 2001. " pg. 14

Interestingly, the only reason that appears to be given in most documents and in most commentaries on mental health, as to why GPs should be a centre focus in primary care mental health, is that they are the "first point of contact for people with mental health problems". There is considerable research to support this contention, showing that up to 50% of GP consults are due to psychological and

emotional reasons. However, this is not a valid or logical reason for GPs to then to provide the psychological therapy.

In fact it could be argued that there are many reasons why it is not good practice to have GPs as centre focus in primary mental health care. One major reason relates to GP workforce limitations and their capacity then to provide mental health services

A paper written by the Primary Mental Health Care Australian Resource Centre, known as PARC, in 2001 titled "Major issues facing primary care mental health in Australia" (Chris Holmwood), has a section on GP workforce issues and summarized this point well.

"In metropolitan areas the overall number of GPs is static with a slowly increasing population. In addition to slow increases in population per full-time workload equivalent GP, the average age of Australias population is increasing (Australian Bureau of Statistics, 1999), and this signifies a steady increase in general practitioner workload to support this aging community. For example the number of services for a person aged 75 yrs and over is approximately 20 per year, compared with the average across all other age ranges being 10 per year. The capacity for General Practice to expand its role into psychological interventions for mental health problems is extremely limited. This is particularly the case in rural and outer metropolitan areas where GP workforce is particularly stretched" (pg.2-3).

This would suggest that any initiative which burdens GPs further with other forms of health care are not in the best interests of GPs or the general public. There is already a shortage of GP hours for medical care and consumers often report the difficulty in getting appointments. Why would the Federal Government wish to burden this sector further and make time available for medical care even less available to consumers, when there are clear alternatives?

4. What alternatives exist?

Although there appears to be a demand by consumers for affordable access to non-drug psychological therapies, access to Clinical and Counselling Psychologists for people with mental health problems has not improved greatly during the 3 National Mental Health Plans so far. It could be argued that **there is need for a greater and more central role for Clinical and Counselling Psychologists in the National Mental Health agenda.**

Examining the barriers to consumers to Psychological services, one major barrier for consumers to private practitioners, as mentioned earlier, is cost. If the Federal

Government choose to place the same funds from the BOMH GP training initiative into MedicarePlus, to support people obtaining psychological health care from Clincal/Counselling Psychologists, this would resolve the issue of public access to highly quality psychological health care and be <u>less expensive</u>. **The Federal Government needs to stop hesitating to support affordable psychological therapy via Medicare, to the same level as that done for medical care.**

A second major barrier to consumers is <u>stigma</u> about seeing a Psychologist. If partnerships wish to be formed between GPs and Psychologists as one way to reduce stigma and aid the referral flow, why not cover Psychology more fully under Medicare, as already suggested, and then **provide incentives to GPs and Psychologists to practice together in the same location.** Why is there a need for the expensive GP training and allied health component in the BOMHI? Other ways to reduce stigma is through use of appropriate education to the community about what Psychologists do, and doing away with the term of "mental illness" in relation to the high prevalence disorders, such as depression and anxiety.

A third major barrier for consumers to Clinical and Counselling Psychologists, in the <u>public sector</u>, is the lack of positions for these professionals in community based services. A statement in a submission made to the Peter Costello in 1999 by the then President of the APS claimed that :

"After more than five years of the National Mental Health Strategy, there is reduced access for consumers to psychological services, partly because the number of psychologists in the public sector has declined and partly because many psychologist positions have been downgraded into generic mental health workers."

Source: (Crowe, 1999) quoted from "Models of primary health care psychotherapy and counselling", PARC, Report to the Commonwealth Dept of Health and Aged Care, 2002)

This situation would appear to still be true today.

Fourthly, it is very concerning that psychological or mental health often does not get a clear platform under the term "health care", but the focus in health care, has been, and remains medical and physical health. If one looks at the website portfolio listing of Health Minister Tony Abbot, it does not list mental health at all, but lists only issues relating to medicine, hospitals and GPs. Psychological health care is not well served when it is subsumed under medical care and delivered or distributed by medical services or divisions. With depression being one of the leading health problems experienced by the population in Australia, it could be argued that mental health care, needs to have an independent platform from medical health care. **The creation of Ministers for Mental Health, with a**

separate portfolio and budget from health, at both State and Federal Levels, would be more effective for providing this much neglected area with appropriate attention and service. I believe a Minister for mental health has actually been created by the Shadow cabinet in NSW.

Finally, it could also be argued that the development and support of **Divisions of Psychological Health Care in each state,** similar to those established for the Divisions of General practice would allow the profile and services of Mental Health in each state to be developed and supported more appropriately.