Models of Primary Health Care
Psychotherapy and Counselling

Report for the Commonwealth Department of Health and Aged Care and the Access to Allied Health Task Group

Primary Mental Health Care Australian Resource Centre
Department of General Practice, Flinders University

September 2002

Eleanor Jackson Bowers
Chris Holmwood
Damian McCabe

Primary mental health care
Australian Resource Centre

Flinders University
Department of General Practice

Models of Primary Health Care Psychotherapy and Counselling

Primary Mental Health Australian Resource Centre
Eleanor Jackson-Bowers
Chris Holmwood
Damian McCabe

TABLE OF CONTENTS

DISCLAIMER

PARC was asked in 2001 to review the literature on the issue of allied health practitioners providing mental health services in primary care, as envisage in the *Better Outcomes in Mental Health Initiative*. The views of PARC are not necessarily the views of the Commonwealth. The report was commissioned by the Commonwealth Department of Health and Ageing and the opinion of the authors is not necessarily the opinion of the Commonwealth. This document does not reflect Commonwealth policy. The development of the *Better Outcomes in Mental Health Initiative* must inevitably meld what is known from research with what is possible in an organisational, political and fiscal sense. This paper is just one input into the final program design and implementation.

We hope that this review will prove useful to those implementing trials and developing ongoing programs for the allied health component of the *Better Outcomes in Mental Health Initiative.*

The resources that will be available for the trials amount to $2.5 million over a twelve-month period. It is understood that there will be $ 8 million in year 2 of the initiative and $11 million in year three, as the initiative becomes available to all Divisions of General Practice.

This review does not specifically address issues regarding credentialing of health professionals for provision of the focussed, time limited, psychological services envisaged in the program.

It offers a set of issues that need to be thought through in the final design of the trials and in the roll out of the Allied Health Program to all Divisions from 2003. These issues are based on both quantitative and qualitative evaluation evidence from the past ten years activity in this area, mostly from Australia the United Kingdom, and America.

This literature review was written in November 2001. Developments in the literature since that time are not included in this review.

EXECUTIVE SUMMARY

Access to allied mental health services is one component of *the Better Outcomes in Mental Health Initiative* . In many cases implementing this program will require the development of new models of service provision, or the modification of existing models. Reviewing the published literature and existing programs of Divisions of General Practice reveals a range of issues to be considered in this process.

Fundholding by GPs was a prominent model in the UK prior to 1999. GPs valued the self-determination in this model, including taking responsibility for functioning and finding solutions to problems. However the counsellors were poorly regulated with widely ranging methods of payment, salary scales and levels of qualification. Due to concerns regarding the low level of qualifications of counsellors it became untenable for counsellors to remain an unregulated profession. Funds are now held by either Mental Health or Primary Care Trusts which are large regional outposts of the NHS who employ the counsellors to work in general practices. In addition counsellors have professionalised themselves through development of the Association of Counsellors and Psychotherapists in Primary Care.

Tension continues regarding whether the mental health practitioner should be located in mental health services or in Divisions/general practices. If they are located in mental health services then links with these services are facilitated. These links support the workers and facilitate a coordinated approach to care, however links with and responsiveness to GPs may be more tenuous. Lines of responsibility need to be clear so that the worker attends to the agenda of the Division and GPs rather than that of the mental health service. This model provides opportunities for creating better links between mental health services and GPs.

Settings within general practice favour informal liaison between workers and GPs at the risk of reducing links with mental health services. This provides a less threatening and less stigmatising setting for consumers and creates opportunities for early intervention. Many Divisions have located practitioners either in the Division's premises or in community health care settings with success.

Reporting, referral and confidentiality issues are prominent in the literature. A tension exists between the well-established ethic of confidentiality of counselling and the need for sharing of information within general practice. This is seen as an ‘equity issue’ as persons able to afford a private therapist are assured confidentiality, whilst those unable to afford private counselling are not. The code of ethics, developed in the UK by the Association of Counsellors and Psychotherapists in Primary Care, takes a middle ground on this issue. It recognises that as counsellors are working as part of a medical team some allowances must be made which address the requirements of the team while safeguarding confidentiality. No Divisional projects specifically reported concerns regarding confidentiality or information sharing. However these concerns are still

prominent for consumers, and rightly so. They also feature prominently in the UK literature.

A further prominent theme in the literature is the need for counsellor supervision. Almost 100% of primary care counsellors in the UK have a formal supervision arrangement in place. Recommended supervision times range between 1.5 hours per month for experienced counselors, through to one hour per six fifty-minute sessions for less experienced workers. A peer support system, managerial supervision and the availability of expert advice by telephone is also recommended. The training of supervisors is also an issue. The Association of Counsellors and Psychotherapists in Primary Care website www.cpc-online.co.uk has many resources on ethics, supervision and training. Attached with permission of the authors (see appendix) is a copy of the *Outline Proposal for a Managed Counselling Service* which gives guidelines for establishing a counselling service in primary care.

Divisions of General Practice in Australia have nearly ten years of experience in running counselling programs. In general they have been well used and outcome evaluations indicate that they result in better health outcomes than treatment as usual. GPs believe that these programs improve the mental health status of their patients. However there has been problems with increasing waiting lists for these services. Key findings suggest that there needs to be adequate administrative support, a uniform referral and liaison protocol, and attention to appropriateness of referral. Foreseeable problems include lack of professional support for counsellors, and difficulty attracting professionals to programs with short term funding. One very important role for the counsellor may be in providing educational sessions for GPs.

Trials will need to examine models that can readily be rolled out after the first year. There will probably need to be at least three models, one for metropolitan areas with large Divisions and significant infrastructure, one for rural and remote areas with smaller Divisions and less infrastructure and fewer outsourcing options, and one involving Aboriginal and Torres Strait Islander people.

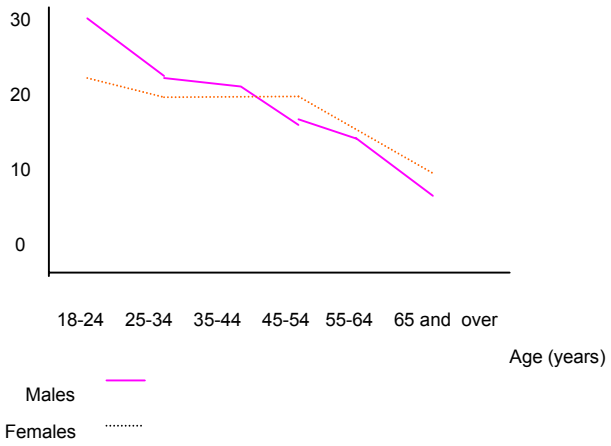
There is sufficient evidence in the literature regarding both group therapy and computer based therapy for people with high prevalence disorders to support these being trialed through *Better Outcomes in Mental Health* on a population basis.

CHAPTER 1 Allied Health in General Practice

Background

The prevalence of mental distress in the Australian community is high. The Australian Bureau of Statistics National Mental Health and Wellbeing Survey (NMHWS) clearly demonstrated this high prevalence for many mental disorders in the Australian community. This data is similar to other cross sectional epidemiological data such as the Epidemiological Catchment Study in the US and the WHO international study (Sartorius et al., 1993; Tohen et al., 2000). The age related prevalence data from the NMHWS is presented in Figure 1.

Figure 1. **Prevalence of major[a] mental disorders in Australian Males and Females**



[a] includes mental disorders from the major groups: anxiety, affective and substance abuse disorders.

Within the general practice profession it is usually agreed that general practitioners (GPs) have a key role in the management of people with mental disorders in Australia (Tohen et al., 2000). GPs are accessible in a physical and economic sense and there is no stigma associated with attending the local doctors' surgery for health care. Such a model of primary care mental health has been accepted across most developed countries with universal health care systems. These systems are based on the premise that strong primary care results in healthier communities and less call on specialised services (Simplest to just leave out the reference here as this I think can be taken as given for the purposes of this report.

The recent budget initiative *Better Outcomes in Mental Health* has identified access to mental health services in the primary care setting as an area requiring

special attention. Through this initiative people with a mental disorder, as assessed by an appropriately trained general practitioner, will have access to time-limited specific psychological treatments. The Commonwealth, through Medicare, has not previously financed specific access to psychological treatments In the majority of situations patients have either had to pay for these services themselves from private psychologist or other private providers, or access them through community health centres and/or non-government organisations providing social services. The latter services have traditionally had long waiting times and, from a population perspective, have not been able to respond in any real way to the need of the community.

For the first time there is an opportunity to address the need for these services in a substantial manner for those patients without the means to pay for them privately or without private health insurance.

Where is the need?

Some argue strongly that there is an immense unmet need out there in the Australian community that must be addressed. While this may be true, the exact extent of the unmet need remains to be defined. The prevalence data that we have is based on the Composite International Diagnostic Instrument (CIDI) that was used in the NMHWS. The CIDI is a diagnostic instrument and has a high level of reliability and addresses both ICD 10 and DSM IV criteria. The issue that arises is that we do not know whether all people detected using a diagnostic instrument as a screening instrument actually require intervention.

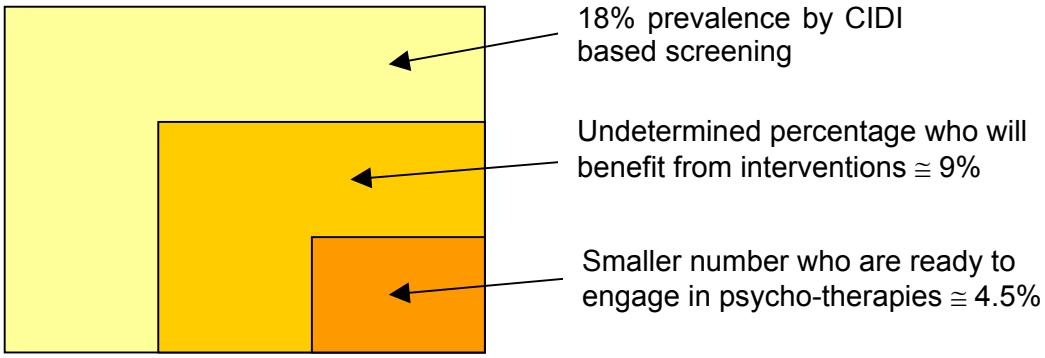
Put another way the NMHWS tells us that 18% of people in Australia have a diagnosable mental disorder. The Survey also told us that these people suffer significant disability from their condition in terms of days they were unable to carry out their usual role.

Whether all 18% of the Australian population identified through screening would benefit from specific interventions has not been empirically tested. Evidence from reviews of smaller studies of the systematic application of screening and treatment has not demonstrated better outcomes (Schade, 1998). Therefore, within that 18% of people diagnosed as having a mental disorder there is probably a significant number in whom interventions will not change the course of their condition.

In addition there will be a significant number of people for whom psychological treatment may be beneficial, but who are not prepared to engage in specific evidence based therapies.

These proportions have not been defined but if the “rule of halves” (see Figure 2) is used then it may be estimated that perhaps 4.5% of the population might have a real need for treatment (either pharmaco-therapy or specific psycho-therapy). These figures correspond with those mooted by Andrews in the Tolkein report (Andrews 1994).

Figure 2. Estimate of need for psychotherapy services.



What services are there that might help?

Direct services face to face with clients/ patients/ consumers

There are now evidence-based treatments for most of the common mental disorders (Sartorius et al., 1993). These treatments (see Table 1) require the provider to be trained but the competencies are within the capacity of general practitioners and other established primary care providers. General practitioners are certainly unique amongst primary care providers in their skill mix with an ability to prescribe drugs, offer psychological treatments if appropriately trained and attend to comorbid physical problems.

Table 1. Conditions and psychological treatments (Sartorius et al., 1993)

Mental disorder	Evidence based therapies
Generalised anxiety disorder	Cognitive behavioural therapy
Panic disorder	CBT incl. psycho-education, exposure and coping skills acquisition
Specific phobias	Exposure based behavioural interventions

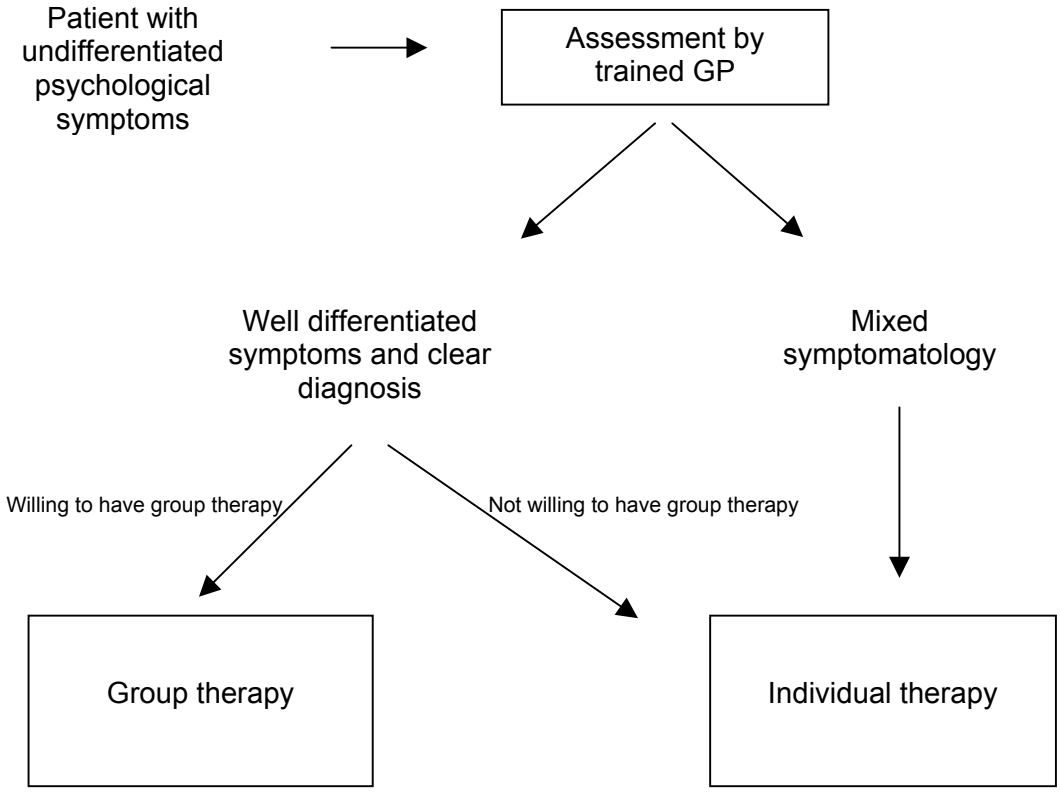
Major depressive disorders	Cognitive therapies, interpersonal therapies, structured problem solving
Bipolar disorder	Psycho-education CBT to enhance medication adherence
OCD	CBT with exposure and ritual prevention
Bulimia nervosa	CBT
Sleep disorders	Behavioural therapies CBT
PTSD	Exposure based behavioural therapies Anxiety management using CBT

In addition many of these people will benefit from pharmacotherapy. Even those people who do not want to engage in counselling or those with severe illness unable to engage in therapy, can benefit from this style of therapy.

Group Therapy

There is evidence that group therapy for some disorders can be very effective. Specifically the psycho-education aspects of management and some specific treatments for conditions such as social phobia can be delivered well through groups (eg. Albano, 1995; Heimberg, 1995; Liebowitz, 1999)). A recent systematic review found that there was strong evidence that group cognitive therapy for moderate to severe depression is as effective as individual therapy (Hodginkinson, 1999). The provision of group psychological treatment in primary care is certainly effective in reducing cost and allowing a larger number of patients to receive service when compared to individual models of counselling.

Where this type of therapy would fit in with the *Better Outcomes in Mental Health Initiative* is unclear. Studies are based on diagnostically homogeneous diagnostic groups of patients, for example those with social phobia, major depressive disorder, generalised anxiety disorder). However, these diagnoses are not always obvious initially. Perhaps the model could involve an initial assessment (over one or more consultations) then allocation to a specific group depending on the specificity of the symptoms and the patients willingness to be involved in a group (as depicted in the following schematic).



Given the size of the potential need and the obvious resource shortfall, there should be early consideration and trialing of group therapy programs for appropriately selected patients in the Australian setting. A trial should have group therapy as the default option with clients having to opt out of groups if they are not suitable. Gaining data in the real life undifferentiated general practice setting about who and what sort of presentations are suitable for group therapy would be very valuable knowledge in developing national strategies and making resourcing decisions.

Computer Based Therapy

Cognitive behavioural therapy (CBT) is an effective approach for depression, anxiety and other mental health problems in which disruptive thought patterns serve an etiological role. Standard delivery of CBT in a general practice setting or otherwise usually involves 10-15 sessions approximately 1-hour in length with reasonably intensive 1-on-1 therapist-patient contact. Even with briefer therapeutic programs as envisaged in the *Better Outcomes in Mental Health iniative* there will be severe limitations on the availability of services.

Computerised CBT has a number of advantages. It may be used to provide a fully evaluated and effective cognitive-behavioural based treatment that requires minimal face-to-face clinician time. Computerised versions of CBT may incorporate interactive media and flexibility that allows the patient to choose the

issues that they want to work on at their own pace. Indeed, computerised CBT may be used to provide cost-effective therapy to people who may not previously have been able to access a face-to-face counselor, particularly those in rural and remote areas. There is also evidence that some clients will engage in computer based CBT who previously did not engage in personal or group CBT.

There are however a number of disadvantages to keep in mind. The initial costs involved in purchasing the hardware and software necessary to run the program may be high. Further problems may include determining appropriate channels of referral, difficulties encountered by patients with literacy problems, and inadequate follow-up treatment or crisis management.

> *"some people may feel that a computer cannot replace the establishment of empathy and rapport with a counselor"*

There have been a number of projects that have attempted to utilise computer technology in their delivery of CBT. The main of these has been 'Beating the Blues' a project that has targeted depression and anxiety. Beating the Blues involved a computer therapy program that consisted of 9 sessions, namely a 15-minute introductory video followed by 8 weekly therapy sessions of approximately 50 minutes duration. Patients were initially assessed by their GP, prescribed psychiatric medication if required and randomly allocated to the treatment conditions. The computer program provided printed reports for the referring GP after every session, to keep them up-to-date with their patients' progress.

Results of this study indicated that the patients that accessed Beating the Blues significantly improved their condition compared to patients that received treatment as usual. These improvements were present at the end of 8 weeks of treatment and remained at follow-up 6 months later.

Other studies comparing delivery methods of CBT support this finding. Computerised CBT has been demonstrated to be effective for patients with anxiety (Jones, 2000), panic disorder (Dow, year unknown) and bulimia (Schmidt et al., 2001). The use of a practice nurse or facilitator to support the patient in a logistic and technical sense has been shown to improve adherence with therapy and outcomes. (Jones, 2000)

In Australia, the Australian National University's Centre for Mental Health Research has used a program named 'Mood GYM' to deliver cognitive behavioural and interpersonal therapy to young people aged 18-24. This program is designed to prevent or manage mental health problems that are troubling but not incapacitating, but is not specifically designed for use by people with clinical levels of depression or anxiety.

The University of Ballarat has conducted a project involving Psychology Masters Students to investigate the use of on-line computer technology to deliver CBT to patients with panic disorder (Richards, 2001). Evaluation of this program is still to be completed, but results are in favor of the on-line treatment of patients.

At this stage further research is needed to determine whether computer technology may be used to deliver effective CBT to people with a range of psychiatric conditions.

In the context of the *Better Outcomes in Mental Health,* with limited resources and potentially large need, computer based therapy should be regarded as a possible way of reaching a much larger number of people than either 1:1 therapy or group cognitive behavioural therapy could.

Liaison

While it is not clear from the descriptions of the *Better Outcomes in Mental Health Initiative,* there will be a need for the allied health providers to communicate and liaise with the referring general practitioner. Particularly given that one of the major criticisms of current mental health service delivery is that communication between GPs and specialists is poor (Sartorius et al., 1993).

Certainly good communication between the allied health provider and the GP who may be prescribing psychotropic medication is critical (Fletcher et al., 1995). It is also critical that systems that are established as part of this initiative facilitate and require a certain minimum standard of communication between the allied health professional and the GP.

Case conferencing and care planning

The major target group for this initiative is people with relatively simple mental disorders with medium levels of disability requiring specific time limited interventions. Specifically excluded are people with complex mental health service needs. The need for case conferencing and care planning for this group of people is therefore limited.

Who might provide these services?

The striking thing about the treatments outlined is the sheer magnitude of what is needed on a population level.

General practitioners can not provide all of the services that people with mental disorders require at the primary care level. Let's say that 4.5% of the population would benefit from psychotherapy and are prepared to engage in it. Then with 19 million people there ought to be about 855,000 Australians with a mental disorder in any 12 months. If they were all to have say 6 forty-five minute sessions of Cognitive Behavioural Therapy then this would require 3.8 million hours of 1:1 clinician contact time. There would need to be about 2000 FTE appropriately skilled practitioners providing services to meet this need. At present best estimates there are perhaps 1000 GPs with the requisite skills for this type of work (see college of Psychological Medicine). The majority of these incorporate mental health work into their general medical practice and so are not "full time" in

mental health related activities. Therefore these services need to be delivered through some other providers.

The competencies required to deliver the above services are not the particular domain of any particular professional group. The determining factor is the level of competence required and the training that professionals have had. Potential providers who might already possess these competencies are social workers, mental health nurses, some occupational therapists trained in the mental health area, some Aboriginal and Torres Strait Islander Health workers, and psychologists.

For the *Better Outcomes in Mental Health* initiative to be implemented effectively there will need to be an adequate supply of appropriately trained professionals willing to work in the areas that the program is established. It is unclear just how much under-utilised capacity there is out in the community.

Experience from some More Allied Health Services projects, even those in readily accessible rural areas, is that getting appropriately trained professionals to work in some of these areas has not been easy [personal communication South Australian Divisions Inc., 2001].

CHAPTER 2 Experience from Australia

Divisional activities in mental health

There has been nearly ten years experience with the provision of allied health services through Divisional programs. The provision of clinical services by Divisions has been criticised by some for further fragmenting community based allied health and nursing services. However, many GPs would respond by saying that primary care based services have not competed with community based services but rather have filled a gap.

Reports from these projects have been collected over this time and lend themselves to analysis. In the majority of these projects the Divisions have served as the fundholder. Exceptions to this include two projects where GPs have served have served as fundholders and one project where funding was shared between the Division and a local mental health service. Placement of the allied health professional has also been somewhat similar across the projects with psychological services being offered with in the general practice setting in the majority of cases. However there is some report of psychologists based elsewhere within the community either in rooms provided by the Division or within community mental health centres. In all projects the aim has been to maintain easy access for people seeking counselling through the service. The method of practitioner payment generally has involved salaried employment of the allied health professional by the Division.

The direct professional interactions that have occurred during these projects have increased practitioner awareness of the interplay between physical and emotional health, the need for improving referral behaviours and enhancing service delivery to all patients. In general the clinical psychology services reported upon have been well used and rated highly by practitioners and consumers. Primary care access to counselling services has been better and more timely and has reduced the burden on local health service waiting times.

Consumer surveys have revealed that patients consider primary care based counselling to be useful in improving their ability to handle their own problems. Surveys of GPs have revealed that nearly all practitioners involved in the programs consider them to have improved the mental health status of their patients. This is supported by outcome based research that has shown that this style of clinical service delivery leads to better mental health outcomes than treatment as usual (Rowland et al., 2001). While the advent of Outcomes Based Funding has seen a movement away from Divisions providing services such as these, lessons may be learnt from programs that have attempted to improve community mental health by providing counselling and psychological services in primary care settings.

Waiting lists

The aim of providing psychological and counselling services in the general practice setting has been to increase access to these services whilst reducing the demoralising effect of being put on long public waiting lists or not receiving treatment at all. Indeed the provision of counselling services through Divisions has seen an increase in patients receiving timely and appropriate psychological care. However in all of these programs there has been a steady increase in demand leading to an increase in waiting times that lessens the effectiveness and appeal of these services. Fixed budgets and difficulties with workload management have made it difficult for Divisions to respond to these waiting list increases.

Available resources need to be fully utilized by ensuring that referrals are appropriate and that missed appointments are kept to a minimum. Program funding must include administrative and secretarial support to prevent expensive practitioner time being drawn away from service provision. A systematic and uniform referral process possibly with a centralised booking and client reminder service will result in less mis-layed referrals and minimise missed appointments. Further, having the allied health professional allocate a portion of their time to educating GPs in assessment of new patients may assist them to assess and refer appropriately, whilst promoting the service. Overall there is always a need for more workers offering an increased service with greater flexibility of sessions available, shorter wait for initial consultation and availability of acute assessments.

Siting of services 'in general practice'

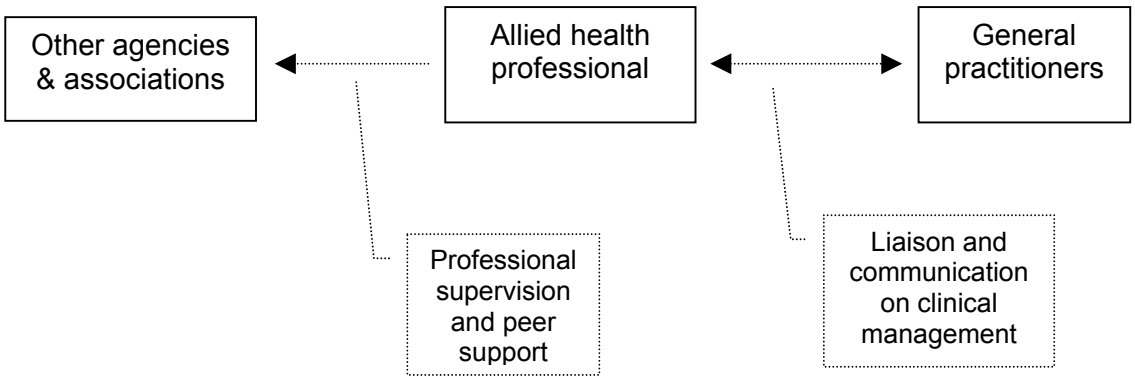
Co-locating allied health workers in the general practice surgery allows patients to access counselling and psychological services in a familiar, less threatening setting. Frequency of access is increased as the fear of stigma that is associated with attending mental health services is removed. This creates opportunities for early intervention that may prevent patients from developing mental health problems of greater severity.

Direct links between GPs and allied health workers are vital. Closer liaison will allow the use of more effective evidence based treatments through facilitating the integration of pharmacological and psychosocial interventions.

Logistically, only a small number of GP practices can be served by specific attachments of allied health personnel. Rotating the service through a number of GP clinics can allow a greater range of GPs to refer to and benefit from the service. However this is at the expense of reducing the number of sessions in each general practice. Alternatively it may be possible to situate allied health professionals in community health centres central to many general practice surgeries. Whether a co-location model is developed or not, interactions between allied health workers and GPs require guidelines that are underpinned by the established principles of 'shared care'. If co-location in general practice

surgeries is adopted as the model, then the infrastructure required in the practices should be supported.

In the past, allied health professionals providing these services have experienced some difficulty fitting into new roles working with GPs in different structures that have not always provided professional support. Good connectivity with peers through association memberships and through organizational structures is an important issue to address in future programs.



Referral and liaison protocols

The development of referral and liaison protocols would allow GPs and allied health workers to take advantage of their closer working arrangement. Psychologists have generally indicated that they require a formal referral procedure that includes the GP providing written information of patient details and the perceived problem for all patients they refer. However, while GPs find a formal referral form initially useful as a guide to the critical elements of the referral, many find these unnecessarily restrictive and redundant once the service and referral patterns are established.

In an environment where the resources are limited it has been important to ensure that referrals are warranted and appropriate. For example under a brief intervention model, GPs may only refer patients that will benefit from short term counselling. A formal referral system with close monitoring can reduce inappropriate load on the service. This monitoring will ensure that space is left for more urgent appointments and that patients who do not attend are followed up.

Informal contact can be maximised when the allied health professional is co-located within the GPs surgery setting. However ensuring adequate communication may require more formal processes even in these settings. Formal liaison between the treating GP and the mental health worker regarding psychological issues of particular patients will allow the GP to remain informed about the mental health status of a patient. This may occur through written

reports on completion of a program of counselling or possibly by contact with the GP after each counselling session. The amount of liaison required by each GP should be negotiated on an individual basis with some flexibility. This 'shared care' may be fostered through use of a comprehensive referral form, letters from the allied health worker regarding counselling status of the patient, discharge report from the allied health worker to the GP, and phone liaison on an 'as needs' basis as deemed appropriate by either practitioner. Whilst neither GPs nor allied health workers generally report concerns regarding confidentiality and information sharing, these issues need to be addressed as they are of major concern to consumers.

Rural areas

Increasing access to allied health services through the provision of MAHS funding has served to acknowledge the importance of allied health services in the provision of comprehensive care. This funding arrangement has also highlighted the need to support rural GPs in their work as primary care providers whilst demonstrating the value of collaboration between GPs and allied health workers in these areas.

A number of problems in the provision of primary mental health services in rural areas have persisted, and need to be addressed. Major issues for rural and remote Divisions over the years have been:

- The size of the resource available (ie generally less than that required)
- Continuity of care is hampered by infrequent visits by psychologists and other allied health workers and frequent staff turnover. Indeed programs with limited short-term funding have found it difficult to attract and hold on to suitable professionals. It remains unclear whether these problems may be reduced or alleviated if the allied health worker were locally based and employed by the Division. Certainly allowing Divisions to hold their own funds would foster a degree of flexibility that would allow the provision of mental health services to be tailored to address local needs. Indeed there is a strong perception that people treated in their own community by a locally based mental health worker have better outcomes than those receiving treatment from workers visiting from outside the community on an infrequent basis.
- Professional support and supervision. Allied health and mental health workers in rural and remote areas work in isolated circumstances and sometimes lack a network of peers with whom to share experiences and at times responsibility. This has been a significant factor in staff turnover. Support and validation of the allied health professionals in their role is also essential to maintain good service delivery. Rurally located workers need to be identified within, and actively supported by a larger team, especially to ensure counsellor 'burn out' does not occur. In addition clinical supervision needs have to be addressed in a systematic way.

Finally the provision of a new service must be promoted to GPs and their patients as rural communities may not rapidly embrace a service that has never been available to them.

Specific needs groups

Divisional needs assessments have identified a number of particularly disadvantaged 'target groups'. Target groups have included people recognised as 'mentally ill', socially and economically disadvantaged people, Aboriginal communities, health care card holders, disabled people and people of non-English speaking background. The quality of primary health care will be improved by providing mental health services that are appropriate to the special needs of disadvantaged groups.

However, while a majority of Divisional programs have been aimed exclusively at people with health care cards, almost all have noted a need to be as inclusive as possible when determining access. With limited resources this has created tension within the programs.

More Allied Health Services program in rural and remote Australia

There has now been a move back to the provision of allied health services through the More Allied Health Services (MAHS) program. This program has been directed towards rural and remote Divisions of General Practice. While intended to aid in the procurement of a wide range of allied health services a large proportion of MAHS activities have been in mental health.

The MAHS program has only recently been put in place and activities conducted under this funding arrangement have not yet been evaluated. However the service arrangements provide some interesting insights at least into what may be acceptable to different stakeholders. Eventually through evaluation we may be able to determine what has been effective in terms of consumer outcomes.

In the MAHS projects the rural and remote Divisions have been the fund-holders. They have procured services from psychologists, youth counsellors, mental health workers or nurses, counsellors and social workers. The role of these mental health professionals has been primarily focussed on service provision with a secondary emphasis on liaison and education. In a few instances the role of the MAHS worker includes limited assessment and therapy ("counselling") but there is generally much more of an emphasis on coordination of referral to existing community agencies. Facilitation and participation in *Enhanced Primary Care* related activities such as Care Planning and Case Conferencing has been identified as a key outcome of the MAHS program.

Models of employment vary. The Divisions themselves employ some of the allied health professionals, others are employed through local area health services or

local councils with the Division purchasing services from these. In other situations there is joint funding for these positions.

The locations of the services also vary. Some are provided in general practices themselves, some from Division offices, some from local area health service facilities. These could loosely be categorised into “in general practice” and “outside general practice” from an organisational viewpoint.

It is still too early in the MAHS program to make definitive statements about what works and what doesn’t. However some early feedback has come through formative evaluation in some regions.

Limited pool of skilled professionals

In some areas Divisions have not been able to fill their positions. In others, allied health professionals and psychologists have moved from other health service positions. In these rural and remote setting this has resulted in health services being unable to fill the vacated positions.

Direct employment

In some areas there is a shortage of potential employers so that some Divisions have taken up a model of direct employment. This direct employment ensures clear lines of responsibility and control over the role of the allied health professional. However, there is resistance within some Divisions to a role as employers of allied health professionals. This is due to a limited infrastructure and support funding for management. Divisions do not necessarily have the expertise to recruit and select appropriate allied health staff for these new clinical roles.

Confidentiality problems with Divisions as fundholders

There are some concerns regarding patient confidentiality. In some, but not all programs the Division may hold a listof people requiring or having had services, so it is important to assure that any patiend data is subjected to the required confidentiality requirements that a clinical setting would use. This not only applies to mental health. Centralised Division-sited databases of patient information are used in several other programs such as diabetes.

The issue of confidentiality has been prominent throughout deliberations with the mental health budget initiatives. There is an assumption that there are strong confidentiality safeguards in place. Confidentiality concerns need to be addressed through the development of appropriate systems and safeguards.

Out-sourcing

Some Divisions have out-sourced allied health services to other providers such as area health services. These arrangements are based either on a legal contract or a MoU or service agreement. There have been a number of concerns with such arrangements.

Lines of responsibility and clear position descriptions.

The allied health professional is employed by the area health service. Therefore responsibility is directly to the health service rather than to the general practitioners. If position descriptions are not tightly defined and performance measures regularly reviewed then there may be some confusion regarding roles.

Similarly lines of responsibility and governance need to be clear so that there is sufficient leverage by the Division to ensure that the allied health professional attends to the agenda of the Division and its members rather than that of the area health service.

Concerns regarding cost shifting and service retraction

There is some concern that if Divisions outsource these services to area health services, then this provider might in turn retract similar services that were previously provided. For example the local area health service might already provide a clinical psychologist 1day per fortnight to a town (0.1 FTE). The Division decides that they need a halftime psychologist and then subcontracts the area health service to provide the clinical psychologist. The area health service does this but also ceases the 0.1 FTE service as there is now a 0.5 FTE psychologist service funded through MAHS. This is specifically mentioned in the DHAC guidelines for the MAHS programs but nevertheless is a concern. Service reduction can also occur informally, for example delay in filling vacant positions.

Confidentiality

Similarly there are concerns with confidentiality with referrals from GPs to counselors based within area health services. Written referrals are sometimes vetted by the mental health team or other third party in determining their urgency or appropriateness. Referrals to allied health based within area health services in the setting of *Better Outcomes in Mental Health* need to be direct and managed in a closed manner by the AHP.

Primary or secondary services?

There is still confusion about exactly what the orientation of allied health engaged through the MAHS programs ought to be. Should they be facing the need for brief primary care oriented interventions or more elaborate and complex interventions appropriate to those clients with complex needs due to comorbidity or severe disablement. Because of the backgrounds of many of the allied health employed through MAHS there is a tendency to gravitate towards previously established ways of working rather than forging new and unfamiliar roles. This means that there is a tendency towards addressing the needs of secondary and tertiary services rather than primary care.

Location of services

There has been wide variation in the sites in which services have been provided. The strengths and weaknesses of “in general practice” and “outside general

practice" are predictable. Generally "in general practice" settings favour informal liaison between GPs and the MAHS health professionals at the risk of reducing links between the MAHS workers and the other community based services. If the MAHS workers are sited in the area health service premises then links with these services are facilitated. These links serve to support the MAHS workers and to facilitate a coordinated approach to care. The downside is that links with and responsiveness to GPs may be more tenuous.

On the other hand this model provides opportunities for creating better links between local area health services and GPs, so long as there are minimum standard requirements for communication with GPs. It provides support for the allied health workers through already existing administrative and management structures.

Infrastructure & support

Several Divisions have mentioned that there is insufficient funding available for infrastructural support for allied health professionals through the MAHS programs. This applies to administrative support (expertise with recruitment, induction and orientation, and supervision) as well as "hardware" such as offices and consumables. In some ways out-sourcing may overcome these shortcomings but at the possible expense of control.

CHAPTER 3 Experience from Overseas

UK experience with practice based counsellors and psychologists

In the UK the place of counsellors in primary health care is now well established. However the proportion of general practices employing a counsellor varies with the research sample. In 1993 Sibbald and colleagues (1997) found that 31% of general practices employed a counsellor. White and colleagues (2000) in 2000 found the figure to be 20.3% in an urban area. In a paper delivered at the Counselling in Primary Care Conference at the Royal Society of Medicine in London in January 2001 (Fletcher et al., 1995) it was reported, that in 1998 51% of general practices had a counsellor. It was estimated that this figure had risen to 90% by 2001.

The profession of Primary Care Counsellor has emerged and a professional association, the Association for Counsellors and Psychotherapists in Primary Care, has been established. The Counselling in Primary Care Trust performs research and has developed standards and guidelines to support this initiative. Many resources are available on the web sites of these organisations at http://www.cpct.co.uk.

Joan Foster, Chair of the Association of Counsellors and Psychotherapists in Primary Care (personal communication 7th November, 2001) indicates that the key issues in developing the system have been:

- establishing counselling as a self-regulating profession;
- establishing the discipline of brief focused counselling;
- relationships with secondary mental health services;
- identifying the referral protocols and the suitability of the presenting problem for counselling in primary care, which is usually, mild to moderate mental health problems;
- integration of counsellors into the primary health care team;
- determining the structure of managed counselling services.

An occasional paper by the Royal College of General Practitioners, (Sibbald et al., 1997) points out the problems of defining what the target population should be, the appropriateness of referral and the evaluation of outcomes.

These issues will be further elaborated with reference to the available British literature.

Funding models

Prior to the introduction of Primary Care Groups in April 1999 (which appear to be similar to our Divisions of General Practice) 60% of counsellors were self employed and contracted to general practices in a variety of ways (Foster, 2001). The dominant model in the UK was of fundholding by general practices which used their budgets to employ a counsellor to work at the practice (Corney, 1995). An alternative was for the funds to be held by a hospital trust and these were then allocated and spent by the GPs.

A study of counsellors in 1995 (Einzig et al., 1995) found that 20 of the 24 respondents surveyed were paid by the GP. One was paid directly by the client and a further two worked as volunteers. There was no consistency of rates of pay or fee structure.

At the same time there were also approximately 160 (1995 figures) community mental health centres in the UK, operating under a variety of management structures, which employed counsellors (Corney, 1995). Goldberg (Goldberg et al., 1996) describes one such service. It was comprised of two community nurses, one social worker, an occupational therapist, a clinical psychologist and secretarial help based at a community health centre. A psychiatrist provided weekly clinics at each group practice. The team was located on a large council estate and served a population of 12,000 people with 11 GPs in three group practices.

Community mental health centres are run by the NHS through the Mental Health Trusts (which are large decentralised regional outposts of the NHS focussed on mental health) and accept patients referred to them by GPs. There are also Primary Care Trusts (NHS outposts managing primary care) and, due to recognition of the need for closer links between primary care and mental health services, there is some indication of a shift towards these taking responsibility for local specialist mental health services and community mental health teams (Department of Health UK, 2001).

The management of primary care counselling, and its structure, is currently being addressed by Primary Care Groups and by Primary Care Trusts around the country. The major issue concerns whether primary care counselling is managed in primary or secondary care (Foster, 2001). Foster believes that

> *"…if the aim is to establish a truly integrated service within primary care where the counsellor is seen as part of the Primary Health Care Team, then the structure needs to be PCT based. If the wish is for integration into secondary services with the concomitant absorption into a bigger bureaucracy with wider agendas, then the service should be based in a Mental Health or Community Trust. Whatever the decision, it is essential that a primary care counselling service is managed by a primary care counsellor."*
>
> (Foster 2001)

Foster acknowledges that locating primary care counselling services within secondary services would provide opportunities to build effective referral pathways. However he cites research evidence that 91% of individuals with a mental health problem are seen only in primary care and confirms the need for counsellors to be located in primary care. This has been the dominant model in the UK and nearly all the literature on primary care counselling locates the counsellor within a general practice as part of the team.

This view is supported by Baty and colleagues (2001) who has examined the structure of the counselling services which were set up by GPs during the time of the 'fundholding' model with the aim of discovering what GPs really want. "In house services were seen to be more acceptable to patients and to allow greater interaction, both formal and informal, between the clinical psychologists and their PCHT colleagues" (Baty et al., 2001 pg. 16). GPs also valued the opportunity to determine, in conjunction with the clinical psychologist, the goals, nature and standards of the service. This included accepting responsibility for the functioning of the service and finding solutions to problems such as long waiting lists or whether to treat few people for many sessions or a larger number of people for fewer sessions. There was a wish to minimise the bureaucracy endemic in centrally run services.

Effects of locating a counsellor in primary care

A number of effects of locating a counsellor at a general practice have been found.

On referral to specialised services

A Cochrane Review of on-site mental health workers in general practice [Bower & Sibbald, 2000 #95] found three out of six studies reported lower mental health referral rates. One study found higher referral costs while another found similar referral rates.

One study (White et al., 2000) found that practices employing a counsellor have significantly higher referral rates to mental health services. However despite the differences in referral rates there does not seem to be any difference in the appropriateness or 'caseness' between practices which do or do not employ a counsellor. The rates of “non-cases” [code for inappropriate referrals] coming from either practices with counsellors or those without counsellors is below 10%. The conclusion drawn is that practices employing counsellors have a higher sensitivity of detection.

Another Cochrane review evaluating the effectiveness and cost effectiveness of counselling (Rowland et al., 2001) found that there was no strong evidence of the effects of counselling on various other aspects of health service usage.

In a study (Firth et al., 1999) of a social work service which relocated to a general practice it was found that the practice developed new clientele with high levels of psychosocial adversity, without a significant increase in

secondary care. It was not clear in this paper whether the social work service functioned as a counselling service.

On medication use

In at least one cross sectional study in the UK it was found that the use of psychotherapeutic medications was in fact more common amongst those general practices that provided counselling services [Fletcher, 1995 #97]. A Cochrane Review of on-site mental health workers in general practice [Bower & Sibbald, 2000 #95] however, has found that in the short term four studies found significant reductions in psychotropic prescribing rates while two studies showed no difference. Long term findings were mixed, however of six studies, three found no difference in psychotropic prescribing rates. Another examination of four studies showed no difference in three studies with higher prescribing rates in one.

This probably reflects the fact that the provision of counselling services in general practice actually results in detection and treatment (by whatever means are available) of people who were not previously managed at all. What does not seem to be happening is that people with mental health problems who were previously having medication based treatments move over to therapy based treatments and stop their medications.

Reporting, referral and confidentiality issues

The issues around referral and reporting and the interaction of GPs and counsellors are clearly the most difficult and well discussed in the literature. A tension exists between the well-established ethic of confidentiality of counselling and the medical team setting of general practice. Some counsellors did not wish to receive referral letters from GPs, thinking that this would adversely affect their perception of the client (Einzig et al., 1995).

Only 14 of the 24 counsellors in Einzig's study reported regularly to the referring GP and there was a great deal of variation in information and note sharing. This had implications for the relationships within the practice. In particular, lack of communication with the GP led to isolation of the counsellor, lack of peer support and their marginalisation within the practice.

Knight also addresses the issue and describes a case where GPs are informed of progress through a brief written summary at the end of the counselling episode. The content was discussed with the client at the last session and the report was filed in their medical records.

The issue of confidentiality was also raised by Kell (1999) who felt that it had a major impact on the integration of the counsellor into the medical team. Kell reports that different practices have different levels of compatibility with the counselling ethic of confidentiality but argues strongly that high levels of counsellor confidentiality must be maintained. This is seen as an equity issue since high-income earners can access private counsellors with assured confidentiality and there should not be a difference for those using the public health system.

The Code of Ethics developed for counsellors and psychotherapists in Primary Care (Association for Counsellors and Psychotherapists in Primary Care, 2001) takes a middle ground on this issue. It recognises that as these counsellors work as members of a medical team some allowance must be made. The ethical principles state that:

- In some circumstances it may be appropriate for the CPC member to reflect the progress of a client's therapy with other members of the PHCT, who may be working with the client in parallel.
- It is therefore appropriate for the counsellor to discuss with other members of that specific PHCT the process and progress of the therapy undertaken.
- The personal content of the sessions remains confidential from other members of the PHCT after due consideration of legal requirements.

Other clauses relate to not taking case material outside of the team without specific consent from the client/and or the client's GP (eg in case discussions), clients being informed of the confidentiality boundaries of working in a team, and the client being able to request that a particular piece of information is kept confidential from the team. Safeguards where self harm or harm to others is a potential also apply.

Education and qualification of counsellors

In 1997-8 a study involving a random sample of 460 counsellors working in primary care was undertaken. This was in response to a widespread belief that primary care counsellors were poorly qualified, unsupervised and treating problems beyond their capabilities. The study found that only 6% of primary care counsellors had no relevant qualifications. 75% held diploma level qualifications with 31% having an additional degree. Only 5% were practicing with a certificate. The average length of work experience was 6.2 years and 99% were receiving regular supervision. The mental health problems most commonly seen were depression, bereavement, anxiety and relationship problems. 78% said they would not treat a person with hallucinations or delusions and 50% would not treat substance abuse.

There is currently a great deal of controversy over the proposal by Tony Blair to recruit 1000 new psychology graduates as primary care counsellors after training in brief therapy (Curtis-Jenkins, 2001). Critics maintain that counselling in primary care requires experienced, mature, educated and capable people as it can be extremely demanding.

The Association of Counsellors and Psychotherapists in Primary Care believed that it was untenable for counsellors to continue as an unregulated profession and believed that the public was at risk through untrained counsellors working in GP surgeries. This led to the formation of the Association of Counsellors and Psychotherapists in Primary Care in 1998 (Foster, 2001). The UK Department of Health has recently published a document looking to regulate psychology, psychotherapy, counselling and other related professions. Among its requirements are that the profession maintains a register of members who have

met defined training standards, that it has a code of ethics and a complaints procedure. The CPC has these structures in place and their code of ethics and complaints procedures are available on their web site.

The Counselling in Primary Care Trust has issued some guidelines, derived from the British Association for Counselling Code of Ethics and Guidelines, regarding the training and experience required as a primary care counsellor. They recommend a three-year training program leading to accreditation with the British Association of Counsellors. This training would include skills and knowledge specific to the medical context, eg diagnosis and management of psychosomatic illness, knowledge of how the NHS operates, dealing with time pressure and waiting lists, and experience of at least 250 hours and preferably 300+ hours of supervised practice over at least 2 or preferably three years (Curtis-Jenkins, No date).

Supervision of counsellors

It is a symptom of the importance of counsellor supervision that there are no British articles to be found arguing that supervision is necessary. Einzig in 1995 and Mellor Clark in 2001(Einzig et al., 1995; Mellor-Clark et al., 2001) both found that almost 100% of counsellors had regular meetings with a supervisor. Supervision arrangements are many and varied. Some supervisors are appointed, other counsellors choose their own. Some supervisors are paid and some counsellors pay for their own supervision (Foster, 2001). The contract between the counsellor and the supervisor is formalised with a signed document setting out expectations including complaints procedures, code of ethics to be followed, note keeping, payment, responsibility, performance, confidentiality.

Curtis-Jenkins (Curtis-Jenkins & Henderson, No date) proposes a four-fold model of counsellor supervision. This involves:

- peer support between counsellors in an area,
- managerial supervision through a line of management inside the practice,
- counselling supervision for 1.5 hours/month or in the case of less experienced counsellors one hour per six fifty minute counselling sessions
- availability of expert consultation by telephone in order to gain specific advice.

There is substantial discussion in the literature regarding the training of supervisors and what qualifications and experience they should have. Required competencies include knowledge specific to the setting of primary care, basic supervisor training as a minimum, knowledge of the organisational structures of the NHS, understanding power and authority structures within the medical team, confidentially issues with the practice team, ethics and accountability with in a medical setting, knowledge of medication therapies, knowledge of time limited work practices and many other aspects specific to counselling in primary care.

An overview of the American and Canadian literature

The American and Canadian literature reveals support for the effectiveness of integrating psychological and other psychotherapeutic services into the primary care setting. The introduction of health maintenance organisations in America created unique opportunities for multi-disciplinary cooperation in the treatment of medical conditions in which behaviour change is important. Most of the experience in the US has come from the integration of psychologists into these organisations. The value of providing psycho-social interventions in these settings has been derived from observation of decreases in morbidity and mortality associated with enhanced treatment outcomes, reduced symptom severity, the offset of medical services utilization and its associated costs, and improvements in adherence to psychiatric medication (Pace, 1995; Bray & Rogers, 1995). Providing mental health services in primary care has become an efficient way of providing care for large numbers of people with mental health problems, many of whom would not have received treatment otherwise. Overall, experiences in the provision of these services have been much the same as those encountered in the UK and Australian contexts, and will be outlined here only in brief. Experience with the provision of these types of services seems to be fairly consistent in most industrialised countries with well-developed health systems.

Whilst the majority of programs have involved clinical psychologists there has also been experience with other professions assisting primary care patients develop healthier behaviours. These include social workers, nurses, health educators and physical therapists. Integration of a range of specialty mental health providers into primary care settings has been found to improve both outcomes and patient satisfaction in treatment of a range of mental health issues (Katon et al., 1996). For example, mental health nurses working in primary care (as independent practitioners) may be involved in diagnosis, clinical decision making and nursing and medical interventions that address patient/family education, psychotherapy, health promotion, pharmacological management, referral and consultation (Dyer et al., 1997). Similarly, providing integrated services involving psychosocially trained social workers is a cost effective means of improving health and mental health care for rural primary care patients (Badger et al., 1997). There is recognition of the need for all mental health service providers (trained and experienced often in secondary and tertiary settings) to adjust to seeing the broader range of clinical problems and populations that present in primary care.

In most cases the programs described in the literature have been well received by providers and patients and interestingly have led to substantial reductions in the use of both outpatient and in-patient mental health services. It is important to ensure that the services offered in the family physicians office complement rather than duplicate the services that are available within the local mental health system. In most cases the interventions offered were short-term with the family physician remaining an active partner.

Problems that have been identified are as follows:

- Logistics There have been difficulties finding adequate office space for counsellors in some practices and problems keeping up with heavy demands for service.
- Skills shortages Similarly there have been reports of difficulties in finding suitably trained staff (Bird, 1998) although this may be alleviated by expanding hiring criteria or using externs from clinical psychology training programs. In-fact, allowing particular practices to determine what type of mental health worker they hire may provide flexibility that will enable them to cater for the specific needs of their local population.
- Lack of promotion of services In some cases the services have remained not well known and/or not easily accessed by the patients that may benefit from them.

Location

Systems that have been most successful have located the mental health and primary care programs in the same clinic (Haley et al., 1998). Co-location of psychological and primary care services has been considered to be successful because it:

- reduces the stigma associated with receiving psychological care
- ensures that behavioural health services are visible to physicians
- maximises informal consultations and facilitates the development of collaborative inter-disciplinary relationships
- facilitates timely and appropriate referral
- enables personal introduction of the psychologist to the patient by the physician.

Evaluation

There is a recognised need for extensive evaluation of primary care based psychological services. One program described its use of a comprehensive database containing demographic, treatment, and outcome data on every patient referred by the family physician (Kates et al., 1997). A permanent unique identifier allowed a longitudinal record for each person to be created with clinical data based on the family physician referral form and the mental health providers assessment and treatment outcome forms. Systematic collection of data such as this enables comprehensive evaluation and clinical outcome analysis that will allow researchers to determine the effectiveness of different programs. Other components of evaluation may include consumer satisfaction questionnaires, surveys of providers' satisfaction, and measurement of changes in physician mental health expertise.

Models of funding

Description of funding and administration has generally been restricted to political discussions of the function of health maintenance organisations and managed care programs. Perhaps the most informative report is one that described a program in Ontario Canada that brought counsellors (and psychiatrists) in to the offices of 87 family physicians in 35 practices (Kates et al., 1998). In this program a central administration team was responsible for organising the allocation and flow of funds to the practices, recruitment of counsellors, clinical and educational activities and evaluation in each practice. Under a single management structure standards and targets may be set with monitoring and regular feedback reports that may be used to ensure that each practice continues to provide effective, efficient services.

> *"This integrated shared care model appears to be well received by providers and patients and its components can be adapted to any community, often by seconding or relocating staff from existing services to work within primary care settings"*
>
> Kates et al., 1998 pg. 112

Stepped care models

Stepped care is based on the idea that many patients may benefit from lower-intensity interventions whilst more expensive individual treatment should be reserved for those patients who require more in-depth care. In stepped care models the lower cost, least restrictive interventions are tried first and more costly, more intensive interventions are used when these initial interventions are inadequate (Haaga, 2000).

One model describes a 3-stage intervention as follows (Pruitt et al., 1998);

Stage 1. 15 minute brief assessment and low intensity intervention is conducted by the mental health worker in conjunction with a 3 minute physician visit with the patient present to discuss management approaches.

Stage 2. More intensive care is provided for patients who require behavioural intervention beyond what can be conducted in a routine primary care visit. This usually will involve a psycho-educational approach. Efficiencies may be maintained by use of group therapy and workshops for small numbers of patients experiencing similar problems.

Stage 3. This stage involves expanded behavioural interventions for patients who do not respond sufficiently to less intensive interventions. This may include use of cognitive behavioural and problem solving based techniques that help patients with behavioural and lifestyle changes that will be beneficial to their physical and mental health.

The 'starting level' should be chosen based on a clinical decision regarding patient need, available resources and likely effectiveness (Wilson, 2000). Lower intensity interventions may be delivered via computers, training videos, or self-help resources. Such approaches have proven effective in treating anxiety (Newman et al., 1997) and depression (Proudfoot et al., submitted but not yet published).

There is also some evidence that providing counselling over the telephone may serve as an effective, inexpensive adjunct to pharmacological treatment of mental health problems (Tutty et al., 2000). Before a stepped approach is implemented research is required to determine predictors of treatment response, and the most effective but least costly interventions suitable for the common mental health problems seen in primary care patients.

Further, care needs to be taken in instigating stepped approaches to mental health as initial failures in therapy provision may have significant negative effects for unstable patients. Such problems may be minimised by individualising treatments based on the patients presenting problem, their beliefs and resources, using empirically supported treatments, selecting treatments that are cost effective (and have broader population reach) but that are still likely to work (Sobell & Sobell, 2000).

Support for use of this approach has come from studies showing that patients who received stepped collaborative care intervention experienced significantly better outcomes than patients who received primary care as usual (Lin et al., 2000). Stepped care models may reduce the costs associated with providing mental health care by reducing excessive or unnecessary services and allowing limited resources to be used more efficiently.

A role for psychologists

In America, psychologists have begun to play a prominent role in health maintenance organisations' provision of primary physical and mental health care. Psychologists may provide clinical services that include assessment and evaluation, individual, family and group psychotherapy, consultation services, psycho-educational groups, referral for additional services, crisis intervention and follow-up care (Haley et al., 1998). However, it is well recognised that psychologists have had to adjust their practice style to adjust to the unique characteristics of working within primary care. Many difficulties have arisen as psychologists adapt to settings that emphasize collaborative care and cost-effective, time-limited, solution focused, outpatient psychological services (Elliott & Klapow, 1997).

The role of psychologists in multi-disciplinary programs may expand even further as they are seen to possess not only expertise in behaviour change but training in basic research and program evaluation. Psychologists have the ability to evaluate research literature and draw practical conclusions for program development and are also able to conduct research to evaluate the programs that they are involved in. Psychologists may help to establish a research program in

which healthcare utilization, outcomes, patient satisfaction, prevalence, incidence, health promotion and effective treatment strategies are all assessed. Further, psychologists may obtain the necessary skills mix to provide supervision for other health service workers providing mental health services in primary care settings.

Strong administrative and professional support along with training and experience in general medical settings is needed for psychologists if they are to achieve their potential in the assessment, clinical treatment, training/education, and program development/evaluation roles that have been described for them.

Communication and collaboration

Too often family physicians and mental health care providers fail to establish the collaborative relationships that would improve the quality of care that primary care patients receive. Collaboration between professionals of differing disciplines is seen as an essential ingredient in making psychological and counselling services more accessible in primary care medical settings (McDaniel, 1995). Effective collaboration is dependent on good communication including an understanding of each others viewpoint, development of a personal relationship, use of common language, shared goals and a contract to work together (McDaniel et al., 1995). The main problems effecting communication include differences in theoretical orientations, a lack of common language, different practice styles, varying expectations for assessment and treatment, and differences in approaches to confidentiality (McDaniel et al., 1992; Bray & Rogers, 1995). The mental health professional must work within the boundaries of confidentiality to communicate what is necessary for good health care whilst maintaining the psychotherapeutic relationship. It is important for the mental health and primary care providers to negotiate regarding how they intend to collaborate and what kind of information each expects about the patient (Bray & Rogers, 1997). The pertinent issues are described and discussed as follows.

Reporting

Reporting between the mental health care provider and the physician is one area where communication difficulties may exist. To be effective, communication from psychologists regarding patients should conform to medical conventions (McDaniel, 1995). A brief report including an assessment summary and treatment recommendations following the first session with the mental health care provider may be followed by a phone call to exchange information regarding the psychological treatment of the patient. There should also be direct communication from the mental health care provider if there is a crisis situation, or if the therapy is prematurely terminated. Medical providers may vary in the amount of information they wish to receive, and discussions between the mental health care provider and the physician will ensure that the frequency, length, and content of reports is sufficient (Bray & Rogers, 1997; Haley et al., 1998). Given that most consultation letters in the health

profession are less than one page in length, a brief report that contains important information is most likely be well received by the referring physician. In addition, daily or weekly meetings between the physician and the psychologist allows discussion regarding cases the psychologist has seen or patients that the physician may be requiring some advice regarding. Overall, regular communication based on some or all of these components will enhance the care that the physician is providing and will strengthen continuity of care as the physician remains informed regarding his/her patients.

Consultation liaison

Joint sessions, where the physician and the psychologist are both present, are described as the most powerful method of collaboration. Indeed, joint sessions for patients with difficult or complex medical, mental or psycho-social health problems are both effective and efficient (Dym & Berman, 1986). Combined sessions may be particularly useful in initial sessions for patients who are reluctant regarding referral, and with patients for whom the psychological and physical complications are unusually complex. Even a brief, fifteen minute session with both mental and physical health care providers can be a very powerful experience for patients struggling with health problems (Haley et al., 1998).

Mutual understanding and trust

Perhaps the most important variable in the development of interdisciplinary relationships is working knowledge and respect for the others profession and approach. A number of clinical and educational activities may foster effective communication and collaboration between these professionals leading to enhanced diagnosis and treatment of medical and psychological problems by both (Bray & Rogers, 1995). For example, having the mental health care provider regularly present cases that focus on psychological approaches to patients care may make physicians aware of how psychology can contribute to the care of their patients (Bray & Rogers, 1995). Similarly monthly case conferences may focus on difficulties with patient treatment that physicians are experiencing (Price at al., 2000). In the Ontario program (Kates et al., 1998) daily meetings were used to allow the family physician and the counsellor to discuss cases allowing the physician to remain informed about patients they have referred strengthening the continuity of care.

CHAPTER 4 Workforce Considerations

The competencies required to deliver the services discussed are not the particular domain of any particular professional group. The determining factor is the level of competence required and the training that each professional has had. Potential providers who might already possess these competencies include social workers, mental health nurses, some occupational therapists trained in the mental health area, some Aboriginal and Torres Strait Islander Health workers, psychologists and general practitioners.

Mental health nurses

The recently released final report of the Scoping Study of the Australian Mental Health Nursing Workforce (Clinton, 2001) described a profession in crisis and at risk of demise. There is a widespread problem with the recruitment and retention of mental health nurses. The Department of Employment, Workplace Relations and Small Business has identified shortages in several nursing specialties including mental health nursing, with shortages in all states except Western Australia (Clinton & Hazelton, 2000).

During the period 1993 to 1996 the number of mental health nurses employed in psychiatric hospitals fell from 7880 to 4140 (AIHW reported by (Clinton & Hazelton, 2000)). No information is available about the career destinations of these nurses. In the same period nurses were employed in occupations other than nursing increased from 12,500 to 17,700. The 1996 census showed that 19.8% of people whose highest qualification was in nursing were employed in occupations other than nursing (Clinton & Hazelton, 2000 pg. 58). A 1997 NSW Department of Health workforce planning study reports an annual wastage rate of 34.7% in the mental health nursing profession (Clinton & Hazelton, 2000 pg. 59). A shortfall of 540 mental health nurses is anticipated for NSW by the year 2005.

There are skill shortages among mental health nurses. Only 11% of registered mental health nurses have a post graduate qualification and 73% of the registered workforce are Level 1 nurses (AIHW quoted in Clinton and Hazelton, 2000). However, despite this Clinton's scoping study found many examples of mental health nurses with advanced qualifications such as higher degrees who were unable to use their knowledge because of rigid divisions of labour and for whom career advancement was not available. Clinton thus points out that the high proportion of Level 1 positions reflects both a shortage of specialised and experienced mental health nurses and a lack of career opportunities.

This lack of career opportunities for mental health nurses with advanced qualifications may mean that these persons would be interested in filling counselling positions located in general practice.

A small number of nurses are currently being trained as psychotherapists. A program is currently being run at Flinders University. It is based on similar

courses in the UK (Allen et al., 2000). There are a few other similar courses around Australia about which details are sketchy.

Occupational therapists

Little systematic analysis of the Australian occupational therapy workforce has been carried out. The 1996 Australian census is the only data available. Millsteed (2000) examines the figures that are available and finds that the proportion of occupational Tterapists in the health labour force has increased from 1% in 1979 to 1.3%in 1991. From 1991 to 1996 the number of practising occupational therapists per 100,000 people increased by 12.5%. There is some evidence of an unequal distribution of OTs in favour of urban rather than rural areas. Millsteed quotes projected figures from the Department of Employment, Education and Training which show that the employment growth for OTs will increase by 79% over the period 1995-2005 compared with 38.2% for 45 other professions. This leaves the impression that there will be a future shortage of OTs although more detailed information can not be obtained at the moment. No information on the numbers of OTs trained in counselling is available.

Psychologists

The Australian Institute of Health and Welfare publication 'Health and Community Services Labour Force 1996' using statistics from the 1996 census gives the figure of 5,255 clinical psychologists in Australia. The national rate was 29.6 per 100,000 population with ACT having more at 49.2/100,000 and Queensland having least at 21.5/100,000.

A workforce planning survey conducted by NSW Psychologists Registration Board in 1998 gave a breakdown in NSW by speciality as follows:

Clinical	20.1%
Community	4.4
Counselling	28.7
Educational and Developmental	15.8%
Forensic	3.1%
Health	5.3%
Neuropsychology	3.5%
Organisational	7.8%
Research	4.7%
Sports	0.5%

A submission to the Hon Peter Costello by the President of the Australian Psychological Society (Crowe, 1999) claims 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."

Crowe also claims that despite the NH&MRC guidelines which recommend Cognitive Behaviour Therapy (CBT) as a primary intervention for depression in young people there are in fact now fewer clinically trained psychologists in the public sector to give it. Given that most GPs do not have skills in CBT there is limited access to this evidence based intervention set for those who do not have private health insurance. Importantly, Crowe quotes the 1993 Burdekin Report stating that "restriction of access to psychologists results in important treatment options being denied to many individuals affected by mental illness" and that the lack of access "is incompatible with human rights and is economically unsound".

A Media Release by the Australian Psychological Society (Cotton, 2001) warns that counselling is not the same as highly focussed psychological treatment and that it is helpful to consider psychological expertise operating on three levels:

1. Basic support counselling as ably carried out by a number of health professionals.
2. Counselling with the ability to deliver specific behaviour change. This can be provided by psychologists with 3 to 4 years training or some GPs with specific additional training.
3. Treatment of more complex mental health problems which require specialised tailored interventions by clinical psychologists or psychiatrists.

There is some controversy within the psychology profession regarding the singling out of clinical psychologists as the only sub group qualified to give specialist treatments. An analysis of the 'turf war" is given by Dunn (2001) who argues that counselling, health or community psychologists are just as competent.

The Australian Psychological Association believe that the best outcome for all Australians would be for the integration of specialist trained psychologists into primary care settings following models of public health in countries such as the UK (Cotton, 2001).

Aboriginal Health Workers

The Australian Institute of Health and Welfare publication *Health and Community Services Labour Force 1996* gives statistics for a group defined as Counsellors broken down into rehabilitation counsellors, drug and alcohol counsellors and family counsellors. 3,358 persons were classified into the statistical category of "Counsellor". Indigenous representation was high at 3.4%. 10.6% of drug and

alcohol counsellors were Indigenous. However Indigenous persons comprised only 0.2% of clinical psychologists.

More information on Aboriginal Health Workers comes from a Profile of Queensland Health's Indigenous Workforce (Workforce Planning and Development Team Aboriginal and Torres Strait Islander Health, 1998). In Queensland Health workers of Indigenous descent represent 1.4% of the workforce as opposed to 2.4% of the population. A total of 538 persons responded to the survey, of whom 277 are Aboriginal Health Workers, who work in Primary Health Care or Community Health Centres in equal numbers, 36 are nurses and 4 medical practitioners.

Of all Aboriginal health workers in Queensland Health 19% have a certificate in Primary Health Care, 4% have a Diploma, and 20% have an Associate Diploma. Of those in the Community Care Stream 72% provide counselling and 29% manage counselling. Aboriginal Health Workers then seem to have considerable experience in counselling but little formal training.

More statistics are available from the National Centre for Epidemiology and Population Health at ANU (Sibthorpe et al., 1998). Survey responses were received from 562 state health department organisations (77% response rate), and 91 Aboriginal Health Services (20% response rate) across Australia. A total of 1,106 Indigenous persons were employed. Of these 792 were in health related occupations. A breakdown of these occupations indicated that there were a total of 17 Mental Health workers, (3 in Aboriginal Health services and 14 in State organisations), 350 Aboriginal Health Workers, 130 Nurses, and 49 Health Assistants with the remainder in miscellaneous support and other occupations. Of the 792 workers in health occupations only 25 (3%) had degree level qualifications. Although response rates were low from Aboriginal Health Services, there were responses from all states and from urban and rural regions so the sample was likely to be representative. Given a 20% response rate from Aboriginal Health Services and 70% response rate from Mental Health Services, an estimate is that there are likely to be about 35 Aboriginal persons trained as Mental Health Workers in Australia.

Specific curricula and training courses for Aboriginal and Torres Strait Islander Mental Health Workers have been developed but numbers being trained at present are low. Any development of the *Better Outcomes in Mental Health Initiative* that will specifically address the needs of indigenous Australians needs to closely engage local communities in workforce planning.

Social Workers

Figures on social worker workforce issues are hard to come by. The AIHW Health and Community Services Workforce 1996 study combines the occupations of social worker with several varieties of welfare and community workers. Figures for these groups of 170.1 per 100,000 population are given with

higher levels of 283.5 in the Northern Territory. There is significant Indigenous representation at 4.1%.

Social workers are not currently a regulated profession, with no registration procedure, which makes gathering workforce numbers difficult. There is concern within the social work profession that there is a move in the community services towards an emphasis on the competencies of staff rather than their professional qualifications with a resulting competition between social workers and other professionals for positions. Occupational boundaries and warnings of 'take overs' by other groups such as nurses are an issue within the profession (McDonald, 1999). Nevertheless social work graduates have among the best employment prospect of any graduate. (Ernst & Young, 1997).

Figures for the numbers of social workers competent in counselling are not available, however the Australian Association of Social Workers website www.aasw.asn.au has a number of media releases advocating the suitability of social workers to perform counselling in primary care.

In summary

Grid of potential differences between the different groups

	Comments about skills match	**Workforce and availability**
Psychologists	Variable skill level. Clinical psychologists are the most skilled but it is unclear whether they are the only psychologists with the level of skills required to provide these services.	Approximately 5000 in Australia with level of skills required for these services. May be under-utilized in clinical areas.
Social workers	Small number working in the mental health area and specifically trained have the required skills	Uncertain numbers with skill-set.
Mental health nurses	Larger number are adequately trained have the required skills	Shortage and difficulty recruiting into training. Those with skills may be attracted to primary care positions further exacerbating the shortage in specialty mental health services.

Nurse therapists	Small numbers trained specifically in the evidence based psychotherapies.	Small numbers as yet. Not a significant potential source of personnel at present.
Occupational therapists	Small proportion working in the mental health area and specifically trained have the skills	Small number with skill set required.
Aboriginal and Torres Strait Islander Mental Health Workers	Have appropriate skills tuned for their cultural requirements	Small numbers and shortages. Would need to be engaged with strong links with local community controlled health services.

CHAPTER 5 Analysis of Key Variables

The models which will be examined here are:

1. Mental Health Service as fundholder and employer of the Allied Health Professional (AHP)
2. The Division as fundholder with services out-sourced to the Mental Health Service (MHS)
3. Division as fundholder and employer of AHP
4. General Practice as fundholder and employer of AHP

Fundholder

Fundholding by a mental health service

The UK Community Mental Health Centres run on the MHS fundholder model. The funds are held by one of the Mental Health Trusts, which are large regional outposts of the National Health Service (NHS). These trusts fund and run Community Mental Health Centres which are community based teams of allied health practitioners with their own premises. GPs refer patients to the team.

There is now recognition of the need for greater links between MHSs and primary care so there is discussion of moving management of Community Mental Health Care teams to Primary Care Trusts (NHS outposts managing primary care).

Locating primary care counselling services within secondary services would provide opportunities to build effective referral pathways. However integration into secondary services includes absorption into a bigger bureaucracy with wider agendas. If the aim is to establish a service within primary care where the counsellor is seen as part of the Primary Health Care Team then the structure needs to be based in primary care.

Fundholding by Divisions – outsourced to mental health services

More commonly in Australia the Division is the fundholder. Some Divisions have out-sourced allied health services to other current providers such as area health services. These arrangements are based either on a legal contract or a MOU or service agreement. Concerns here include:

Lines of responsibility and clear position descriptions.

The AHP is employed by the area health service. Therefore responsibility is directly to the AHS rather than to the general practitioners. If position descriptions are not tightly defined and performance measures regularly reviewed then there may be some confusion regarding roles.

Similarly lines of responsibility and governance need to be clear so that there is sufficient leverage by the Division to ensure that the AHP attends to the agenda of the Division and its members rather than that of the Area Health Service.

Cost shifting and service retraction

There is some concern that if Divisions outsource these services to Area Health Services, then the AHS might in turn retract similar services that they previously provided.

In the MAHS projects the rural and remote Divisions have been the fund-holders. There is some resistance within some Divisions to a role as employers of AHPs. This is due to a limited infrastructure and funding for administrative support and supervision. Divisions do not necessarily have the expertise to recruit and select appropriate allied health staff for these new clinical roles.

In some areas Divisions have not been able to fill their positions. In others AHPs and psychologists have moved from other health services positions. In the rural and remote setting this has resulted in those health services being unable to fill the vacated positions in their services.

Fund-holding by Divisions – AHP employed by Divisions

Some Divisions have operated with this model. There are issues around the infrastructural support required for this model. Resources need to be allocated for recruitment, induction, supervision and administrative support for these services. Larger Divisions have been able to manage this but some small Divisions have had difficulty with the support roles needed to effectively administer this model. Ironically it is the smaller Divisions in rural areas that are least able to provide the support this model needs and yet they have the least number of options in whom else they might subcontract these services to.

Fundholding by GPs

Fundholding by GPs was a prominent model in UK prior to 1999. A variation of this model involved funds held by a trust but spent and allocated by GPs. GPs valued self determination in this model, opportunity to determine in conjunction with psychologist, goals, nature and standards of service. Included taking responsibility for functioning and finding solutions to problems.

However the profession of PC Counsellor was poorly regulated, with complaints of poorly qualified counsellors, wide variety of contracting models and models of payment with no standard as to qualifications /experience and remuneration. Most counsellors were self-employed, and some were volunteers.

It is likely that with the *Better Outcomes for Mental Health* program, the services will be shared by several general practices (perhaps with the exception of very large clinics) and so the question arises as to which general practice should be

the fundholder. This model is also likely to reduce access for smaller practices that do not have the size to sustain a counselor.

Other possibilities

Other possible fund-holders are Universities and or State Health or Community Services.

While Universities have a long tradition of fund-holding for research projects, there is not much experience with Universities being fundholders for major health service initiatives. The aim of the trials in year 1 is to fine-tune a model that can be rolled out to larger areas in years two and three. The models then need to trial structures that are as close to what is envisaged in the long run as possible. Therefore fund-holders other than the Universities are favoured as that will be the inevitable structure in the future should the trials be successful.

There are significant difficulties with State Health being the fund-holders for an initiative that is essentially general practice focussed. All of the risks discussed above regarding mental health services as being fund-holders apply to State Health Departments.

Method of Practitioner Payment

In UK during the fundholding period there was no consistency of rates of pay or fee structure for counsellors. Most were paid directly by general practice from their funds. Due to concerns regarding the low level of professional qualifications of counsellors it became untenable for Primary Care Counsellors to be an unregulated profession. The Association of Counsellors and Psychotherapists in Primary Care was established to regulate and certify practitioners.

Funds are now held by Trusts ie National Health Service and detailed pay scales, levels of responsibility, and qualification grades have been developed. Counsellors are employed now by the NHS to work in counselling services located in general practices.

Salary or sessional?

Both of these terms imply non fee for service. Another way of looking at this would be whether the AHP is employed or contracted as an independent provider. The independent contractor model is more flexible but the key terms of the contract need to be explicit and easily measurable. The employment model gives the employer more control but at the expense of reduced flexibility.

Case Payment?

A type of fee for service. There will be some variability in the number of sessions required for each client. Payment at the conclusion of the program of counselling might ensure that certain key processes are adhered to; (eg completion of letters

back to the GP, summary of ongoing management planned for the client post discharge, etc). However there are potential problems with non-attendance. This model does not necessarily compensate for clients who may engage and then not complete their therapy. Payments could legitimately be withheld despite work having been done but not completed through no fault of the counselor.

Voucher?

Once again this is a type of fee for service. There is some precedent for the voucher system in the Department of Veterans Affairs system for referral to allied health and other support services by GPs. In this system while the referrals are for a limited period of time, funding seems to be open ended effectively and in this way is different from what might be envisaged in the *Better Outcomes in Mental Health Initiative*. Funding for honouring the vouchers could be held by Divisions or the HIC.

One issue that continually arises is confidentiality. Under salary or sessional payment systems there is less need for the clients to be specifically identified in any way other than through pooled evaluation data. With fee for service models there is a need for the client to be identified for accountability purposes. It is critical that there be clear procedures for safeguarding the confidentiality of clients accessing these services at all levels. This would include in the practice, at the level of the administration of the funds and at the evaluation level.

Conditions could be placed on the voucher system so that payment would be contingent upon adequate communication with the referring GP and the provision of long term follow up if required.

Co-payments?

Issues around co-payments are complex. Co-payment could be used in any of the above models. On the philosophical side, the advantage of co-payment is that there is a contractual arrangement between the therapist and the client and the co-payment “stake” underpins that the client’s commitment. In addition a co-payment increases the resources available for administrative support or for payment of the allied health professional.

The obvious downside is access. There is empirical evidence that co-payment acts as a brake on service usage (Rosenman, 1992). Inevitably planners need to make a judgement regarding the implementation of a co-payment and it should be up to the service provider to determine whether to waive the co-payment if it is implemented.

Service Delivery Mechanism

Infrastructure & support

Several Divisions have mentioned that there is insufficient funding available for administrative support (expertise with recruitment, induction and orientation, and supervision) as well as "hardware" such as offices and consumables. In some ways out-sourcing may overcome these shortcomings but at the possible expense of control.

Responsibility is directly to the MHS rather than to the general practitioners. In this model lines of responsibility and governance need to be clear so that there is sufficient leverage by the Division to ensure that the MHS attends to the agenda of the Division and its members rather than that of the MHS.

There is some concern that if MHSs are funded under this model they might, in turn, retract similar services that they previously provided.

If the workers are sited in the area health service premises then links with these services are facilitated. These links serve to support the workers and to facilitate a coordinated approach to care. The downside is that links with and responsiveness to GPs may be less satisfactory.

On the other hand this model provides opportunities for creating better links between local Area Health Services and GPs, so long as there are minimum standard requirements for communication with GPs. It provides support for the allied health workers through already existing administrative and management structures.

However, the evidence is that patients would prefer to be seen in primary care due to sigma issues.

Lines of responsibility, liaison and loyalty issues

When a MHW is employed by a MHS responsibility is directly to the MHS rather than to the general practitioners. If the workers are sited in the MHS premises then links with these services are facilitated. These links serve to support the workers and to facilitate a coordinated approach to care.

Lines of responsibility and governance need to be clear so that the AHP attends to the agenda of the Division and its members and their patients rather than that of the Area Health Service.

This model provides opportunities for creating better links between local Area Health Services and GPs, so long as there are minimum standard requirements for communication with GPs. It provides support for the allied health workers through already existing administrative and management structures. However there are concerns about whether the administrative and clinical structures

actually serve the need of primary care based clients requiring these types of limited interventions.

Referral processes should be as simple as possible. Experience from the UK indicates that “non-caseness” [code for inappropriate referrals] accounts for less than 10% of referrals in that setting where strict criteria for referral are not used. With a selected group of GPs (those credentialled with appropriate training and experience) the inappropriate referral rates should be low. Therefore the imposition of tiers of administration for the purposes of “vetting” referrals should be avoided. Referrals should be reviewed by the counsellor for prioritization. This could involve a conversation with the GP if this has not already occurred.

There should be minimum standard for referrals from and for feedback to the GP. There has been extensive experience with referral proformas but these should be used as an aid or template rather than being an absolute requirement with each referral.

Location of the AHPs

Generally “in general practice” settings favour informal liaison between GPs and the health professionals at the risk of reducing links between the workers and the other community based services.

Co-locating allied health workers in the general practice surgery allows patients to access counselling and psychological services in a familiar, less threatening setting. Frequency of access is increased as the fear of stigma that is associated with attending MHSs is removed.

This also creates opportunities for early intervention. Direct links between GPs and allied health workers may facilitate the use of coordinated psychological and medication interventions.

Logistically, only a small number of GP practices can be served by specific attachments of allied health personnel. Rotating the service through a number of GP clinics would allow a greater range of GPs to refer to and benefit from the service. Alternatively it is possible to situate AHPs in community health centres central to many general practice surgeries. There is less stigma associated with consulting counselors in these settings or in general practice than there is in attending a mental health service.

Cochrane Reviews

A Cochrane Review of on-site mental health workers in general practice [Bower & Sibbald, 2000 #95] found three out of six studies reported lower mental health referral rates. One study found higher referral costs and another found similar referral rates.

Another Cochrane review evaluating the effectiveness and cost effectiveness of counselling (Rowland et al., 2001) found that there was no strong evidence of the effects of counselling on various other aspects of health service usage.

A Cochrane Review of on-site mental health workers in general practice [Bower & Sibbald, 2000 #95] has found that in the short term four studies found significant reductions in psychotropic prescribing rates and two studies showed no difference. Long term findings were mixed.

Interaction of allied health professionals and GPs

The PARC Review of Mental Health Shared Care 2001 revealed the difficulties GPs are having in establishing lines of communication with MHSs. Compliance with referral and reporting mechanisms remain problematic.

Lines of responsibility

If the AHP is employed by the area health service responsibility is directly to the AHS rather than to the general practitioners. As stated above if position descriptions are not tightly defined and performance measures regularly reviewed then there may be some confusion regarding roles.

On the other hand this model provides opportunities for creating better links between local Area Health Services and GPs, so long as there are minimum standard requirements for communication with GPs.

Employment or contracting by the Division directly with the counsellor has the advantage of ensuring that lines of responsibility and the role of the counsellor is absolutely clear. This model has the capacity to ensure that adequate communication occurs by detailing these types of interactions in contracts and position descriptions.

Reporting, referral and confidentiality issues

The issues around referral and reporting and the interaction of GPs and counsellors are clearly the most difficult and well discussed in the literature. A tension exists between the well-established ethic of confidentiality of counselling and the medical team setting of the GP practice.

This is seen as an equity issue since high-income earners can access private counsellors with assured confidentiality and there should not be a difference for those using a free service.

The Code of Ethics developed for Counsellors and Psychotherapists in Primary Care (Association for Counsellors and Psychotherapists in Primary Care, 2001) takes a middle ground on this issue and recognises that as counsellors work as members of a medical team some allowance must be made. However confidentiality concerns need to be addressed through the development of

appropriate systems and safeguards. The issue of the keeping of confidential counselling records by Divisions has been raised.

Findings from examination of Divisional projects show that while informal contact is maximised when the AHP is co-located within the GPs surgery setting, ensuring adequate clinical communication may require a more formal liaison protocol. Formal liaison between the treating GP and the mental health worker regarding psychological issues of particular patients will allow the GP to remain informed about the mental health status of a patient. This may occur through written reports on completion of counselling or possibly by contact to the GP after each counselling session. The amount of liaison required by each GP should be negotiated on an individual basis with some flexibility.

This 'shared care' may be fostered through use of a comprehensive referral from, letters from the allied health worker regarding counselling status of the patient, discharge report from the allied health worker to the GP, and phone liaison on an 'as needs' basis as deemed appropriate by either practitioner. Whilst no Divisional projects reported concerns regarding confidentiality and information sharing, these issues will need to be addressed as strict codes of ethics govern both professions.

The development of referral and liaison protocols will allow GPs and allied health workers to take advantage of their closer working arrangement. Psychologists have indicated that they require a formal referral procedure that includes the GP providing written information of patient details and the perceived problem for all patients they refer. However, GPs find a formal referral form unnecessarily restrictive and they often do not comply with even minimal paper work requirements.

Case conferencing and care planning

It is assumed that these will not be necessary at the level envisaged in the EPC items. By definition the people accessing these services will be people with mental health problems needing time limited specific interventions. These people do not need to be case conferenced or care planned. Good three way communication between the counsellor, the client and the GP are all that will be necessary in most circumstances.

Brief case discussion

This might be via telephone or face to face and would occur at the end of the counseling program or in the course of it if there were a need to coordinate management. For example, if there were a need for medication as well as for the psychotherapy.

Joint consultation

The focus of the *Better Outcomes in Mental Health Initiative* is service provision. The purpose of joint consultations is usually educative. While joint consultations may be useful they are difficult to coordinate and pay for. Which practitioner is

providing the service? Which practitioner is paid? There may be a role for joint consultations in the context of an education and training program but there is a real possibility of further dilution of scarce resources even more if these are entertained as a possibility in the service delivery component of the model.

Service Parameters

Primary or secondary services?

It is assumed that the services that will be provided through the *Better Outcomes in Mental Health* will be time limited specific therapies for people with uncomplicated metal health problems. These services are primary care based services. They will not in general require complex care planning or case management.

Individuals or groups?

There is also evidence that group therapy for some disorders can be very effective. The provision of group psychological treatment in primary care is certainly effective in minimising cost and allowing a larger number of patients to receive service when compared to individual models of counselling. Given the size of the potential need and the obvious resource shortfall, there should be early consideration and trialing of group therapy programs for appropriately selected patients in the Australian setting.

Practitioner support

Training of counsellors

It is assumed that counsellors providing these services would already be skilled in the types of specific interventions envisaged in the *Better Outcomes in Mental Health Initiative*. However there will probably be a need for some induction process to familiarise them with the structure of the program and the requirements regarding processing of referrals and liaison with the referring GPs.

Supervision and peer support

In the past, AHPs providing counselling services have experienced some difficulty fitting into new roles working with GPs in different structures that have not always provided professional support. Good connectivity with peers through association memberships and through organisational structures is an important issue to address in future programs.

The Association of Counsellors and Psychotherapists in Primary Care believed that it was untenable for counsellors to continue as an unregulated profession

and believed that the public was at risk through untrained counsellors working in GP surgeries. This led to the formation of the UK Association of Counsellors and Psychotherapists in Primary Care in 1998 (Foster 2001).

The UK Department of Health has recently published a document looking to regulate the psychology, psychotherapy, counselling and other related professions. Among its requirements are that the profession maintains a register of members who have met defined training standards, that it has a code of ethics and a complaints procedure. The Association of Counsellors and Psychotherapists has these structures in place and their Code of Ethics and Complaints Procedures are available on their web site at www.cpct.co.uk

Almost 100% of counsellors in UK have regular meetings with a supervisor. Supervision arrangements are many and varied. The contract between the counsellor and the supervisor is formalised with a signed document setting out expectations. Foster gives a model contract (Foster, 2001).

In UK there is a four element model of counsellor supervision that involves:

- Peer support between counsellors in an area,
- Managerial supervision through a line of management inside the practice,
- Counselling supervision for 1.5 hours/month or in the case of less experienced counsellors one hour per six fifty minute counselling sessions and
- The availability of expert consultation by telephone in order to gain specific advice.

Training of supervisors

The Counselling in Primary Care Trust has issued some guidelines, derived from the British Association for Counselling Code of Ethics and Guidelines, regarding the training and experience required as a supervisor of primary care counsellors.

Supervisors need to have a grasp of the issues for counselors working in the primary care setting; they need to understand the context of general practice, how general practices operate and how they communicate with counsellors.

Summary of Issues by Models of Funding and Service Provision

MHS as Fundholder and Employer of AHP

Advantages

- Provides opportunities to build effective referral pathways and links between primary care and MHSs;
- Provides support for AHP through existing administrative and management structures and ample opportunity for professional supervision and continuing education.

Disadvantages

- Integration into secondary services carries the danger of absorbtion into a bigger bureaucracy with wide agendas;
- If the intention is to establish a service within primary care, then the service needs to be located in primary care;
- Because of the background of AHPs working in MHS there may be a tendency to gravitate towards established ways of doing things rather than forging new and unfamiliar roles;
- Responsibility is to the MHS rather than the GPs. Lines of responsibility and governance need to be clear so there is sufficient leverage by the Division to ensure that its needs are met.
- Links with GPs may become tenuous;
- Patients would prefer to be seen in general practice due to stigma issues;
- Current research indicates that reporting and referral mechanisms between GPs and MHS are still problematic;

Division as a Fundholder with Employment of AHP Out-sourced to MHS

Advantages

- If the workers are sited in the area health service premises then links with these services are facilitated. These links serve to support the workers and to facilitate a coordinated approach to care.
- On the other hand this model provides opportunities for creating better links between local Area Health Services and GPs, so long as there are minimum standard requirements for communication with GPs.
- Support for the allied health workers through already existing administrative and management structures.
- Some Divisions have limited infrastructure and support funding for management of a counselling service;
- Divisions may not have the expertise to recruit and select appropriate AHPs for new clinical roles or to provide professional supervision;

Disadvantages

- Responsibility is to MHS rather than GPs so there may be some role confusion;
- The AHP is employed by the MHS so lines of responsibility need to be tightly defined to ensure that the MHW attends to the agenda of the Division and GPs rather than that of the MHS;
- If Divisions outsource these services to MHS there is some concern that the MHS will retract similar services they previously provided.
- Links with GPs and responsiveness may become tenuous;
- Great potential for confusion over whether this service will be primary or secondary in orientation. Primary services need to be located in primary care.
- Because of the background of AHPs working in MHS there may be a tendency to gravitate towards established ways of doing things rather than forging new and unfamiliar role.

Division as Fundholder and Employer of MHW

Advantages

- Clear lines of responsibility and control over the role of the AHP;
- Favours informal liaison between GPs and AHPs;

Disadvantages

- Some resistance within Divisions to employing AHPs due to limited infrastructure, funding for administrative support, limited expertise to recruit and select appropriately trained AHPs;
- Appropriately trained and experienced supervisors will have to be located and supervision contracts will need to be negotiated;
- In some areas Divisions have been unable to fill positions due to limited availability of qualified persons;
- Favours links between GPs and AHP at the expense of links with MHS;
- The issue of the keeping of confidential counselling records by Divisions has been raised.

General Practice as Fundholder and Employer of MHWs

Advantages

- GPs in UK valued the opportunity for self-determination in this model, opportunity to develop, in conjunction with the MHW, goals, nature and standard of the service.
- In UK GPs took responsibility for the functioning of the service including problem solving and finding solutions to problems;
- Favours informal liaison between GPs and MHWs;
- Setting is less threatening and less stigmatising for patients;
- More opportunities for early intervention;
- Possible reduction of psychotropic drug use in the short term;

Disadvantages

- In UK the counsellors were poorly regulated under the fundholding model. Some counsellors were poorly qualified and there was no consistency in rates of pay for qualifications and experience;
- A tension exists between the ethic of confidentiality and the liaison requirements of the primary health team. Appropriate compromises must be reached;
- Supervision structures must be put into place;
- Appropriately experienced supervisors must be found.

Regarding payment method

	Pros	Cons
Salary	Control over terms of service provision	Less flexibility Requires infrastructure to recruit and supervise More administrative employment related requirements and responsibilities
Contracted private provider	Flexible More responsive on 1:1 basis and less likely to be hindered by 3rd parties' agendas Fewer administrative employment related requirements and responsibilities	Potentially less control over performance
Case payment	May ensure compliance with requirements by delaying payment until sign off	May penalise unjustly if "no shows" are frequent. May not be flexible enough to allow for varying service requirements Confidentiality of third party held data
Voucher	Precedent with DVA May allow HIC or Division to administer funds	Confidentiality of third party held data

BIBLIOGRAPHY

Divisional Projects from the PARC Collection

Central Australian Aboriginal Congress 1995 Mental health project. 6 month report 94-820.3 PARC ID 879

Dandenong & District Division of General Practice 1997 Dandenong regional psychology project. 12-Month progress report. 95-0315.2 PARC ID 581

Great Southern WA Division of General Practice 1995 Services of a psychologist and physiotherapist project. Final report 93-0392.05 PARC ID 608

Greater Bunbury Division of General Practice 1997 Evaluation of the family therapy service in general practice PARC ID 646

Hornsby Ku-ring-gai Division of General Practice 1995 Collaborative shared mental health care Project: Research protocol for the shared care intervention for the seriously mentally ill PARC ID 497

Ipswich & West Moreton Division of General Practice 1995 General Practice Family Counselling Service PARC ID 688

Mornington Peninsula Division of General Practice 1998 Psychology for the disadvantaged. 6 Month report, 1 year report and final report. 96-0316.15 PARC ID 592

Perth Central Coastal Division of General Practice 1996 Multidisciplinary assessment and treatment of sexual dysfunction. Final report 94-0602.7 PARC ID 618

Perth Division of General Practice 1997 Clinical psychologist in general practice. 15 Month report 96-0601.06 PARC ID 614

Perth Division of General Practice 1999 Depression in general practice program. Program monitoring report PARC ID 615

Perth Division of General Practice 2000 Healthy Minds: A General Practice Approach to Depression, Anxiety & Related Disorders PARC ID 656

Perth Division of General Practice 2001 Healthy Minds II A General Practice Approach to Depression, Anxiety and Related Disorders Twelve Month Report PARC ID 960

Redcliffe-Bribie-Caboolture Division of General Practice 1999 Clinical/counselling psychologist project. Progress reports and project evaluation report 96-0407.02 PARC ID 532

Rowe, Dr Leanne 1999 Clockwork Young People's Health service: Progress Report to the Commonwealth Mental Health Branch, Department of Health and Family Services PARC ID 696

Sherbrooke and Pakenham Division of General Practice 1995 Sherbrooke and Pakenham psychologist service. 9 Month and final report 94-0321.02 PARC ID 602

Toowoomba & District Division of General Practice 1996 Psychology services to rural areas. Final report 94-0409.01 PARC ID 536

Yorke Peninsula Division of General Practice 1996 Stress management project. 6 Month report 95-0507.3 PARC ID 578

MAHS Reports

The section on MAHS activities was based on:

1. Interim reports and personal communications with:

   Barossa Division (personal communication)

   South Australian Divisions Inc (personal communication)

   Central West Gippsland Division (MAHS brief report)

   Southern Division of General Practice South Australia (MAHS brief report)

   Western Victoria Division (MAHS brief report)

   Ballarat and District Division (MAHS brief report)

   Mallee Division (MAHS brief report)

   Top End Division (Previous Innovations Funding Grant)

   Central Australian Division of Primary Health Care (Proposal for extension of current MAHS program and evaluation)

   Adelaide Hills DGP (MAHS brief report)

   Limestone Coast DGP (MAHS brief report)

2. General Practice and Primary Care Information Service Database of 2001-2 Business plans and strategic plans

References

Albano, A. M., Marten, P. A., Holt, C. S., Heimberg, R. G., & Barlow, D. H. (1995). Cognitive-behavioural group treatment for social phobia in adolescents. A preliminary study. *Journal of Nervous & Mental Disease.* 183(10): 649-56.

Allen, K., B. Tolchard, et al. (2000). Behavioural psychotherapy training for nurses in Australia : A pilot program. *Australian and New Zealand Journal of Mental Health Nursing*. 9**:** 75-81.

Andrew, S. (1995). Qualified privilege attaches to psychiatrist's report : Dubsky v Jagermann, South Australian Supreme Court, Millhouse J, 23 November 1994. *Australian Media Law Reporter* 2(5): 86.

Andrews, G. (1994). The Tolkein Report - A model for matching the available workforce to the demand for services, University of NSW.

Association for Counsellors and Psychotherapists in Primary Care (2001). *CPC Code of Ethical Principles for Primary Care Counsellors*, Association for Counsellors and Psychotherapists in Primary Care. http://www.cpc-online.co.uk/downloads/downloads.htm

Association for Counsellors and Psychotherapists in Primary Care (2001?). *CPC Complaints and Disciplinary Procedure*, Association for Counsellors and Psychotherapists in Primary Care. http://www.cpc-online.co.uk/downloads/downloads.htm Accessed 6th Nov 2001

Association of Counsellors and Psychotherapists in Primary Care (2001). Counselling in Primary Care-Evidence-2001, Association of Counsellors and Psychotherapists in Primary Care.

Association of Counsellors and Psychotherapists in Primary Care (2001). CPC Information Sheet August 2001, Association of Counsellors and Psychotherapists in Primary Care.

Association of Counsellors and Psychotherapists in Primary Care (2001). CPC Information Sheet: What is a Primary Care Counsellor? Association of Counsellors and Psychotherapists in Primary Care.

Association of Counsellors and Psychotherapists in Primary Care (2001). Outline Proposal for a Managed Counselling Service, Association of Counsellors and Psychotherapists in Primary Care.

Australian Institute of Health and Welfare (1996). *Health and Community Services Labour Force 1996*. Canberra, Australian Institute of Health and Welfare. Available on line http://www.aihw.gov.au/inet/publications/hwl/hcslf96/index.html

Australian Psychological Association (2001). Psychologists say mental health needs more than GP counselling. Why increasing demands on GPs is simply not effective. *Media Release Thurs 25th January 2001*. on line http://www.psychsociety.com.au/mediarels/mr_250101.htm

Australian Psychological Society (1993). Mental health workforce issues: A submission from the Australian Psychological Society Limited. *Bulletin of the Australian Psychological Society* 15: 3-6.

Badger, L. W., Ackerson, B., Buttell, F., & Rand, E. H. (1997). The case for integration of social work social services into rural primary care practice. *Health and Social Work* 22: 20-29.

Baty, F., R. Blakey, et al. (2001). What has GP fundholding taught us? *Clinical Psychology* 5: 16-18.

Booth, H. and D. Cushaway (1997). Evaluation of counselling in primary care: How can research be made more useful for practitioners? *Counselling Psychology Quarterly* 10(1): 51.

Botting, J. and J. Chetwynd (1989). The influence of a social worker on the general practitioner management of psychosocial problems. *New Zealand Family Physician* 16(1): 3-6.

Bower, P., & Sibbald, B (2000). On-site mental health workers in primary care: Effects of professional practice. *Cochrane Database of Systematic Reviews*, Issue 3.

Bower, P. and B. Sibbald (2001). On-site mental health workers in primary care: Effects of Professional practice. *Cochrane Database of Systematic Reviews,* Issue 3.

Bray, J., & Rogers, J. (1995). Linking psychologists and family physicians for collaborative practice. *Professional Psychology Research and Practice* 26(132-138).

Clinton, M. (2001). *Scoping Study of the Mental Health Nursing Workforce: Report from the Australian and New Zealand College of Mental Health Nurses Incorporated to the Mental Health and Special Programs Branch of the Commonwealth Department of Health and Aged Care*. Canberra, Commonwealth Department of Health and Aged Care.

Clinton, M. and M. Hazelton (2000). Scoping practice issues in the Australian mental health nursing workforce [Series of four parts] Part 3. *Australian and New Zealand Journal of Mental Health Nursing* 9: 109.

Clinton, M. and M. Hazelton (2000). Scoping the Australian mental health nursing workforce. *Australian and New Zealand Journal of Mental Health Nursing* 9: 64.

Coleman, C. and K. Cronk (2000). *Queensland health Indigenous workforce management strategy "Careers in Queensland Health"*. 12th National Health Conference Inequalities in Health - reflecting back, stepping forward.

Corney, R. (1995). Social work involvement in primary care settings and mental health centres: A survey in England and Wales. *Journal of Mental Health UK* 4(3): 275-280.

Cotton, P. (2001). *Psychologists say that mental health needs more than GP counselling*, Australian Psychological Society. http://www.psychsociety.com.au/news/mediarels/mr_250101.htm Accessed 6th Nov 2001

Counselling in Primary Care Trust (2001). *Latest News 4th October 2001*, Counselling in Primary Care Trust. http://www.cpct.co.uk/cpct/welcome2.htm Accessed 6th Nov 2001

Counselling in Primary Care Trust (No date). *10 Years of Research Studies: Good and Bad*, Counselling in Primary Care Trust. http://www.cpct.co.uk/cpct/CiP_anniversary/Research.htm Accessed 6th Nov 2001

Crowe, B. (1999). *Extended Psychological Services for CBT*, Australian Psychological Society. http://www.psychsociety.com.au/news/submission.htm Accessed 6th Nov 2001

Crowe, B. (1999). Submission from the Australian Psychological Society to The Hon Peter Costello MP 4th March 1999. on line http://www.psychsociety.com.au/news/submission.htm

Curtis Jenkins, G. (2001). The new improved graduate mental health worker: Spin or reality? Counselling in Primary Care Trust Accesssed 6th Nov 2001. http://www.cpct.co.uk/CIP2001/Spindoc.htm

Curtis-Jenkins, G. (No date). Action Learning: Helping the Counsellors and General Practitioners to Develop Counselling Services. Counselling in Primary Care Trust http://cpct.co.uk/cpct/SUPPLEMS/InfoBooklet/ib3.htm Accessed 6th Nov 2001

Curtis-Jenkins, G. (No date). The Cost Implications of Counselling Services in Primary Medical Care, Counselling in Primary Care Trust. http://www.cpct.co.uk/cpct/SUPPLEMS/SUPP1/S1.4.htm Accessed 6th Nov 2001

Curtis-Jenkins, G. (No date). An Introduction to Counselling in Primary Care. .Counselling in Primary Care Trust http://www.cpct.co.uk/cpct/SUPPLEMS/SUPP1/intro.htm Accessed 6th Nov 2001

Curtis-Jenkins, G. (No date). *The Work Specification for Counsellors Working in General Practice*, Counselling in Primary Care Trust. http://www.cpct.co.uk/cpct/SUPPLEMS/SUPP2/S2.3.htm Accessed 6th Nov 2001

Curtis-Jenkins, G. and P. Henderson (1996). *Suplement No 3: Supervision of Counsellors in Primary Health Care: Conclusions from Seminars*, Counselling in Primary Care Trust. http://www.cpct.co.uk/cpct/supplems/supp3/s3cft.htm Accessed 6th Nov 2001

Curtis-Jenkins, G. and P. Henderson (No date). *Supplement No 3: Supervision of Counsellors in Primary Health Care: Setting the Scene-Supervision of Counsellors in General Practice-A Four Fold Model*, Counselling in Primary Health Care Trust. http://www.cpct.co.uk/cpct/supplems/supp3/s3sts.htm Accessed 6th Nov 2001

Curtis-Jenkins, J. and P. Hederson (No date). Supplement No 3: Supervision of Counsellors in Primary Health Care: Contracting with Supervisors in Primary Health Care. Counselling in Primary Care Trust. http://www.cpct.co.uk/cpct/supplems/supp3/s3cws.htm Accessed 6th Nov 2001

Dow, M. (Year unknown). A comparison of delivery methods of cognitive behavioural therapy for panic disorder: A multicentre trial to determine if efficiency can be improved - the Scottish study. Clinical Psychology Department, Straheden Hospital, Fife.

Duckett, S. (2000). The Australian health workforce: Facts and futures. *Australian Health Review* 23: 60-77.

Dunn, S. (2001). Would all appropriately trained psychologists please stand up? *Inpsych,* June.

du-Plessis, P. and R. Bor (1999). Evaluating counselling in primary health care. *Bor, Robert (Ed); McCann, Damian (Ed). (1999). The practice of counselling in primary care. (pp. 229-244). London, England: Sage Publications Ltd; London, England: Sage Publications Ltd. xii, 251*

Dyer, J. G., Hammill, K., Regan-Kubinski, M., Yurick, A., & Kobert, S. (1997). The psychiatric-primary care nurse practitioner: A futuristic model for advanced psychiatric-mental health nursing. *Archives of Psychiatric Nursing* 11: 2-12.

Dym, B., & Berman, S. (1986). The primary health care team: Family physician and family therapist in joint practice. *Family Systems Medicine* 4: 9-21.

Einzig, h., G. Curtis-Jenkins, et al. (1995). The training needs of counsellors in primary mental health care. *Journal of Mental Health* 1995(4): 205-209.

Elliot, T. R., & Klapow, J. C. (1997). Training psychologists for a future in evolving health care delivery systems: Building a better boulder model. *Journal of Clinical Psychology in Medical Settings* 4: 255-267.

Ernst and Young (1997). An evaluation of graduate qualities and employment potential. Adelaide, University of South Australia.

Firth, M., M. Dyer, et al. (1999). Reducing the distance: Mental health social work in general practice. *Journal of Interprofessional Care* 13(4): 333-44.

Foster, J. (2001). Counselling in Primary Care-A National Overview, Unpublished paper, Association of Counsellors and Psychotherapists in Primary Care, UK.

Foster, J. (2001). Quality standards, professional regulation and education for counsellors and psychotherapists who work in primary care. A shortened version of a

paper given at The Counselling in Primary Care Conference at The Royal Society of Medicine 29th January 2001. Counselling in Primary Care Trust . http://www.cpct.co.uk/cpct/CIP2001/fosterpaper.htm Accessed 6th Nov 2001

Friedmann, P. D., J. A. Alexander, et al. (1999). On-site primary care and mental health services in outpatient drug abuse treatment units. *Journal of Behavioral Health Services & Research* 26(1): 80-94.

Galvin, K., C. Andrewes, et al. (1999). Investigating and implementing change within the primary health care nursing team. *Journal of Advanced Nursing* 30(1): 238-47.

Goldberg, d., G. Jackson, et al. (1996). The treatment of common mental disorders by a community team based in primary care: A cost effectiveness study. *Psychological Medicine* 26: 487-492.

Gordon, K. and C. Graham (1996). The impact of primary care counselling on psychiatric symptoms. *Journal of Mental Health* 5(5): 515-23.

Haaga, D. A. F. (2000). Introduction to the special section on stepped care models in psychotherapy. *Journal of Consulting and Clinical Psychology 68*(547-548).

Haley, W. E., McDaniel, S., Bray, J. H., et al. (1998). Psychological practice in primary care settings: practical tips for clinicians. *Professional Psychology: Research and Practice* 29: 237-244.

Heimberg, R. G., Juster, HR Hope, DA Mattia, JI (1995). Cognitive Behavioural Group Treatment for Social Phobia. *Social Phobia: Clinical and Research Perspectives*. S. MB. Washington DC, American Psychiatric Press**:** 193-321.

Henderson, P. (1999). Supervision in Medical Settings. *Counselling Supervision in Context*. M. Carroll and H. Holloway. London, Sage.

Henderson, P. (No date). Supplement No 3: Supervision of Counsellors in Primary Health Care: Context in Supervision of Counsellors in Primary Care. http://www.cpct.co.uk/cpct/supplems/supp3/s3cis.htm Accessed 6th Nov 2001

Hodginkinson, B., Evans, D O'Donnell, A Walsh, K (1999). Comparing the effectiveness of individual therapy and group therapy in the treatment of depression. Adelaide, The Joanna Briggs Institute for Evidence Based Nursing and Midwifery, Royal Adelaide Hospital.

Hoot, S. J. (1993). (Mental Health Workforce Issues Discussion Paper (1993)) -letter. *Australian Journal of Mental Health Nursing* 2(5): 205-7.

Hudson-Allez, G. (1999). Brief versus open-ended counselling in primary care: Should the service be expanded to include both models? *European Journal of Psychotherapy, Counselling and Health* 2(1): 7-18.

Inskipp, F. (No date). Supplement No 3: Supervision of counsellors in primary health care: training for supervisors working with counsellors in primary care. What do supervisors need beyond basic supervision training? . http://cpct.co.uk/cpct/supplems/supp3/s3tfs.htm Accessed 6th Nov 2001

Jones, R. (2000). An investigation of the feasibility of practice nurse led cognitive behavioural therapy for patients with anxiety in primary care.

Kates, N., Craven, M., Crustolo, A. M., et al. (1997). Integrating mental health services within primary care. *General Hospital Psychiatry* 19: 324-332.

Kates, N., Craven, M., Crustolo, A., & Nikoloau, L. (1998). Mental health services in the family physician's office: A Canadian experiment. *The Israel Journal of Psychiatry and Related Sciences* 35: 104-.

Katon, W., Robinson, P., Von Korff, M. et al. (1996). A multifaceted intervention to improve treatment of depression in primary care. *Archives of General Psychiatry* 53: 924-932.

Kell, C. (1999). Confidentiality and the counsellor in general practice. *British Journal of Guidance and Counselling* 27(3): 431-440.

King, P. and S. Roeg (1997). Alcohol problems in general practice: an urban division based project supporting GPs. *Proc Autumn Sch Stud Alcohol Drugs*: 153-6.

Knight, L. (1997). A model of short term counselling in primary care. *Counselling Psychology Quarterly* 19(4): 365.

Kubiszyn, T. (1999). Integrating health and mental health services in schools: Psychologists collaborating with primary care providers. *Clinical Psychology Review* 19(2): 179-198.

Lenihan, P. and S. Iliffe (2000). Counselling the community: The contribution of counselling psychologists to the development of primary care. *Counselling Psychology Quarterly* 13(4): 329-343.

Liebowitz, M. R., Heimberg, R. G., Schneier, F. R., Hope, D. A. et al. (1999). Cognitive-behavioural group therapy versus phenelzine in social phobia: long-term outcome. *Depression & Anxiety* 10(3): 89-98.

Lin, E., Von Korff, M., Russo, J. et al. (2000). Can depression treatment in primary care reduce disability? A stepped care approach. *Archives of Family Medicine* 9: 1052-1058.

Lymbery, M. (1998). Social work in general practice: Dilemmas and solutions. *Journal of Interprofessional Care* 12(2): 199-208.

McCann, D. (1999). Supervision in primary care counselling. *Bor, Robert (Ed); McCann, Damian (Ed). (1999). The practice of counselling in primary care. (pp. 214-228). London, England: Sage Publications Ltd; London, England: Sage Publications Ltd.*

McDaniel, S. H. (1995). Collaboration between psychologists and family physicians: Implementing the biopsychosocial model. *Professional Psychology: Research and Practice* 26: 117-122.

McDonald, c. (1999). Human service professional in the community services industry. *Australian Social Work* 52(1): 17-25.

Mellor-Clark, J., J. Connell, et al. (2001). Counselling outcomes in primary health care. A CORE system profile. *European Journal of Psychotherapy Counselling and Health* 4(1). Counselling in Primary Care Trust. Available on line accessed 6th Nov 2001 http://www,cpct.co.uk/cpct/CiP_anniversary/Researchmellor.htm

Mellor-Clark, J., R. Simms-Ellis, et al. (2001). National Survey of Counsellors Working in Primary Care: Evidence for Growing Professionalism, Royal College of General Practitioners, London.

Millsteed, J. (1999). Australia's Welfare 1999: Services & Assistance

Australia's occupational therapy workforce: jobs for the future. *Australia's Welfare* 46(2): 38-42.

Millsteed, J. (2000). Issues affecting Australia's rural occupational therapy workforce. *Australian Journal of Rural Health* 8: 76.

Monheit, B., T. Brooks, et al. (1996). Controlled drinking programs in general practice. *Proc Autumn Sch Stud Alcohol Drugs* 21: 3-5.

Muchnick, S., B.-L. Davis, et al. (1993). Collaboration between family therapy and health care: An internship experience. *Family Systems Medicine* 11(3): 271-279.

Nathan, P. and J. Gorman (1998). *A Guide to Treatments that Work.* New York, Oxford University Press.

National Forum for Development of Strategies to Increase the Numbers of Aboriginal and Torres Strait Islander People in, Nursing. (1997). National Aboriginal and Torres Strait Islander Nursing Forum: an initiative to develop strategies for the recruitment and retention of Indigenous peoples in nursing.

National Information Service (2000). *General Practice Evaluation Program Conference*, Hobart, National Information Service.

National Inquiry Concerning the Human Rights of People with Mental Illness, Australia, Human-Rights-and-Equal-Opportunity-Commission, Burdekin, Brian, Commissioner Guilfoyle Margaret, Commissioner Canberra : AGPS

Hall David, Commissioner (1993). Human rights and mental illness : report of the National Inquiry into the Human Rights of People with Mental Illness. *Canberra : AGPS*.

Newman, M. G. (2000). Recommendations for a cost-offset model of psychotherapy allocation using generalized anxiety disorder as an example. *Journal of Consulting and Clinical Psychology* 68: 549-555.

Nuthall, J. (1987). The missing factor in general practice x = sw. -abstract. *Community Health Studies* 11(3): 245.

Pace, T., Mullins, L. L., Chaney, J. M., & Olson, R. A. (1995). Psychological consultation with primary care physicians: Obstacles and opportunities in the medical setting. *Professional Psychology Research and Practice* 26: 123-131.

Pembroke, G. (1999). Training in counselling in primary health care. Bor, Robert (Ed); McCann, Damian (Ed). (1999). The practice of counselling in primary care. (pp. 201-213). London, England: Sage Publications Ltd; London, England: Sage Publications Ltd.

Phongsavan, P., J. Ward, et al. (1995). Mental Health Care Practices and Educational Needs of General Practitioners. *Medical Journal of Australia* 162: 139-142.

Price, D., Beck, A., Nimmer, C., & Bensen, S. (2000). The treatment of anxiety disorders in a primary care HMO setting. *Psychiatric Quarterly* 71: 31-45.

Pruitt, S. D., Klapow, J., Epping-Jordan, J. E., & Dresselhaus, T. R. (1998). Moving behavioural medicine to the front line: A model for the integration of behavioural and medical sciences in primary care. *Professional Psychology: Research and Practice* 29: 230-236.

Prusnofsky, L. and R.-E. Feinstein (1999). Consulting and Counselling in Primary Care. *Feinstein, Robert E. (Ed); Brewer, Anne A. (Ed). (1999). Primary Care Psychiatry and Behavioral Medicine: Brief Office Treatment and Management Pathways. (pp. 405-429). New York, NY, US: Springer Publishing Co, Inc.*

WHO Collaborating Institute of Psychiatry. (2000). *WHO Guide to Mental Health in Primary Care*. London, WHO.

Queensland Health (1998). A profile of Queensland health's Indigenous workforce. Executive summary of the final report. online accessed November 2001 www.health.qld.gov.au/indigenous_health/2912abtsi_workfull.htm .

Queensland Health. (1998). A profile of Queensland health's Indigenous workforce. Summary report. On line accessed November 2001 www.health.qld.gov.au/indigenous_health/2913abtsi_worksummary.htm.

Rosenman, S. M., A (1992). General practitioner services under Medicare. *Aust J Public Health* 16(4): 419-26.

Rowland, M., P. Bower, et al. (2001). Effectiveness and cost effectiveness of counselling in primary care. *Cochrane Database of Systematic Reviews* Issue 3, 2001.

Sartorius, N., B. Uston, et al. (1993). An International Study of Psychological Problems in Primary Care. *Archives of General Psychiatry* (50): 819-824.

Schaefer, T., J. Chesshyre, et al. (1999). Managing referrals. *Bor, Robert (Ed); McCann, Damian (Ed). (1999). The p*ractice of counselling in primary care. (pp. 77-97). London, England: Sage Publications Ltd; London, England: Sage Publications Ltd.

Schmidt, U., Williams, C., Barra-Carril, N., Palmer, R., et al. (2001). CD-ROM based treatment for Bulimia Nervosa reduces binge eating and use of laxatives. The Royal College of Psychiatrists, UK.

Sibbald, B., J. Addington-Hall, et al. (1997). *The Role of Counsellors in General Practice*, Royal College of General Practitioners Occasional Papers. http://www.rcgp.org.uk/rcgp/publications/catalogue/occasional/counselrole.asp Accessed 6th Nov 2001

Sibthorpe, B., F. Baas Becking, et al. (1998). Positions and training of the Indigenous health workforce. *Australian and New Zealand Journal of Public Health* 22(6).

Strosahl, K. (1996). Confessions of a behavior therapist in primary care: The odyssey and the ecstasy. *Cognitive and Behavioral Practice* 3(1): 1-28.

Strosahl, K. (2000). The psychologist in primary health care. *Kent, Alan J. (Ed); Hersen, Michel (Ed). (2000). A psychologist's proactive guide to managed mental health care. (pp. 87-112). Mahwah, NJ, US: Lawrence Erlbaum Associates, Inc., Publishers; Mahwah, NJ, US: Lawrence Erlbaum Associates, Inc., Publishers.*

Tohen, M., E. Bromet, et al. (2000). Psychiatric Epidemiology. *Harv Rev Psychiatry* 8(3): 111-25.

Trowbridge, C. (1999). Setting up a counselling service. *Bor, Robert (Ed); McCann, Damian (Ed). (1999). The practice of counselling in primary care. (pp. 7-23). London, England: Sage Publications Ltd; London, England: Sage Publications Ltd.*

Tutty, S., Simon, G., & Ludman, E. (2000). Telephone counseling as an adjunct to antidepressant treatment in the primary care system. *Effective Clinical Practice* 4: 170-178.

Twilling, L.-L., M.-E. Sockell, et al. (2000). Collaborative practice in primary care: Integrated training for psychologists and physicians. *Professional Psychology: Research and Practice* 31(6): 685-691.

UK, Department of Health (2001). National Service Framework for Mental Health. Accessed 12th Nov 2001. http://www.doh.gov.uk/nsf/mhnsf1.htm#nsf1

Vines, R. (2001). Models of clinical psychological service/treatment delivery in the primary care setting, Unpublished paper, Charles Sturt University.

Walker, L., P. Barker, et al. (2000). The required role of the psychiatric-mental health nurse in primary health-care: An augmented Delphi study. *Nursing Inquiry* 7(2): 91-102.

Waskett, C. (1999). Confidentiality in a team setting. *Bor, Robert (Ed); McCann, Damian (Ed). (1999). The practice of counselling in primary care. (pp. 118-139). London, England: Sage Publications Ltd; London, England: Sage Publications Ltd.*

White, M., N. Bijlani, et al. (2000). Impact of counsellors in primary care on referrals to secondary mental health services. *Psychiatric Bulletin* 24(11): 418-420.

Wilkin, P. (2001). The primary care role of the community psychiatric nurse. *Primary Care Psychiatry* 7(2): 79-84.

Wilson, G. T., Vitousek, K. M., & Loeb, K. L. (2000). Stepped care treatment for eating disorders. *Journal of Consulting and Clinical Psychology* 68: 564-572.

Winefield, H., J. Taplin, et al. (No date). Integrated Primary Mental Health Care: A Pilot Project Involving GPs and Clinical Psychologists in Adelaide, Unpublished paper, Adelaide University.

Workforce Planning and Development Team Aboriginal and Torres Strait Islander Health Unit. (1998). A profile of Queensland health's indigenous workforce. Full report. www.health.qld.gov.au/indigenous_health/2912abtsi_workfull.htm Accessed November 2001 .

Workforce Planning and Development Team Aboriginal and Torres Strait Islander Health, Unit. (1998). A profile of Queensland health's indigenous workforce. Summary report. .www.health.qld.gov.au/indigenous_health/2913abtsi_worksummary.htm Accessed November 2001