CLINICAL PSYCHOLOGY IN RURAL GENERAL PRACTICE

A NATIONAL PILOT OF A NEW MODEL OF COLLABORATIVE
MENTAL HEALTH SERVICE DELIVERY

By

Robyn F. Vines
BA(Hons); MSc(Clin Psych)

School of Psychology
The University of Sydney

December 2008

A thesis submitted to the Faculty of Science of the University of Sydney in fulfilment
of requirements for the degree of Doctor of Philosophy
DEDICATION

This thesis is dedicated to my mother

Vera F. Vines (PhD)
DECLARATION: CERTIFICATE OF AUTHORSHIP

The work contained in this thesis is, to the best of my knowledge and belief, original; except as acknowledged in the text. The material has not been submitted, either in whole or in part, for a degree at this or any other university. All the raw data pertaining to the study reported in this thesis, as well as the analyses, have been retained and are available upon request.

Signed:…………………………………………………

Date:……………………………………………………

(ii)
ETHICS APPROVAL

All experimentation/evaluation reported in this thesis was approved by Charles Sturt University, the University of Sydney, Ballarat University and the University of New England Ethics Committees, the results being obtained from primary care patient treatment and control groups established by a number of University Clinical Training Programmes in a variety of geographic locations in regional and rural Australia.
ACKNOWLEDGEMENTS

I would like to thank the many people and organisations who have made the completion of the research outlined in this dissertation possible.

- The Australian Government Department of Health and Ageing – and (originally) The Partnerships in Service Reform Section of the Mental Health and Special Programmes Branch for their financial support of the Clinical Psychology in Rural General Practice Project ($771,000) from 2001 to 2004. I would specifically like to thank Dermot Casey; Dr. Stephen Castle, Colleen Krestensen, Rose Ross, Doris Corcoran and Dr. Bronwen Harvey for their encouragement during the course of the project.

- The NSW Central West, Ballarat and Armidale Divisions of General Practice for their support of the project and in establishing clinical psychology registrar internships within their local general practices. In particular, I would like to thank Dr. Louise Roufeil, then at the CWDGP, who assisted greatly in implementing and disseminating the model of care in central west NSW.

- All of the general practitioners involved, without whom the research would not have been possible. In my own region of the Central West of NSW in the city of Bathurst I would specifically like to thank the GPs in the Russell Street and George Street Medical Practices who have been wonderfully supportive in their desire to help pilot the concept of collaborative service delivery in primary care.

- The Australian Psychological Society and specifically Professor Lyn Littlefield (CEO) for ongoing encouragement for the project and the concept of collaborative mental health care involving psychologists and general practitioners.

- The Department of General Practice, Faculty of Medicine, Nursing and Health Sciences, Monash University - and in particular Professor Leon Piterman, Head, School of Primary Health Care - for continuing support in the second phase of the project.

Specifically, I would like to thank:

- Professor Don Thomson, previously of Charles Sturt University, for his support as co-chief investigator, associate supervisor, colleague and friend.

- Professor Stephen Touyz: my PhD Supervisor for his ongoing support, invaluable assistance and guidance throughout this project.

- The late Professor Jeff Richards (Professor of Psychology at Ballarat University at the time of the research, and later Professor and Director of Primary Care Research, Department of General Practice, Monash University) – a valued colleague and mentor;
Professor Paul Martin (previously at the University of New England, President of the Australian Psychological Society, now Professor of Clinical Psychology at Monash University); Dr. Margaret Brechman-Toussaint (previously at the University of New England, now with the Queensland Government Department of Health) for their involvement in piloting the provision of clinical psychology registrar traineeships in general practice within their regions.

- Professor Stephen Leeder for his inspirational support and involvement in lobbying for mental health care policy reform at a crucial time in the lead-up to the February 2006 COAG deliberations.

To those who worked on the project I would like to extend my gratitude:

- Ms. Michelle Kluin research assistant/project administrator; Ms. Louise Vesely (research assistant in Michelle’s absence who contributed much to the data analysis); Mr. Paul Davies; and particularly Ms. Nancy Robertson (statistician at the Australian National University) whose work and support were invaluable both during the completion of project and in the final stages of the dissertation.
- the 22 clinical psychology registrars who made the trial of collaborative care in general practice possible, and
- the patients involved who willingly collaborative in the research.

Most importantly I would like to express my sincere thanks to my family for their support over the years of engagement on the project and in later lobbying for mental health service reform:

- my husband John and children Megan and Robert for providing the “other life” beyond academia and practice, and loving support during the process of writing,
- my father: Bob who, with my mother Vera, has provided inspiration for the completion of this doctoral thesis.
ABSTRACT

Approximately 23% of Australians suffer from a mental disorder in any 12 month period. The vast majority of mental health service delivery is undertaken in primary care by general practitioners (GPs). Current research evidence indicates that a combined pharmacological and psychological approach is required for maintained improvement in the treatment of depression, with appropriate evidence-based psychological interventions on their own proving effective in a large number of cases. Previous lack of public funding of psychological services meant that many patients in need were unable to access appropriate psychological interventions. This thesis reports on research undertaken on behalf of the Commonwealth Government of Australia into the effectiveness of providing clinical psychology services in the primary care setting as an adjunct to previously available primary medical services. A collaborative model of treatment involving GPs and clinical psychologists was trialed in three geographic locations in Australia: Bathurst, Ballarat and Armidale, entailing the placement of clinical psychology registrars (interns) in the primary care setting. A controlled trial was undertaken in which patients’ levels of improvement on a number of mental health indices were monitored and compared with a control group of patients surveyed in the general practice waiting room. In addition, added parameters of patient, GP and clinical psychology registrar satisfaction with the model were included as part of the study. Findings indicated that whilst GP treatment of patients alone resulted in significant gains on measured indices, those undertaking collaborative care involving both GPs and clinical psychologists improved significantly more than those receiving medical care alone. A matched-pair analysis of 48 patients confirmed this, highlighting significantly greater gains from the additional clinical psychological intervention and further validating the effectiveness of the collaborative care model. Follow-up patient, clinical psychology registrar and GP satisfaction surveys indicated highly positive perceptions of the model of collaborative care as a treatment, training and adjunctive care framework. These responses suggested that it would be an optimal model to articulate nationally beyond the original confines of the three research locations, and that initial government financial support should be continued.
# TABLE OF CONTENTS

DEDICATION ............................................................................................................. (i)
CERTIFICATE OF AUTHORSHIP ........................................................................... (ii)
ETHICS APPROVAL ...............................................................................................(iii)
ACKNOWLEDGEMENTS ....................................................................................... (iv)
ABSTRACT ............................................................................................................... (vi)
TABLE OF CONTENTS .......................................................................................... (vii)
LIST OF APPENDICES ........................................................................................... (xii)
LIST OF TABLES .................................................................................................... (xv)
LIST OF FIGURES ...............................................................................................(xviii)
LIST OF PUBLICATIONS AND PRESENTATIONS .......................................... (xix)
PREFACE ............................................................................................................... (xxii)

## CHAPTERS

1. **INTRODUCTION**............................................................................................1

   Project Rationale and Overview ........................................................................1
   - Section 1: The Context.............................................................................2
   - Section 2: The Research...........................................................................3
   - Section 3: Beyond the Research ..............................................................3

2. **MENTAL HEALTH IN AUSTRALIA**..........................................................5

   2.1 Burden of disease due to mental disorders in Australia ......................... 5
   2.2 Patterns of care .......................................................................................9
   2.3 The incidence of mental disorders in primary care ............................... 9
   2.4 The detection of psychological symptoms in primary care ................. 10
   2.5 Medicalisation of mental health difficulties ........................................ 13
       2.5.1 Common pathways of care ......................................................... 13
       2.5.2 Antidepressant use in Australia ................................................. 13
       2.5.3 Cultural considerations .............................................................. 19
   2.6 Best practice ......................................................................................... 20
   2.7 Primary care psychology ....................................................................... 22

3. **MENTAL HEALTH SERVICES IN AUSTRALIA**.................................25

   3.1 Background.............................................................................................. 25
   3.2 General Practice ..................................................................................... 30
       3.2.1 Annual survey of Divisions of General Practice ......................... 31
       3.2.2 Annual BEAC H surveys ............................................................. 36
   3.3 Psychiatry ............................................................................................... 38
   3.4 The psychological workforce ............................................................... 44
       3.4.1 Registered psychologists .............................................................. 45
       3.4.2 Clinical psychologists ................................................................. 47
       3.4.3 Characteristics of the psychology workforce ......................... 48
   3.5 Mental Health Nursing in Australia ....................................................... 49
       3.5.1 Workforce issues ......................................................................... 49
       3.5.1.1 Definition ............................................................................ 50
       3.5.1.2 ACMHN membership ......................................................... 51
       3.5.1.3 Credentialing for Medicare ................................................. 52
<table>
<thead>
<tr>
<th>Section</th>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.5.2</td>
<td>The Australian College of Mental Health Nurses</td>
<td>53</td>
</tr>
<tr>
<td>3.5.3</td>
<td>Training</td>
<td>54</td>
</tr>
<tr>
<td>3.5.4</td>
<td>Overview/summary</td>
<td>55</td>
</tr>
<tr>
<td>3.6</td>
<td>New directions in collaborative care</td>
<td>55</td>
</tr>
<tr>
<td>4.1</td>
<td>Measuring rurality</td>
<td>57</td>
</tr>
<tr>
<td>4.1.1</td>
<td>RRMA vs. ARIA</td>
<td>58</td>
</tr>
<tr>
<td>4.2</td>
<td>An overview of rural mental health issues</td>
<td>59</td>
</tr>
<tr>
<td>4.3</td>
<td>Risk factors and needs of rural people</td>
<td>59</td>
</tr>
<tr>
<td>4.3.1</td>
<td>Social exclusion</td>
<td>61</td>
</tr>
<tr>
<td>4.4</td>
<td>Indigenous Australians</td>
<td>62</td>
</tr>
<tr>
<td>4.5</td>
<td>Incidence of mental (and other) health issues in rural communities</td>
<td>64</td>
</tr>
<tr>
<td>4.6</td>
<td>Equity of access to services</td>
<td>65</td>
</tr>
<tr>
<td>4.7</td>
<td>Mental health specialities</td>
<td>67</td>
</tr>
<tr>
<td>4.7.1</td>
<td>Psychiatry</td>
<td>69</td>
</tr>
<tr>
<td>4.7.2</td>
<td>Psychology</td>
<td>72</td>
</tr>
<tr>
<td>4.7.3</td>
<td>General Practice</td>
<td>77</td>
</tr>
<tr>
<td>4.7.3.1</td>
<td>Overseas trained doctors</td>
<td>78</td>
</tr>
<tr>
<td>4.7.3.2</td>
<td>Mental health nursing</td>
<td>80</td>
</tr>
<tr>
<td>4.8</td>
<td>Conclusion</td>
<td>84</td>
</tr>
<tr>
<td>4.9</td>
<td>Conclusion</td>
<td>84</td>
</tr>
<tr>
<td>5.1</td>
<td>Overview</td>
<td>85</td>
</tr>
<tr>
<td>5.2</td>
<td>The situation in Britain</td>
<td>85</td>
</tr>
<tr>
<td>5.2.1</td>
<td>Clinical psychology workforce data: England</td>
<td>86</td>
</tr>
<tr>
<td>5.2.1.1</td>
<td>Current estimates</td>
<td>86</td>
</tr>
<tr>
<td>5.2.1.2</td>
<td>Estimated need</td>
<td>87</td>
</tr>
<tr>
<td>5.2.2</td>
<td>Clinical psychology service provision</td>
<td>88</td>
</tr>
<tr>
<td>5.2.3</td>
<td>Patient access to services</td>
<td>90</td>
</tr>
<tr>
<td>5.2.4</td>
<td>Professional registration</td>
<td>91</td>
</tr>
<tr>
<td>5.3</td>
<td>The situation in Canada</td>
<td>92</td>
</tr>
<tr>
<td>5.3.1</td>
<td>Overview</td>
<td>92</td>
</tr>
<tr>
<td>5.3.2</td>
<td>Organisation, accreditation and training of psychologists</td>
<td>94</td>
</tr>
<tr>
<td>5.3.3</td>
<td>Clinical psychology</td>
<td>97</td>
</tr>
<tr>
<td>5.3.4</td>
<td>Recent primary care initiatives</td>
<td>98</td>
</tr>
<tr>
<td>5.3.5</td>
<td>Health policy developments</td>
<td>100</td>
</tr>
<tr>
<td>5.4</td>
<td>Conclusions</td>
<td>102</td>
</tr>
<tr>
<td>6.1</td>
<td>Overview</td>
<td>104</td>
</tr>
<tr>
<td>6.2</td>
<td>Preliminary Pilot Study</td>
<td>106</td>
</tr>
<tr>
<td>6.2.1</td>
<td>Patient survey</td>
<td>107</td>
</tr>
<tr>
<td>6.2.2</td>
<td>GP survey</td>
<td>108</td>
</tr>
<tr>
<td>6.2.2.1</td>
<td>Value to patients</td>
<td>109</td>
</tr>
<tr>
<td>6.2.2.2</td>
<td>Value to GPs</td>
<td>109</td>
</tr>
<tr>
<td>6.3</td>
<td>Design</td>
<td>110</td>
</tr>
<tr>
<td>6.3.1</td>
<td>The Project</td>
<td>110</td>
</tr>
<tr>
<td>6.3.1.1</td>
<td>Project stages</td>
<td>110</td>
</tr>
<tr>
<td>6.3.1.2</td>
<td>Participating surgeries and clinical psychology registrars</td>
<td>111</td>
</tr>
<tr>
<td>6.3.2</td>
<td>Design issues</td>
<td>113</td>
</tr>
<tr>
<td>6.3.2.1</td>
<td>Control group</td>
<td>113</td>
</tr>
</tbody>
</table>
6.3.3 Ethics Approval ................................................................. 114
6.3.4 Patients in the intervention group ................................... 114
6.3.5 Normative comparison group .............................................. 115
6.3.6 Patients in the intervention and control groups .................. 115
   6.3.6.1 Attrition ........................................................................ 116
   6.3.6.2 Comparison of demographic data .................................. 118
   6.3.6.3 Medication .................................................................. 121
   6.3.6.4 Varied numbers across measures .............................. 121
6.3.7 Intervention ...................................................................... 122
   6.3.7.1 Model of collaborative service delivery ...................... 122
6.3.8 Data Collection ................................................................ 124
   6.3.8.1 Pre- and post- measures/indices ................................. 124
      6.3.8.1a) DASS: Depression, Anxiety and Stress Scale ... 126
      6.3.8.1b) GHQ: General Health Questionnaire 28 ........... 128
      6.3.8.1c) GWBI: General Well Being Index .................. 129
      6.3.8.1d) Qualitative measures ........................................ 130
      6.3.8.1e) Patient Satisfaction Questionnaire .................. 130
6.3.9 Statistical methods/analyses ............................................... 130
   6.3.9.1 Comparison of Intervention and Control Groups .......... 131
      6.3.9.1a) Pre- and post-measures .................................... 131
      6.3.9.1b) Pairing data across intervention and control groups .... 131
6.3.10 General practitioners ....................................................... 132
6.3.11 Clinical Psychology Registrars ......................................... 133
   6.3.11.1 Clinical psychology registrar placement protocols .... 133
   6.4.11.2 Allocation of patients ............................................... 133
   6.4.11.3 Patient parameters and procedures .......................... 134
   6.4.11.4 Intervention ............................................................ 134
   6.4.11.5 Internship evaluation .............................................. 135
   6.4.11.6 Clinical placement documentation ........................... 135
6.5 Summary and hypotheses ..................................................... 135
   6.5.1 General objectives of the collaborative model of care ..... 135
   6.5.2 Hypotheses ................................................................... 136

7. RESULTS ...................................................................................... 138
7.1 Overview ............................................................................... 138
7.2 Patients .................................................................................. 138
   7.2.1 Summary ......................................................................... 138
      7.2.1.1 Varied numbers across measures .......................... 139
   7.2.2 Between group comparison of pre-test scores .................. 139
      7.2.2.1 Gender differences ................................................ 142
      7.2.2.2 Medication .............................................................. 144
   7.2.3 Pre- and post-intervention comparisons between treatment and control groups .......... 146
      7.2.3.1 Simple “Sign Test” pre- to post-intervention for treatment and control groups ...... 146
      7.2.3.2 Differences between pre- and post- intervention scores for control and intervention groups on mental health measures .......................................................... 148
      7.2.3.3 Levels of severity on the DASS scales .................... 151
         7.2.3.3a) Between-group comparisons on DASS subscale scores: pre- and post-intervention .... 151
         7.2.3.3b) Comorbidity ......................................................... 153
7.2.3.4 Gender: Analysis of treatment effects comparing male and female patients........................................154
7.2.3.5 Medication..............................................................155
7.2.3.6 Graphic representation of pre- and post-test results........157
7.2.3.7 Conclusions from pre- and post-test comparisons ..........161
7.2.4 Pairing the data...........................................................161
7.2.4.1 Pre-test comparisons...............................................162
7.2.4.2 Post-test comparisons..............................................164
7.2.5 Patients whose scores worsened......................................165
7.2.5.1 Treatment ...............................................................165
7.2.5.2 Control.................................................................166
7.2.5.3 Paired participants..................................................168
7.2.6 Qualitative results amongst treatment group patients........171
7.2.7 Patient Satisfaction Questionnaire...................................171
7.2.7.1 Responses...............................................................172
7.2.7.2 Summary and conclusions.................................176
7.3 General Practitioners..........................................................177
7.3.1 Attitudes and Behavioural Changes ................................177
7.3.1.1 Preliminary/baseline survey of GP attitudes...............177
7.3.1.1a) Key points arising from the data .......................178
7.3.1.1b) Data from specific questions .........................179
7.3.1.2 Post-survey: Attitudes of GPs involved in collaborative
service delivery .........................................................187
7.3.1.2a) Analysis of GP responses to General
Practitioners’ Questionnaire ..............................188
7.3.1.2b) Conclusions.........................................................192
7.4 Clinical Psychology Registrars .............................................192
7.4.1 Registrar placement questionnaire......................................192
7.4.1.1 Responses to registrar placement questionnaire ...........193
7.4.1.2 Conclusions...............................................................204
8. DISCUSSION AND CONCLUSIONS .................................................205
8.1 Overview .................................................................205
8.2 Summary of Findings .......................................................207
8.2.1 Pre-test results ............................................................207
8.2.2 Potential confounding factors .........................................207
8.2.2.1 Gender, age and socioeconomic status ......................207
8.2.2.2 Treatment effect, geographic location and gender ........208
8.2.2.3 Medication..............................................................208
8.2.3 Pre- and post-test comparisons of treatment and control groups...209
8.2.3.1 Statistical analyses...................................................209
8.2.3.2 Graphic representations..............................................210
8.2.3.3 Simple sign test ......................................................210
8.2.3.4 Conclusion..............................................................211
8.2.4 Matched pair analysis ..................................................211
8.2.6.1 Pre- and post-test comparisons...................................211
8.2.6.2 Comparison of patients in both groups whose scores
worsened .................................................................212
8.2.6.3 Conclusions...............................................................212
8.2.7 Questionnaires/surveys....................................................213
8.2.7.1 Overview .................................................................213
8.2.7.2 Patient satisfaction questionnaire .........................213
8.2.7.2a) Findings ..............................................................213
8.2.7.2b) Summary ..............................................................214

(x)
8.2.7.3  GP questionnaires .............................................................. 215
  8.2.7.3a) Pre-trial: “Clinical Psychology in General Practice Survey” .............................................................. 215
  8.2.7.3b) Post-trial questionnaire ................................................ 216
8.2.7.4 Clinical psychology registrar questionnaire ...................... 217
  8.2.7.4a) Findings ........................................................................ 217
  8.2.7.4b) Summary ..................................................................... 218
8.3 Strengths and limitations of the study ........................................................... 219
  8.3.1 Overview ........................................................................... 219
  8.3.2 Measures ........................................................................... 220
  8.3.3 Patient numbers ............................................................... 220
  8.3.4 Control groups ................................................................. 220
    8.3.4.1 Normative comparison group ...................................... 220
    8.3.4.2 Matched pairs ............................................................ 221
  8.3.5 Completion rates .............................................................. 222
  8.3.6 Potential confounding variables ........................................ 222
8.4 Future directions and opportunities for further research .............. 223

9. FURTHER DEVELOPMENTS .................................................................225
9.1 Australian Government initiatives ...................................................... 225
  9.1.1 More Allied Health Services Program ...................................... 226
  9.1.2 Better Outcomes in Mental Health Care Initiative .............. 227
  9.1.3 Clinical Psychology in General Practice Project .................. 229
  9.1.4 Lead up to COAG’s Better Access Initiative in November 2006 ... 230
    9.1.4.1 “Not for Service” Report ........................................ 231
    9.1.4.2 Detention of Cornelia Rau ........................................ 232
    9.1.4.3 Senate inquiry into the nation’s mental health system ...... 233
    9.1.4.4 Productivity Commission’s report on Australia’s health workforce ..................................................... 234
  9.1.5. Council of Australian Governments (COAG) .................... 235
  9.1.6 National Action Plan on Mental Health .................................. 236
    9.1.6.1 Better Access to Mental Health Care ......................... 236
    9.1.6.2 Evaluation of Better Access to psychology ............... 238
9.2 Overview of recent changes ......................................................... 240
9.3 Workforce development recommendations arising from the dissertation .... 241
9.4 Future research directions ......................................................... 244

REFERENCES .........................................................................................................245
LIST OF APPENDICES

A) Disks (appended at end of thesis) ........................................................... 266
   A.1 Data Files and Annotated Document Containing Tables, Analyses and the Syntax Producing Them
   A.2 Commonwealth Reports (see also Appendix 9.2)

B) Published Articles ..................................................................................... 267

C) Method (Chapter 6) ................................................................................... 290
   6.1 Patient survey from pilot study (see section 6.2.1) .............................. 291
   6.2 GP survey from pilot study (see section 6.2.2) .................................... 293
   6.3 National Primary Care Research Group ......................................... 295
   6.4 Patient/intervention group consent form ............................................ 297
   6.5 Control group consent form .............................................................. 298
   6.6 Depression Anxiety and Stress Scales (DASS) ................................. 299
   6.7 DASS Profile Sheet ........................................................................... 301
   6.8 General Health Questionnaire (GHQ) ............................................... 302
   6.9 General Well Being Index (GWBI) ................................................... 304
   6.10 Problems to Goals Sheet ................................................................. 306
   6.11 Case study examples of qualitative indices ...................................... 307
   6.12 Patient Satisfaction Questionnaire .................................................. 308
   6.13 General Practitioners in General Practice Survey .......................... 310
   6.14 General Practitioner follow-up Questionnaire ................................ 312
   (xii)
6.15 Clinical Psychology Form: Treatment plan and discharge summary........316
6.16 Evaluation of Placement Experience Questionnaire..........................317
6.17 Clinical psychology registrars’ questionnaire....................................320
6.18 Client Case Register used on placement............................................321
6.19 GP Patient Referral Form.................................................................324

D) Results (Chapter 7) ..................................................................................325
7.1 Early analysis by gender of Bathurst treatment and control patients’ mean
pre-test scores..............................................................................................326
7.2 Results in relation to medication as a factor:
7.2a: Medication: Mean scores on pre-test measures for control and
treatment group members by whether or not they were taking
medication....................................................................................................327
7.2b: Mean Difference Scores for Treatment and Control Group
Patients by Use of Medication..................................................................328
7.2c: T-test of difference scores (pre-test minus post-test) for
control group Bathurst patients with both pre-Test and post-test
scores.............................................................................................................329
7.2d: T-test of difference scores (pre-test minus post-test) for
treatment group Bathurst patients with both pre-test and post-test
scores.............................................................................................................329
7.3 Analysis of variance (ANOVAS):
7.3a: Pre-test scores by three factors: Condition (1,2 ie. treatment vs.
control); Location (1,2,3) and Gender (1,2)............................................330
7.3b: Difference scores between pre- and post-test scores by three
factors: Condition (1,2), Location (1,2,3) and Gender (1,2) ............332

E) Further Developments (Chapter 9)..........................................................334
9.1 Number of services and FTE for allied health professionals engaged
by Divisions and funded through MAHS in 2005-2006 .........................335

Reports:
9.2 “Clinical Psychology in Rural General Practice” Reports
Commonwealth Department of Health and Ageing – see Disk 2 appended to
the thesis.
• June 30, 2001
• December 31, 2001
• June 30, 2002
• October 31, 2002
• December 31, 2002
• December 31, 2003
• March 31, 2004
• August 31, 2004
Policy Submissions

9.3 Submission to The Hon. Tony Abbott, Minister for Health, 20th November, 2003: “Clinical Psychology in Primary Care: An Early Intervention and Prevention Approach to Common Mental Disorders in General Practice” (Evidence-Based Best Practice in Mental Health Service Delivery)

a) Submission ................................................................. 336
b) GP Support letters ......................................................... 348

9.4 Submission to Council of Australian Governments, 23rd January, 2006:

a) Letter to the Prime Minister: “Early Intervention for Mental Illness: Primary Care Psychological Services” ........................................ 357
b) Summary submission .................................................... 361
c) Opinion/editorial in the Australian: 8 February 2006 .................. 363
d) Articles in New Matilda .................................................... 366
e) Follow-up letters to the Prime Minister .................................. 379
f) Response letters ............................................................ 386

9.5 Submission to the Federal Health Minister, the Hon. Nicola Roxon, 31 March 2008: “Collaborative Primary Mental Health Care”

a) Letter to Nicola Roxon with appendix (re: press articles).......... 403
b) Cover email to Bob Debus ............................................... 410
c) Response letters ............................................................ 411

9.6 20/20 Submission ................................................................. 413
LIST OF TABLES

Table 3.1: Chronology of a decade of major events impacting on reforms to mental health care in Australia ............................. 27
Table 3.2: Number of Division members, 2005-2006 ............................................. 34
Table 3.3: Number of practices in Division catchment by state, 2005-2006 .......... 35
Table 3.4: 2004 distribution of fully qualified psychiatrists by state ................. 42
Table 3.5: Registered psychologists in Australia by state ..................................... 46
Table 3.6: Specialist registration amongst Western Australian Psychologists ........ 47
Table 3.7: Profile of 2005 Mental Health Nurse workforce across Australia .......... 51
Table 4.1: NSW Rural Psychiatry Workforce February 2003 ................................. 70
Table 4.2: Total APS membership metropolitan vs rural split ............................... 73
Table 4.3: Metropolitan vs rural split of APS College memberships ...................... 74
Table 5.1: Clinical psychology staff in England (at 30 September each specified year): NHS hospital and community health services .............. 86
Table 5.2: NHS hospital and community health services: Qualified clinical psychology staff in England by organisation type as at 30 September 2003 ................................................................. 87
Table 6.1: Number of psychological registrars in participating surgeries .......... 112
Table 6.2: Numbers of control and treatment patients from each town/research centre ................................................................. 116
Table 6.3: Comparison of intervention and control groups from Bathurst on the basis of demographic data .................................................. 120
Table 7.1: Pre-test Data:
  7.1a: Comparison of pre-test scores of treatment patients with only pre-test data to those with both pre- and post-test data ........ 140
  7.1b: Comparison of pre-test scores of control patients with only pre-test data to those with both pre- and post-test data ......... 141
Table 7.2: Between group pre-test comparison:
  7.2a: Pre-test comparisons between all control and treatment participants who took initial pre-test ........................................ 142
  7.2b: Pre-test comparisons between control and treatment participants who completed both pre- and post-intervention measures .... 142
Table 7.3: Gender: Pre-test comparisons between male and female patients:
  7.3a: Treatment group patients ........................................................................ 143
  7.3b: Control group patients ........................................................................... 143
Table 7.4: Use of medication in members of treatment and control groups:
Bathurst patients only .................................................................................... 144
Table 7.5: Frequency of prescriptions for Bathurst patients ................................. 145
Table 7.6: Simple “Sign Test” of improvement or worsening of scores pre-
to post-test for patients in the treatment and control groups:
7.6a: Depression ................................................................. 146
7.6b: Anxiety ................................................................. 147
7.6c: Stress ................................................................. 147
Table 7.7: Percentage of treatment patients in the “Clinical Range” whose scores
improved, remained the same or worsened ................................. 148
Table 7.8: Comparison of initial and follow-up scores of control and intervention
groups on mental health measures .............................................. 149
Table 7.9: Pre- and post-test comparisons for all participants (including
treatment and control groups) .................................................. 150
Table 7.10: Pre- and post-test comparisons for treatment participants ...... 150
Table 7.11: Pre- and post-test comparisons for control participants ......... 151
Table 7.12: Levels of severity on DASS scores in treatment and control groups:
Pre- and post:
7.12a: Depression ................................................................. 152
7.12b: Anxiety ................................................................. 152
7.12c: Stress ................................................................. 153
Table 7.13: Correlations among pre-test measures for treatment patients
with full data ........................................................................... 154
Table 7.14: 7.14a: Comparisons between male and female treatment group members
on the difference between pre-test and post-test measures ......... 154
7.14b: Comparisons between male and female control group members on
the difference between pre-test and post-test measures ............ 155
Table 7.15: The use of medication in Bathurst treatment and control patients
with pre-test and post-test data available ..................................... 156
Table 7.16: Pre-test comparisons between paired control and treatment participants .... 162
Table 7.17: DASS levels for the paired participants:
7.17a: Depression ................................................................. 163
7.17b: Anxiety ................................................................. 163
7.17c: Stress ................................................................. 163
Table 7.18: Post-test comparisons between paired control and treatment
participants ............................................................................. 164
Table 7.19: Summary table comparing pre- and post-test scores for 48
treatment-control pairs ................................................................ 165
Table 7.20: Pre-test comparisons between control and treatment participants
whose scores worsened at pre-test ................................................. 166
Table 7.21: Post-test comparisons between control and treatment participants
whose scores worsened at post-test .............................................. 167
Table 7.22: Pre- and post-test comparisons for treatment participants ............ 167
Table 7.23: Pre- and post-test comparisons for control participants ............. 168
Table 7.24: Pre- and post-test comparisons for control paired participants
whose scores worsened ............................................................. 169
Table 7.25: Pre- and post-test comparisons for treatment participants whose scores worsened ................................................................. 169
Table 7.26: Post-test comparisons between control and treatment participants when control participants scores worsened at post-test ........................................ 170
Table 7.27: Post-test comparisons between control and treatment participants when treatment participants scores worsened at post-test................................. 170
Table 7.28: Numbers of patients returning patient satisfaction questionnaires .......... 172
Table 7.29: Research centre/location of GP respondents ................................................................. 187
Table 7.30: Gender of clinical psychology registrars ................................................................. 193
Table 7.31: Age of clinical psychology registrars ................................................................. 193
LIST OF FIGURES

Figure 2.1: Prevalence (%) of single and comorbidity anxiety, affective and substance use disorders among Australian adults ............................................................ 7
Figure 2.2: Comparative analysis of rates of antidepressant drug use in eight western countries ........................................................................................................ 16
Figure 2.3: Percentage split of antidepressant sales by drug class in 1998 across countries ............................................................. 17
Figure 3.1: Number of GPs in Australia ........................................................................................................ 31
Figure 3.2: Estimated number of GPs in Division catchment by RRMA, 2005-2006..... 32
Figure 3.3: Number of practices in Division catchment by RRMA, 2005-2006 ....... 33
Figure 3.4: Distribution of Divisions by population – 30 June 2005......................... 36
Figure 6.1 Diagrammatic Model Presenting Design of the Project .............................. 111
Figure 6.2: Numbers of control and treatment patients from each research centre at beginning and completion of study ............................................................. 117
Figure 6.3: Numbers of control and treatment patients by gender at beginning and completion of study ............................................................. 118
Figure 6.4: Diagrammatic model of patient parameters and data collection ............. 125
Figure 7.3a: Histograms representing distribution of the DASS PRE-TEST depression measure for control and treatment groups ......................... 158
Figure 7.3b: Histograms representing distribution of the DASS POST-TEST depression measure for control and treatment groups ......................... 158
Figure 7.4a: Histograms representing distribution of the DASS PRE-TEST anxiety measure for control and treatment groups ................................. 159
Figure 7.4b: Histograms representing distribution of the DASS POST-TEST anxiety measure for control and treatment groups ................................. 159
Figure 7.5a: Histograms representing distribution of the DASS PRE-TEST stress measure for control and treatment groups ................................. 160
Figure 7.5b: Histograms representing distribution of the DASS POST-TEST stress measure for control and treatment groups ................................. 160
LIST OF PUBLICATIONS AND PRESENTATIONS

PUBLICATIONS:


COMMONWEALTH REPORTS:

Vines, R.F., & Thomson, D.M.: "Clinical Psychology in General Practice Project". Reports for the Partnerships in Service Reform Section, Mental Health Branch/Health Priorities and Suicide Prevention Branch, Commonwealth Department of Health and Ageing:

- June 30, 2001
- December 31, 2001
- June 30, 2002
- October 31, 2002
- December 31, 2002
- December 31, 2003
- March 31, 2004
- August 31, 2004

CONFERENCE PAPERS/PRESENTATIONS/PUBLIC LECTURES/SUBMISSIONS

2000:


2001:


2002:

Paper at GP Conference in Melbourne.
Ran a Symposium at the APS National Conference, Gold Coast.

2003:

Paper at the National Rural Health Alliance Rural Health Conference in Hobart.

Paper at the APS NSW State Conference in Newcastle, May.


Chaired Symposium and gave a paper at the APS National Conference, Perth, October.

Submission (20.11.03): 2004 Health Budget Submission to the Federal Health Minister, The Hon. Tony Abbott: “Clinical Psychology in Primary Care: An Early Intervention and Prevention Approach to Common Mental Disorders in General Practice (Evidence-Based Best Practice in Mental Health Service Delivery)”.

2004:


2006:

23.1.06: Submission to the Prime Minister of Australia: “Early Intervention for Mental Illness: Primary Care Psychological Services” (also 20.4.06 & 30.5.06).

April 2006: “Funding for Primary Care Psychological Services: Time for Permanent Resourcing Under the Public Health System”. Newsletter of the Public Health Association of Australia.

Articles in New Matilda:

3.5.06: “Mental health and the federal budget”.
17.5.06: “The Federal Budget and Mental Health”.
22.9.06: “Mental Health Reform: Will we realise this opportunity?”
2008:

31.3.08: Submission to the Federal Health Minister: “Collaborative Primary Mental Health Care”.

BROADCASTING:

11.11.03: ABC Radio National: Bush Telegraph: “Psychology in General Practice”.

(xxi)
PREFACE

From the personal perspective of the author, the origins of this dissertation go back to the late 1970’s and early 1980’s whilst training and practising as a clinical psychologist in the United Kingdom. During two years of full-time study for a Masters of Science in Clinical Psychology – funded under the Grampian Health Authority in Scotland: 1976-1978 - the Trethowan Report (1977) was released. This landmark document recommended and established clinical psychology as a specialist mental health profession under the National Health Service in Britain, equal and parallel to psychiatry. As such, it was equitably available to all without barriers determined by affordability as was - until very recently - the case in Australia.

Whilst working as a basic grade and senior clinical psychologist at University College Hospital in London (1978-1984), it became apparent that the two professions of psychiatry and clinical psychology were both vital parts of the public mental health sector and that clinical psychology was playing an increasingly important role in mental health service delivery. Figures in the early 1980’s indicated there were approximately 780 full time equivalents (FTEs); with rapid growth resulting in an increase to approximately 4,846 FTEs in 2002 - a total number of 6,092 in England alone (see Chapter 5 for International Comparisons).

There were two characteristics of the profession in the UK in the early 1980’s which starkly contrasted to the situation in Australia:

- clinical psychology services were publicly funded and equitably available/accessible to all;
- there was already a considerable presence of these services, dating from the early/mid 1970’s, in primary care (ie. patients in some locations could access specialist clinical psychology services in the general practice setting, having presented to their GP with some degree of psychological dysfunction).

On returning to Australia, the author worked in the private sector (3 years) before moving to the university student services sector - 9 years in Melbourne and Sydney; 7 years at the University of NSW - where there was at least some semblance of equitable service provision. In 1997, as the new Director of the Psychological Services Centre at Charles Sturt University in the regional town of Bathurst, the same issue arose of patients having to pay to access psychological services. Unless practitioners chose to provide their services “pro bono”, which
a number of the university clinical staff did, it was found that most people in regional and rural areas could not afford fees, even if they could access services - geographic distances frequently providing a double disincentive. Service sustainability, contingent on meeting facility costs and salaries, was therefore difficult in regional and rural areas outside the public sector as fees were not feasible for most people with mental disorders. As is well known, there were very few public sector mental health services available in rural areas at that time (eg. in 2003, only 114 psychiatrists were practicing across the whole of rural Australia). As a consequence, people outside the metropolitan context frequently went without appropriate treatment for mental health problems – as they continue to do, despite positive changes over the past seven years. This situation also applies in outer-metropolitan settings (see Chapter 4: Rurality and Equity).

The project which this thesis describes, emerged from discussions of the local Mental Health Advisory Committee of the NSW Central West Division of General Practice (CWDGP) based in Bathurst. Deliberations centered on how the psychology department at the regionally-based Charles Sturt University could assist local GPs in dealing with the large mental health component of their primary care work. It was proposed that masters and doctoral post-graduate trainees in clinical psychology might undertake internships in primary care, thereby trialing a new model of collaborative care in the general practice setting.

The trial of the model started from very small beginnings in 1998 when psychological services were provided by the author one morning a week in one of the general practices in Bathurst, as part of service outreach of the Psychological Services Centre. As a consequence of the later expansion of the original trial described in this thesis, similar clinical services began to develop elsewhere and ultimately, at the height of the project in 2004, were provided under public funding in thirteen regional and rural towns in the Central West of NSW (Bathurst, Blayney, Canowindra, Condobolin, Cowra, Forbes, Lithgow, Molong, Parkes, Tullamore, Trundle, Rylestone and Kandos) and in a number of towns in New England (Armidale, Inverell and Glen Innes). Successful service trials had also been initiated in Ballarat, Victoria. Whilst not all locations were part of the research evaluation reported in this dissertation, service outreach to these towns was a direct consequence of the original trial.

Robyn F. Vines
30 June 2008
Chapter 1

INTRODUCTION

Project Rationale and Overview

“There is an urgent requirement to address the mental health needs of the people of Australia. The burden of disease due to mental disorders/mental health problems is high and rising. The escalating cost of pharmaceutical benefits in treating mental disorders is unsustainable. There are effective psychological treatments of mental disorders that empower patients and ensure more positive health outcomes. Cost savings can be made by the Commonwealth Government in medical and pharmaceutical benefits, if appropriate planning is undertaken for the provision of early psychological intervention for patients with Common Mental Disorders at the Primary Care level.”


The research described in the following dissertation formed part of the “Clinical Psychology in Rural General Practice Project”. Sponsored by the Commonwealth Department of Health and Ageing between 2001 and 2004, the aim was to pilot and evaluate a new model of collaborative mental health service delivery involving clinical psychologists in the rural primary care setting. The project involved clinical psychologists and clinical psychology registrars/interns in the provision of psychological services in a number of general practices in three rural regions of NSW and Victoria. During the course of the research 22 clinical psychology registrars were trained - their internships entailing:

- observation of general practitioners in their consultations with patients;
- assessing, diagnosing and treating 20+ patients in the primary care setting;
- analysing pre- and post-assessment results of their patients; and
- making qualitative observations of the model and of the general practice setting during the course of their placements.
The dissertation brings together findings from service provision in the general practices involved in these three rural regions over a period of three years (2001-2003). Participants in the project - clinical psychology academics and senior clinicians, general practitioners, clinical psychology registrars, the Divisions of General Practice involved and members of the communities to whom the services were provided - indicated that the model of care trialed in the project was helpful and needed to be maintained and developed further.

Whilst piloting the provision of collaborative care in the rural general practice setting, the objective of the research was broader: to evaluate the efficacy of clinical psychology as a profession in the primary care setting in the provision of early intervention for patients with high prevalence, common mental disorders in the community. At the time of the research, this population had been largely neglected, with many GPs being left to manage them on their own/as best they could with pharmacological treatment, time-limited consults and brief counseling - for which many GPs felt ill-equipped.

The desire at outset, if the services proved effective, was to facilitate inclusion of the profession of clinical psychology under the public health system in Australia – as it was well known that many needing these services could not access them due to cost of treatment in the private sector. The thesis is therefore not just an empirical piece of work about the development and evaluation of a collaborative model of mental health service delivery. It also became a case study of policy engagement focused on restructuring mental health service delivery in Australia to include the specialist profession of clinical psychology as part of the primary care workforce.

The dissertation is divided into three main sections:

**Section 1: The Context**

There are four chapters in this section:

Chapter 2: Covers the issue of mental health in Australia – the growing burden of disease, detection, modes of treatment, etc. – and provides a brief
overview of mental health policy developments up to 2001 when the “Clinical Psychology in Rural General Practice Project” began.

Chapter 3: Delineates the role and distribution of professions involved in mental health service delivery across the country including: general practice, psychiatry, psychology and mental health nursing.

Chapter 4: Looks specifically at the issue of “rurality and equity” and the dilemmas facing those needing to access mental health services in regional, rural and remote (RRR) Australia.

Chapter 5: Provides a comparison with other western countries, including brief descriptions of the service delivery situation in the United Kingdom and Canada.

Section 2: The Research

There are two chapters in this section:

Chapter 6: Outlines the methodological framework used to pilot and evaluate the provision of clinical psychology services in general practice and the impact of the model of collaborative care on the patients, GPs and clinical psychology registrars involved.

Chapter 7: Presents the results of the trial (quantitative and qualitative), again from the perspective of the patients, general practitioners and registrars.

Section 3: Beyond the Research

Includes one chapter (Chapter 9) outlining “Further Developments” since the advent, running and conclusion of the research. Mental health policy developments since 2001 up to the present are covered, highlighting that important changes have occurred during this time, key amongst which has been the long overdue inclusion of psychological services under the public health system via medicare.

“Poor mental health costs the economy directly through medical and social welfare costs - for each dollar spent on services, four more dollars”
are lost indirectly through poor education and training achievement (ie. lost life opportunities) reduced workplace productivity, lost tax earnings and reduced participation by carers (and patients themselves) in the wider economy” (Hickie, Groom & Davenport, 2004).

The project described in this dissertation piloted and evaluated a new model of early intervention collaborative mental health care, the aim of which was to arrest the huge costs of common mental disorders to sufferers, their families, the economy and to our society at large.
Chapter 2

MENTAL HEALTH IN AUSTRALIA

2.1 Burden of disease due to mental disorders in Australia

It is well known that the incidence of mental health problems and mental disorders is high and rising. Murray and Lopez in their 1996 comprehensive assessment of global disease patterns - a World Bank Project carried out by the Harvard School of Public Health and the WHO in Geneva - estimated that by 2020 depression will be one of the greatest health problems worldwide and will constitute the biggest burden on health spending in the Western World (Murray & Lopez, 1996; Murray & Lopez, 1997; Bell, 2005). The WHO has estimated that approximately 1.5 billion people worldwide suffer some kind of mental illness (WHO, 2000) and that prevalence of mental disorders is on average higher across nations than any other class of chronic condition. It is also estimated to have more significant impacts on role functioning than many serious chronic physiological conditions (WHO Survey Consortium, 2004).*

There is some evidence that mental disorders are already the most significant cause of disability in Australia as well as in other developed economies (Andrews & The Tolkien II Team, 2007). Until recently, epidemiological data on mental health conditions in the United States was relied upon for Australian estimates (Teeson & Burns, 2001). In 1997, however, the National Survey of Mental Health and Well Being was undertaken by the Mental Health and Special Programs Branch of the Commonwealth Department of Health and Aged Care, surveying a representative sample of 10,641 Australians (Commonwealth Department of Health & Aged Care, 1999). This provided the first national data on the prevalence and patterns of mental disorders in the Australian population. According to Teeson and Burns (2001), the survey was designed to answer three main questions:

---

* Thanks are due to Bernadette Hurley for some input to Sections 2.1, 2.2 and 2.4 - see Hurley, B.M., “The Conditions Required for Psychological Symptom Disclosure by a Patient to their General Practitioner”; BSocSc(Hons); CSU Thesis under my supervision. Also see Vines, R.F., Hurley, B.M., & Thomson, D.M. (2002). Clinical Psychology in Rural General Practice: A Pilot of a Collaborative Model of Mental Health Service Delivery; Clinical Psychologist, 6 (2), 29-40 (ISSN 132804207).
• how many Australians have which mental disorders?
• how disabled are they by these disorders?
• what services have they used for these disorders?

Together with the Australian Burden of Disease Study (Mathers, Vos & Stevenson, 1997) the survey confirmed the high incidence of mental health morbidity in Australia, results indicating approximately 18%, or up to 4.7 million Australians, are affected by at least one mental disorder in a 12 month period (Commonwealth Department of Health & Aged Care, 1999). Further analysis of the figures suggested an even higher figure of 22% meeting criteria for one or more mental disorders during the previous year and 14% for a current disorder during the past month (Andrews, Henderson & Hall, 2001).

Analysis of current cases (ie. the 14%) indicated that approximately 50% were moderately or severely disabled by their condition; only half of those disabled had consulted anyone about their mental health disorder; and of the half that did not consult 60% said they “preferred to manage themselves”, whilst 40% said they had a need, but had visited their doctor without receiving help for their mental condition (Andrews & the Tolkien II Team, 2007). These figures indicate several problems in terms of accessing treatment in Australia: with only 50% of those disabled consulting specifically about their condition, there is a serious problem in mental health literacy in the community about the benefits of treatment (Andrews & the Tolkien II Team, 2007; Jorm, Korten & Jacomb, 1997). Further, if 40% expressed a need, had visited the doctor but not received help for their mental disorder (as was reported), there is a significant problem in GPs’ capacity to perceive and manage mental health difficulties (Andrews & the Tolkien II Team, 2007).

Further analyses of the 1997 data indicated that of people meeting criteria for one of the ten major disorders during the previous year (ie. the 22% of respondents), only 40% of those ill received treatment with only 23% indicating that it was effective. Similarly, in the USA, “even the most conservative estimates reveal the staggering number of those with untreated psychological or psychiatric disturbances” in the community (Haas, 2004; Narrow & Rae, 2002).
Estimates vary across Australian studies in relation to prevalence of particular disorders. Clarke, Drake, Mellsop, Stedman and Yellowlees (1997) suggested that 12.6% of the population suffer from an anxiety disorder, 9.5% an affective disorder, 9.5% substance abuse and .5% schizophrenia. Results from the 1997 National Survey suggested slightly different prevalence rates for anxiety, depression and substance use disorders of 9.7%, 5.8% and 7.7% respectively, with gender differences and levels of comorbidity as follows:

Figure 2.1.: Prevalence (%) of single and comorbidity anxiety, affective and substance use disorders among Australian adults

The data indicates (as outlined in Figure 2.1) that comorbidity of mental health and substance-use disorders, or co-occurrence of more than one mental disorder, is prevalent (Teeson & Burns, 2001). Comorbidity of mental health conditions with
alcohol and other drugs (A&OD) disorders, as well as physiological and other psychosocial conditions, have a number of implications for treatment and management in mental health service delivery. However, the contentious issue of overlap and possible two-way causation of comorbid conditions remains largely unaddressed in treatment agenda across the country. Physiological conditions such as cardiovascular disease, diabetes, asthma and arthritis have significant comorbidity rates with mental health problems, the latter frequently needing to be addressed if successful intervention for these conditions is to take place (Britt et al., 1999b; Creed, Gask & Sibbald, 1997; Galassi, Schanberg & Ware, 1992; Goldberg, 1984). Similarly, patients with conditions such as hypertension, functional gastrointestinal disorders, or lower back pain would also benefit from psychological interventions (Trask & Schwartz, 2002). It has not yet been established how treatment success would be enhanced by including these as a normal adjunct to medical treatments.

Age discrepancies in prevalence are also of interest. In older adults, the prevalence of mental disorders drops to 6% among those aged 65 years, with some indication that stress diminishes in the same age group (Stress in America, 2007). However, an additional 6.1% are estimated to have dementia which is strongly age-related and significantly increases with age after this time - from 1.6% of 65 to 70 year-olds, to 39% of 90-94 year-olds (Commonwealth Department of Health and Aged Care, 2000b; Sawyer, Arney, Baghurst, Clark, Graetz, Kosky, Nurcombe, Patton, Prior, Raphael, Rey, Whaites & Zubrick 2000). Only a proportion of dementia care, however, falls within the aegis of mental health services, being largely the responsibility of specific psychogeriatric services (Andrews & the Tokien II Team, 2007).

The implications of age-linked differences in prevalence for treatment are not clear. However, policy-makers and practitioners need to be aware that varying models of access and treatment may be appropriate for those at different stages of the life cycle (Boyd, Hayes, Sewell, Caldwell, Kemp, Harvie, Aisbett & Nurse, 2008; Pachana, Helmes & Koder, 2006).
2.2 Patterns of care

In Australia, as elsewhere in the developed world, general practitioners/family physicians are the key primary care service providers and the gatekeepers to secondary care (Creed, Gask & Sibbald, 1997). The 1999 BEACH study: “Bettering the Evaluation and Care of Health” (Britt et al., 1999a, 1999b) conducted by Sydney University and the Australian Institute of Health and Welfare - in which approximately 1,000 GPs from metropolitan, regional and rural areas of Australia were interviewed and 98,400 patient consultations were covered - found that 85% of the Australian population visit a GP at least once in any one year and 90% in any two-year period (Britt et al., 1999b). In the USA, whilst many patients need but do not seek psychological help on their own initiative for their mental health difficulties, more than 80% of them visit their primary care physician in any given year (Haas & deGruy, 2004). Prior to November 2006, approximately 95% of people in Australia with a chronic mental illness were cared for in the community, either by their GP, psychiatrist and/or community mental health team (Creed, Gask & Sibbald, 1997; Alston, Hustig, Keks, Sacks & Tanaghow, 1998). The majority of patients with mental disorders and mental health problems saw their GPs and received all care from them (Holmwood, 1998). Publically-funded psychological services were scarce, frequently invisible, unattainable or too expensive in Australia. It became apparent that to make any appreciable difference to the quality of mental health care in the community and for the population as a whole, psychologists must be involved in the primary care setting. (Coleman & Patrick, 1976; Haas, 2004). This was one of the key rationales underpinning the current study.

2.3 Incidence of mental disorders in primary care

The “point prevalence” of mental health problems amongst general practice patients is high (Holmwood, 1998). Of those presenting in the primary care setting, it has been estimated that between 19% and 40% of patients have mental disorders (Aloizos, Harris, Hickie & Penrose-Wall, 1998; Britt et al., 1999b; Chamberlin, Jackson & Kroenke, 1999; Creed, Gask & Sibbald, 1997; Goldberg, 1984; Hennrikus & Sanson-Fisher, 1988; Hickie, 1999; Robinson & Roter, 1999). Of these, between 31% and 46% present with significant psychological distress that warrants further assessment.
Chapter 2: Mental Health in Australia

The results from the National Survey of Mental Health and Well Being suggest that at least 40% of people with depression consult with a GP within the first year of onset of the condition. Of these, only 6.2% were referred to psychologists and 8.4% to psychiatrists. As outlined previously, in Australia less than half of the adults with mental disorders (38%) and less than a third of children (29%) receive professional help for those disorders (Sawyer et al., 2000).

2.4 The detection of psychological symptoms in primary care

The detection of psychological symptoms in primary care patients and the use of early appropriate mental health intervention at the primary care level are extremely important - due to the fact that, apart from the obvious quality-of-life issues for patients, use of medical services is far higher amongst those with psychological disorders than for those without. (Brugha, Smith & Wing, 1989; Chamberlin, Jackson & Kroenke, 1999; Franco, 1991; Hennrikus & Sanson-Fisher, 1988; Hickie, 1999). The resultant cost burden (and likelihood of inappropriate use of the health system by those with such difficulties) remains a cause of concern.

Despite, however, a high prevalence of psychological disorders in the primary care environment, accurate detection by GPs of patients with a psychological disorder is quite low (Andrews & the Tolkien II Team, 2007). Recognition of mental health problems, particularly the high prevalence/common mental disorders of depression and anxiety, varies between practitioners and is deemed to be sub-optimal (Andrews & Carter, 2001; Brodaty, Andrews & Kehoe, 1982; Dowrick & Buchan, 1995; Goldberg & Huxley, 1992; Goldberg & Lecrubier, 1995; Goldberg & Gater, 1996; Groom, 2002; Holmwood, 1998). A detection rate of approximately 30% is consistently reported – within a wide range of between 20% and 74% (Andrews, Brodaty, Andrews & Kehoe, 1982; Bowers, Harris, Henderson & Jorm, 1990; Andrews, Chancellor & Mant, 1977; Franco, 1991; Gordon, Hennrikus, Redman, Sanson-Fisher & Webb, 1991; Hennrikus & Sanson-Fisher, 1988; Hickie, 1999; Holmwood, 1998; Ormel, Simon & Tiemens, 1996; Robinson & Roter, 1999). Hickie (2001) found that only 44% of patients presenting in general practice with high prevalence mental disorders were given a psychological diagnosis, the rate being slightly better (54%) but again sub-optimal for more severe disorders. Other findings
also indicate that the best detection rates are still only around 60% of those presenting with mental health conditions (Holmwood, 1998).

Various hypotheses have been proposed to explain the consistently low detection-rate of psychological disorders by GPs (as Hickie indicates, less than 50%), including the common co-morbidity of psychological symptoms with physical illnesses (Britt et al., 1999b; Creed, Gask & Sibbald, 1997; Galassi, Schanberg & Ware, 1992; Goldberg, 1984). The BEACH report highlighted hypertension, back complaints, menopausal complaints, diabetes and sleep disturbance, as commonly co-occurring with a depressive disorder (Britt et al., 1999b), frequently making it difficult for the GP to disentangle the physical and psychosocial symptoms in order to make an accurate diagnosis.

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

a) the possible stigma associated with such a label (Aloizos et al., 1998; Hennrikus & Sanson-Fisher, 1988);

b) the perceived likelihood that recognition of the condition does not improve treatment outcomes (Chamberlin, Jackson & Kroenke, 1999; Hennrikus & Sanson-Fisher, 1988; Ormel, Simon & Tiemens, 1996). Many GPs do not feel confident to treat common mental disorders, which is not surprising since they receive little training in this area (Goldberg & Huxley, 1992; Groom, 2002). Whatever training they do receive as medical students is usually focused on low prevalence, high severity conditions (e.g. psychoses and severe mood disorders) whilst on rotation in psychiatric hospitals (Groom, 2002). In addition, mental health facilities have often been difficult to access, particularly in rural areas, if a mental disorder is diagnosed. It is therefore hypothesised that, in these circumstances therefore, “treatable conditions” are focused upon more readily as there is no point in making a diagnosis of mental disorder if all that results is a “raised level of dissonance in the doctor or the
A further argument lies in the possible mismatch between clinical task (ie. complex
diagnosis and management plan) and resources (ie. time) available. A further dilemma
for the GP is that in making the diagnosis, there may not be sufficient time to
adequately treat the patient in the primary care setting, or alternatively (as mentioned
above) there may not be adequate access to secondary or tertiary resources.

Variability between practitioners despite these difficulties, however, does indicate
scope for improvement in detection rates via both training and attitudinal change
(Holmwood, 1998) – particularly if increased collaborative support is available so that
GPs are not left to handle assessment, diagnosis and treatment on their own when
there is inadequate time to do so - even if they did have the skills.

Patient perceptions also play a part in inhibiting the likelihood of detection. It has
been found that many patients view the role of their GP as being focused on physical
rather than psychological symptoms (Andrews, Chancellor & Mant, 1977; Bridges &
Goldberg, 1984). In one study it was found that 83% of patients opted not to disclose
psychological symptoms to their GP (Robinson & Roter, 1999). Similarly, Andrews,
Chancellor and Mant (1977) determined that patients suffering anxiety and depression
were generally reluctant to disclose their emotional needs to their GP, preferring to
present physical symptoms, such as prolonged fatigue and sleep disturbance as more
appropriate. Patients’ choice to present physical rather than psychological complaints
could thus contribute to the low detection rate of psychological disturbance. As Haas
outlines:

“... the common currency of medical settings is physical complaints,
and it is not surprising that somatic symptoms and pain complaints
form themes that constantly recur in primary care patients” (Haas,
2004).
2.5 Medicalisation of mental health difficulties

2.5.1 Common pathways of care

Data on common pathways of care in general practice indicate that patients whose symptoms don’t have an immediate medical explanation are often referred for further diagnostic tests (ie. “the full work-up” at the local pathology clinic). This excludes underlying physiological conditions that may contribute to the symptoms. Another frequent outcome when the doctor diagnoses a possible mental health condition (often via short interview) is prescription of an antidepressant (Haas, 2004). Most psychoactive medication prescriptions are written by GPs/primary care physicians and not by psychiatrists. Anti-depressant medications are the most available first-line treatment for moderate-to-severe major depressive episodes (Ravindran & Kennedy, 2007). In some circumstances this is sufficient to stabilise the patient; in others it provides a basis on which to institute further therapy.

2.5.2 Antidepressant use in Australia

Use of antidepressant drugs in Australia has escalated, with figures from 1990 to 1998 showing an increase in dispensing of prescriptions through community pharmacies from 12.4 defined daily doses (DDDs) per 1000 population per day (5.1 million prescriptions) to 35.7 DDDs/1000 population per day in 1998 (8.2 million prescriptions) (McManus, Mant, Mitchell, Montgomery, Marley & Auland, 2000). This trend has continued into the first decade of the new millennium to the point where in 2007, 35 million prescriptions were issued for ‘nervous system drugs’ (one-twentieth of the 184 million scripts issued during the year – Guilliatt, 2008). Details on more recent figures are discussed below. Despite this increase, the evidence suggests that prescribing antidepressants does not necessarily mean that the depression has been treated, up to 50% of these prescriptions either not being filled, taken without adherence to guidelines, or with a proportion of responses being placebo reactions (Moncrieff et al., 2001).

The debate about efficacy, effectiveness and efficiency (Andrews, 2000) relating to anti-depressants is ongoing. Recent research undertaking meta-analyses of studies involving new-generation antidepressant SSRI (selective serotonin reuptake inhibitor) medications (including Effexor, Aropax, Prozac and Serzone) indicates only modest
benefits over placebo treatment and, including unpublished trial data, indicates overall effectiveness below recommended criteria for clinical significance (Kirsch, Deacon, Huedo-Medina, Scoboria, Moore & Johnson, 2008). These findings build on earlier research in which it is alleged that the relatively small effects found in RCT (randomized control) depression trials of anti-depressants over placebo can be accounted for by non-specific pharmacologic (e.g. sedating side effects, improvement in sleep patterns, etc.) and psychological (e.g. placebo) effects, and that there is no reason to conclude that they can reverse the diverse problems labelled as depression (Moncrieff, 2007). Rebuttal to these arguments maintains that:

“MDD (Major Depressive Disorder) is a highly prevalent illness, with evidence to support its biological basis coming from multiple sources, including neurochemical and neuroimaging studies. Because of the range of physical, social and societal sequelae that can result, detection, diagnosis, and effective treatment are of paramount importance. ... Although other approaches to depression, including lifestyle changes, psychoeducation, and structured psychotherapies, play an important role, pharmacotherapy remains a cornerstone of effective treatment of depression” (Ravindran & Kennedy, 2007).

Moncrieff (2008) argues in turn that:

“... the mass prescribing of antidepressants and the concomitant message that depression is a brain disease have helped to create this situation [an age characterized by an ‘epidemic of psychological disorders] not to improve it. By persuading people that their thoughts and feelings originate from a biological defect, we are preventing them from finding real solutions to the complex problems of modern living” (Moncrieff, 2007b).

These arguments have recently played out again in the Australian Press (Cresswell, 2008a) with Professor Gordon Parker claiming that, whilst depression is over-diagnosed (Parker, 2007), patients should not shy away from anti-depressants since patients in the studies analysed (by Kirsch et al., 2008):

“... bear very little correlation to the people we see in real-life clinical practice ... participants were usually hospital outpatients rather than admitted patients”.
He goes on to maintain that:

“65-to-70% of patients [with melancholic depression] responded to antidepressants, whereas only 10 to 15% improved after taking placebo”.

However, the rate of antidepressant use in Australia goes far beyond the small patient population whose severe depression has resulted in hospitalisation. Professor Ian Hickie argues in support of this saying that suicide rates have fallen in countries where antidepressant use is most widespread (from 2,720 to 2,101 in the past nine years – see Taylor, 2008), and that:

“... it would be a mistake to say that drug treatment should be withheld for anything other than the most severe depression. ... Even quite low levels of depression significantly increase suicide risk” (Hickie cited in Cresswell, 2008a).

He does not, however, indicate how the inference is made that this social phenomenon of a relatively small suicide rate decline (see numbers above), which has occurred not only in Australia but also in the United States, Sweden, Finland, and Hungary (Grunebaum, Ellis, Li, Oquendo & Mann, 2004) is directly attributable to medication ingestion (in massive numbers across all of these countries). Indeed, he and co-authors state in a 2003 paper, in which the association between antidepressant prescribing and suicide in Australia is analysed, that there is little direct evidence that antidepressants reduce the suicide rate, suggesting that “the increase in antidepressant prescribing may be a proxy marker for improved overall management of depression”. They indicate that the prescription of antidepressants is often “accompanied by other assessments (such as asking about suicide risk, giving information to family members) and clinical interventions (counselling, support and ongoing clinical review)” concluding that “these interventions, in combination with medication, may reduce suicidal behaviour” (Hall, Mant, Mitchell, Rendle, Hickie & McManus, 2003).

In addition to the above points, the claimed beneficial results of medication frequently do not take into account the decrease in quality of life as a result of side effects that some patients experience as a result of drug ingestion. For some, side effects have included: tremor, nausea, cramps, thirst, interference in sleep patterns, concentration difficulties, corneal lesion (a listed side-effect of fluoxetine), bleeding gums (a
reported side-effect of aropax), emotionality and seeming personality changes. In addition, it has been reported that antidepressants at high doses can cause serotonin imbalance, triggering fever, agitation and muscle rigidity (Guilliat, 2008). These potential side-effects of either single medications or combinations of medications are sometimes not explained and/or the patient not alerted to the possibility of them occurring “… in fact the ‘cured’ may not always be happier” Guilliat (2008).

Whatever the outcome of the debate, current use of antidepressants in Australia is high. Comparative figures from 1993 and 1998 indicate that we are (per capita) the third largest users in the world after Sweden and France (see Figure 2.2).

Figure 2.2: Comparative analysis of rates of antidepressant drug use in eight western countries

![Figure 2.2: Comparative analysis of rates of antidepressant drug use in eight western countries](source)

Of the three drugs remaining on the market included in the analysis done by Kirsch et al. (2008), ie. Effexor, Aropax and Prozac - Serzone was withdrawn after being linked to liver and eye problems, all have achieved massive sales in Australia since their introduction in the 1990’s. Nearly four million scripts were written for them alone in 2006-2007, costing the PBS (Pharmaceutical Benefit Scheme) $130 million. The most commonly prescribed of the three, Venlafaxine (ie. Effexor), was the 8th biggest drain on the PBS that year (Cresswell, 2008) – a surprising shift in light of it being such a small component of total antidepressant drug use in 1998, outlined in the above analysis of provision through pharmacies.

In 2004, 12 million prescriptions for all antidepressants (both new scripts and monthly repeats) were dispensed in Australia through the PBS, amongst a population of, at the time, less than 20 million people. Two hundred and fifty thousand of these were written for patients under 20 years of age. In 2005-2006 the figure had again increased to 12.3 million, considered a staggering amount for a country with a
population of only 20 million (Taylor, 2008). These figures indicate a dramatic increase during the 14-15 years since 1990 when, as outlined earlier, five million scripts were issued, and from the 8.2 million issued in 1998 (Bell, 2005). In the decade from 1990 to 2000, antidepressant use in Australia increased by 352%. This trend has continued with conservative figures indicating that in 2007, 12 million scripts for SSRIs alone were subsidised by the PBS, with 224,792 being prescribed for children and teenagers aged 10 to 19 years. The data do not include children under 10 years old who are also being prescribed antidepressants, or private prescriptions which fall below the PBS threshold - which most of the SSRI drugs do (Davies, 2008).

Worldwide, antidepressant sales passed $20 billion US dollars by 2005. In 2004, Australians spent $3 billion dollars on prescription drugs, four of the top 50 prescribed on the PBS being antidepressants - Cipramil: 16th, Zoloft: 25th, Aropax: 27th and Effexor: 46th (Bell, 2005). Since 2005, as mentioned above, Effexor has risen to 8th. Recent figures indicate that almost 35 million prescriptions were issued for the broad descriptor of ‘nervous system drugs’ (including antidepressants and sedatives) in 2007 – ie. one-twentieth of the 184 million total scripts issued across Australia - reflecting a near tripling in antidepressant prescriptions since 1992 (Guilliatt, 2008).

Little is known about either the impact of changing medications or their interactive effects on other medications the patient may be taking at the same time (a not infrequent occurrence due to common comorbidities of several mental health disorders and/or physiological issues mentioned earlier in the chapter). “How drugs interact in the body is a poorly understood phenomenon, because pharmaceuticals are generally tested individually and on healthy subjects”. It is suggested that each additional medication “exponentially increases the likelihood of unforeseen side-effects” (Guilliatt, 2008). There is also no evidence for patients being on the cocktail of drugs frequently ingested, nor to support that kind of prescribing. The effects of drug combinations are unknown and can vary, as individual reactions to pharmaceuticals differ – however, an inherent danger is that the drugs themselves can be “iatrogenic” (ie. generate conditions different to, and sometimes worse than the original illness which they are meant to treat – sometimes again leading to further medication to counteract these effects).
Potential factors determining the increased rate of antidepressant consumption are multiple. Bell (2005) argues that the increase in usage is attributable to:

“the cooperation of three large but inherently unequal groups:

- the multinational drug companies [who “sell sickness” and argue that “depression is under-diagnosed”];
- the physicians who write the prescriptions [to whom the pharmaceutical companies have sold their argument and product]; and
- the public who turn to medicine for answers” [ie. the culture amongst consumers of associating illness with a drug cure and consequent expectations of a “prescription-outcome” when visiting the doctor].

It remains speculative that drug companies sell sickness, that doctors buy the argument and that the public wants a pill. There are alternative explanations:

a) that medical research has produced new, powerful and effective drugs that were simply not available in a previous generation;

b) further, that the incidence of drug-taking needs to be assessed in relation to an ageing population and the maintenance of their quality of life.

2.5.3 Cultural considerations

It has been argued that Australia’s rapidly accelerating pharmaceutical bill, including psychotropic medication, reflects a culture in which it is believed that “there is no condition that can’t be regulated or relieved by medications” (Guilliatt, 2008). However, some current explanations of the recent rise in prevalence of depression (Murray & Lopez, 1996) emphasise the current rapidity of social change and inability of people to keep pace with modern challenges as key etiological factors (Bell, 2005). If these hypotheses are correct, it is questionable whether a “drug cure” for such non-illness/social phenomena can be either valid or effective. Indeed, it can be argued that if depression is the culmination of “learned helplessness” (Peterson, Maier & Seligman, 1993; Seligman, 1994), then the consumption of antidepressant medication, prescribed by someone else, as a way of resolving life’s complex difficulties may indeed further contribute to the problem. What may be needed instead is “assistance
with issues in life” (Guilliatt, 2008) which may be causing the distress in the first place.

2.6 Best practice

If medication continues to be the “most available first-line treatment for moderate-to-severe major depressive episodes” (Ravindran & Kennedy, 2007) and indeed for much of diagnosed depression and other mental disorders in the community (Bell, 2005) despite the lack of conclusive evidence as to its efficacy across the board, then what is the preferred alternative/“best practice” approach to such conditions? The clinical/research literature indicates that, for most depression and anxiety disorders, psychological treatments are as effective as medication and are likely to be more effective in the longer term. It has been found that individuals receiving medication alone are prone to relapse after the discontinuation if no alternative method of maintaining treatment gains is provided. A number of psychological interventions (“focused psychological interventions”) have been found to be effective in the treatment of depression, anxiety and substance-use disorders in adults; and disruptive-behaviour disorders, anxiety disorders and depression in children and adolescents (eminently preferable in children as long-term impacts of medication are unknown).

“Current best practice in the treatment of all serious mental disorders requires integrated pharmacological and psychosocial interventions. This means that for best practice, i.e. empirically supported interventions in the primary care setting to occur, increasing access to effective non-drug treatments, or focused psychological interventions such as cognitive-behavioural therapies, is essential. Currently (at the time of writing) health consumers in Australia have very little access to effective psychological treatment. By contrast, (according to the Productivity Commission’s figures in March 2000) the prescribing of psychotropic medications such as antidepressants has doubled over the past six years. This situation is now out of step with the evidence from the scientific literature on effective treatments for mental disorders” (Australian Psychological Society†, 2000).

Until recently (November 2006 – i.e. the advent of medicare funding for psychological services) mental health consumers continued to have limited access to psychological treatments, even though research indicated that cost-effective psychological/

† I am grateful to the Australian Psychological Society for permission to quote the above APS document.
behavioural interventions were available and effective for a broad range of health problems - including mental health disorders (more so than psychotropic medication in the treatment of most anxiety and depressive disorders, antisocial behaviour, etc.) and physical health disorders, for which changing behaviours such as smoking, eating, drinking alcohol and inadequate exercise greatly reduce risk factors (eg. for heart attacks and stroke, cancer, diabetes, asthma, etc). Specifically with mental disorders there was a clear “efficacy-effectiveness gap” in terms of lack of availability of best-practice interventions in practice, and it remains debatable whether current massive subsidies of psychotropic medications (in addition to new allocation of funds to psychological interventions) is the most efficient use of resources.

Whilst it became apparent from the above that support needed to be given to upgrade the mental health assessment and intervention skills of GPs, practical limitations on the capacity of the GP workforce to develop the necessary psychological expertise and to carry the large number of patients needing in-depth psychological treatment were also recognised - given that extensive training is required to for the delivery of individually-adapted/flexible, specialised psychological therapies. Existing demands on already busy GPs, time limitations inherent in primary care and varying skill and interest levels in mental health amongst GPs, all mitigate against doctors developing the psychological intervention-capacity needed to deliver the majority of specialised mental health services in the primary care setting (Christensen, Griffiths, Gulliver, Clack, Kljakovic & Wells, 2008). As a consequence, it was suggested that patients with mental health disorders could be classified conceptually at different levels of complexity, with differing levels of skill required to treat them adequately (APS, 2000). It was also suggested that whilst GPs are, both practically and professionally, capable of carrying out psychological assessment and treatment at lower levels for a large range of patients presenting with mental health disorders, specialised input is required for patients with more complex mental health problems. This has formed the basis of the “stepped care” approach, the aim of which is to initially use the least intensive and expensive treatment, a more expensive intervention becoming appropriate only if the first treatment fails or if initial signs are clear that a more complex approach is required. The optimal sequence of care runs from “GP advice and self management (often via the web), to GP treatment, to allied mental health staff.
(usually clinical psychologists) treatment, to psychiatrists in ambulatory care, to inpatient admissions” (Andrews & the Tolkien II Team, 2007). Analyses have been done on 15 of the key adult mental disorders (ie. the mood disorders: depression, dysthymia, bipolar disorder; anxiety disorders: panic/agoraphobia, social phobia, generalised anxiety disorder, post-traumatic stress disorder, obsessive compulsive disorder; alcohol use disorders: alcohol abuse and dependence; psychotic disorders: schizophrenia, and the additional disorders of: neurasthenia, borderline personality disorder, and eating disorders: anorexia nervosa and bulimia nervosa). These analyses have established recommended ‘ideal’ evidence-based, stepped care treatment of people with these disorders (with different pathways for each of the 15 disorders) (Andrews & Hunt, 1998; Andrews & the Tolkien II Team, 2007). At the core is the general practitioner with both treatment and coordination skills. Patients prefer to be assessed by their general practitioner rather than mental health specialists (Jorm, Korten & Jacomb, 1997) and, in addition, retention of longer term care (both physical and mental) resides with the GP. Stepped care therefore needs to be focused on primary care which provides an acceptable, stigma-free venue for provision of care - the “hub-of-the-wheel”.

The aim of the current research was to assess one component of this “stepped-care” approach and to establish a viable model for GPs and clinical psychologists to work together more effectively in the primary care setting.

2.7 Primary care psychology

Primary care psychology, involving co-location and close liaison between the psychologist and doctor in the general practice setting is a relatively new phenomenon in Australia. These shared primary care arrangements, however, have been operating in the UK and the USA for considerably longer, and lessons can be learnt from models used elsewhere.

As outlined by Haas (2004), practising psychology in primary care enables the practitioner to:
address mental health problems of patients where they are most often presented;
address the psychosocial aspects of medical complaints;
participate in ensuring that the primary care system truly meets the needs of patients, without contributing further barriers to care.

However, the practice of primary care psychology demands skills, attitudes, and a broader knowledge base than is frequently characteristic of many conventionally trained psychologists (Haas & deGruy, 2004) – some of whom retain the belief that autonomy and independence are necessary to the good practice of their profession. Collaboration and effective work in primary care can indeed result in some reduction of professional autonomy but, in compensation, offers the chance to be more relevant in affecting a much larger system and offering psychological service where it is most needed (Hass & deGruy, 2004). It differs from the usual/traditional link between primary care and mental health services through referral, which can be inefficient, puts further barriers to access and frequently results in attrition at this point. Co-location of GPs and psychologists ensures that patients’ problems can be dealt with at the time, in the same (acceptable) location, and in a holistic manner without “compartmentalisation of medical phenomena and human experience” (Holmwood, 1998). There is enormous potential for improvement in the care of people with mental disorders in this way.

Key aspects and components of primary mental health care are as follows:

- integrated [GPs are responsible for coordinating care across different professions and often settings];
- accessible [GPs are available at the time needed];
- accountable [GPs are responsible for the quality of and usually long-term care of the patient];
- large majority of health care needs [ie. responsibility for breadth of care];
- sustained partnership [ie. continuity of care – sometimes over a lifetime];
- in the context of family and community [ie. with knowledge of the bio-psychosocial context in which the patient lives];
- whole person approach [emphasising the relationship between the psychological and physical dimensions of health presentations]. (Haas & deGruy, 2004)
Given that primary care is at the core/centre of health service delivery in Australia, it is within this context that effective mental health services must operate.

Specialist psychiatry can help in the management of the major psychiatric disorders presenting in primary care. However, these constitute a minority of mental health presentations in general practice (Holmwood, 1998). GPs need to be skilled in brief, effective interventions which can be incorporated into their busy everyday schedules. Beyond that, however, they need improved access to both secondary and tertiary care to ensure rapid access to effective treatments by patients (and doctors) with common mental disorders at time of need. Provision of evidence-based psychological treatments in the general practice setting fulfils these requirements. In addition it fulfils the three guidelines for best-practice care (Andrews, 2000): efficacy (the treatments work); effectiveness (they work and are accessible in actual practice settings); and efficiency (cost-effective early intervention can prevent need for more expensive care down-stream). The “court is still out” on whether the new mental health funding arrangements in Australia (from November 2006), which were designed to facilitate best collaborative primary mental health care, have in fact achieved their objective in the way intended or whether they have merely perpetuated previous patterns of practice on a larger scale.
3.1 Background

Until fairly recently, mental health care in Australia frequently entailed incarceration of the mentally ill in psychiatric institutions, sometimes for decades and often without treatment (Barrand, 1997). This followed an historical process in which the first Australian asylum (commissioned in 1881 by Governor Macquarie and intended as a place of refuge, providing “cleanliness, kindness, nutrition, medical attention, recreation and good record keeping” (Lewis, 1988)) was replicated across the country in state based mental hospitals where the concept of “asylum” was replaced by that of the “bin”, in which ill people were dumped and often forgotten (Health & Community Services, 1993). These facilities were the responsibility of the eight state and territory governments, with little or no coordination nationally.

In the decades prior to the 1990’s, Australia (along with other Western countries) was criticised for both the quality and quantity of its mental health services (Whiteford, Buckingham & Manderscheid, 2002). In response, a Mental Health Statement of Rights and Responsibilities was formulated in 1991 by the Australian Health Ministers (1992), leading to the formation of the first National Mental Health Policy (known as the National Mental Health Strategy) which was adopted by all Australian states, territories and the Federal Government in April 1992 (an early precursor to the Council of Australian Governments’ recent mental health policies). This entailed a five year process of reform implemented via the National Mental Health Plan (1993-1998), the aim of which was to deliver real and practical benefits to consumers via equitable access to compassionate, high quality mental health services; mainstream mental health services within the general health system; and redirect funding into integrated community based treatment and support services (Barrand, 1997). It also attempted to “clarify the roles and responsibilities of the Commonwealth and State Governments in a National approach to mental health care reform” (Australian Health Ministers, 1992). For the first time since Federation in 1901 a nation-wide approach
to the coordination and development of public mental health services was established. Shortly after the advent of the Strategy, community concern for the human rights of people with a mental illness precipitated a national enquiry into the issue by the Human Rights and Equal Opportunity Commission. The Report of the National Enquiry into the Human Rights of People with Mental Illness (1993), known as the “Burdekin Report”, strongly endorsed earlier criticisms, painting a bleak picture and concluding that:

a) 'people affected by mental illness are among the most vulnerable and disadvantaged in our community. They suffer from widespread, systemic discrimination and are consistently denied the rights and services to which they are entitled'; and
b) 'poor inter-sectoral links, the ambivalent stance of the private sector and a reluctance on the part of government agencies to cooperate in the delivery of services to people with mental illness have contributed to the alarming situation described in this report' (Human Rights & Equal Opportunity Commission, 1993).

Key recommendations put forward by the Report included:

a) increased funding for community-based mental health care;
b) development of effective collaboration across all sectors of the health system including the private sector; and
c) establishment of a set of national standards for mental health service delivery.

The Report played a key role in the early stages of the new National Mental Health Strategy, both in highlighting and generating public concern about the issue of mental illness in the community. It was followed by the commissioning (1995) and endorsement (1996) of the National Standards for Mental Health Services (Commonwealth Department of Health & Family Services, 1997) which, although not mandatory, were strongly encouraged as “benchmarks of good practice” across the country.

The National Mental Health Strategy, in addition to a number of national and international research projects conducted throughout the 1990’s, ensured that mental health became and remained a high priority in health policy development and
implementation throughout the decade (Groom, 2002). A brief summary of some of the key events follows.

Table 3.1: Chronology of a decade of major events impacting on reforms to mental health care in Australia

<table>
<thead>
<tr>
<th>Year</th>
<th>Event/Research Study / Report</th>
</tr>
</thead>
<tbody>
<tr>
<td>1991</td>
<td>The Mental Health Statement of Rights and Responsibilities 1991</td>
</tr>
<tr>
<td>1992</td>
<td>National Mental Health Policy/Strategy</td>
</tr>
<tr>
<td>1993</td>
<td>National Mental Health Plan</td>
</tr>
<tr>
<td>1993</td>
<td>National Inquiry Concerning the Human Rights of People with Mental Illness</td>
</tr>
<tr>
<td>1996</td>
<td>WHO Global Burden of Disease Study</td>
</tr>
<tr>
<td>1996</td>
<td>McKay Report into the Specialist Psychiatric Workforce</td>
</tr>
<tr>
<td>1997</td>
<td>Mental Health and Well-being Profile of Adults</td>
</tr>
<tr>
<td>1997</td>
<td>Depression identified as the focus of the National Health Priority Areas Initiative</td>
</tr>
<tr>
<td>1997</td>
<td>The Joint Consultative Committee Report on Primary Care Psychiatry</td>
</tr>
<tr>
<td>1998</td>
<td>Second National Mental Health Plan</td>
</tr>
<tr>
<td>1999</td>
<td>National Health Priority Areas 1998 Report, Mental Health: A Report Focusing on Depression</td>
</tr>
<tr>
<td>1999</td>
<td>The National Primary Mental Health Care Initiative</td>
</tr>
<tr>
<td>2000</td>
<td>National Action Plan for Depression</td>
</tr>
<tr>
<td>2000</td>
<td>The National Depression Initiative</td>
</tr>
<tr>
<td>2000</td>
<td>The Australian Burden of Disease Study</td>
</tr>
<tr>
<td>2000</td>
<td>Review of the Supply and Requirement of Specialist Psychiatry Workforce in Australia</td>
</tr>
<tr>
<td>2001</td>
<td>Federal Budget Measure of $120.4 million for Better Outcomes in Mental Health Care.</td>
</tr>
</tbody>
</table>


Results from the first National Mental Health Strategy and Plan (1993-1998) - gleaned from the Australian National Mental Health Report 2000 (Commonwealth Department of Health & Aged Care, 2000b), indicated a 30% increase in overall expenditure on mental health including an increase in expenditure of 87% in the community, 38% in general hospitals, a decrease of 29% in funding for psychiatric hospitals, and a reversal in the previous 6% growth in private psychiatry. An increase in consumer and carer involvement was also claimed (Whiteford, 2000). It was concluded that, whilst significant gains had been achieved, five years was insufficient time to reach required outcomes. A second National Mental Health Plan (1998-2003) was therefore endorsed by the Commonwealth and States with priorities including:
improved service quality (still seen to be lacking, despite structural changes achieved by the first plan); extension of the role of consumers and carers, private sector reform, consistency (and reliability) of data across and within state jurisdictions; and an introduction of population approaches to prevention and promotion (Whiteford, 2000; Australian Health Ministers, 1998). One key limitation found was that there was still little data available on primary mental health care “where most patients with a mental disorder in Australia receive treatment” (Whiteford, 2000).

The first National Mental Health Plan focused largely on government/public sector specialist mental health services, with little regard for the private sector. In addition, the care of those with high prevalence, common mental disorders (eg. depression and anxiety) was not considered. It was not until 1995 (in the commissioning of the National Standards for Mental Health Services) that the first public policy statement highlighted the need for collaboration between mental health services and private providers such as GPs and psychiatrists (Groom, 2002).

The increasing recognition by policy makers and health care providers that GPs play a crucial and key role in the provision of mental health care in the community was endorsed by the National Profile of Mental Health and Well Being (Australian Bureau of Statistics, 1997) which indicated that, whilst only 38% of people sought help for mental health issues, 75% of these sought help in the first instance from a GP (Andrews, Hall, Teeson & Henderson, 1999). In parallel, after a review was undertaken of the psychiatry workforce in Australia which found both an undersupply and unequal geographic distribution of psychiatrists (McKay & Associates, 1996 – see later section on Psychiatry), research was undertaken into the role of primary care psychiatry (ie. ‘the provision of mental health care to those with mental disorders by GPs in the primary care setting’). This project, conducted as part of a “strategic alliance” between the Royal Australian College of General Practitioners (RACGP) and the Royal Australian and New Zealand College of Psychiatrists (RANZCP) in 1996-1997, confirmed the core role of GPs in primary mental health care and recommended enhanced roles for GPs and additional training and support to underpin these roles (Joint Consultative Committee in Primary Care Psychiatry, 1997). Further, the General Practice Strategy Review Group - a Commonwealth Department of Health and Ageing initiative (1998 - commissioned in 1997) – again endorsed this
direction by requiring GPs to develop new collaborative working relationships with a variety of other health service providers; whilst also proposing Divisions of General Practice (founded as part of the National Health Strategy in 1992) as a viable support infrastructure for such reforms (eg. by facilitating GP training and developing shared care activities in areas such as mental health). An additional and increasing emphasis on continuity of care (one of a number of emerging policy trends in the 1990’s in Australia and elsewhere) also focused attention on the necessity to develop partnerships and alliances between primary, secondary and tertiary health care providers (Groom, 2002).

The second National Mental Health Plan (1998-2003) placed particular emphasis on collaborative working relationships between GPs and specialist mental health providers as follows:

“Key strategic alliances will vary according to individual consumer need and preference. However, important partnerships will include: *general practitioners* (bold in the original) who are major service providers for people with mental illness and who assume even greater responsibility in areas of geographic isolation or cultural sensitivity. Productive partnerships are dependent on identifying and addressing funding issues, sharing consumer information, and education and training” (Australian Health Ministers, 1998, p.16).

As can be seen from the above, the political context in which mental health care was being delivered showed a dramatic shift in Australia in the 1990’s towards a broader more collaborative approach emphasising the need for better early intervention at primary care level. There was a significant move away from custodial care towards more community-based services, largely helped by the outcry caused by the National Enquiry (1993). These cumulative developments all indicate that the traditional system of mental health care had failed to meet community needs and that a new approach was required in which collaboration between GPs (with enhanced training in diagnostic and management skills) and mental health specialists was the key (JCC, 1997). Reforms to general practice have been driven both by community requirements for GPs to collaborate more closely with other health system sectors in better serving population needs, and also by their own professional training and support requirements (Groom, 2002).
It is within this “organically evolving” mental health policy context - which involved the confluence of a number of different studies, reports and events (as outlined in Table 3.1), that the current project had its origins. Commencing in regional NSW in 1998, it provided one of the first empirical trials of collaborative care between GPs and appropriately trained/clinical psychologists in the provision of mental health care in the primary care setting in Australia. Its aim was to establish whether these new/experimental collaborative care arrangements fulfilled the three core requirements for “best practice” (as outlined at the end of Chapter 2).

a) efficacy (ie. do the psychological treatments actually work for patients with a mental illness?);

b) effectiveness (ie. are they more accessible and do they work when set in the primary care setting?); and

c) efficiency (ie. do they provide cost effective early intervention, preventing the need for more expensive treatment “down-stream”?).

The main body of the study and its outcomes is outlined in Chapters 5, 6 and 7. Later mental health policy developments from 2001, which emerged in parallel with or after the project, are described in Chapter 9. An outline of the four key mental health professions in Australia (as endorsed under the new Australian Government sponsored Mental Health Professionals’ Association of Australia: General practice, psychiatry, psychology and mental health nursing) is provided below, with their relative distributions in metropolitan vs. rural areas (“the bush”) described in Chapter 4 - Rural Areas and Equity. This provides a further context in which to locate the experimental trial of collaborative mental health care between GPs and clinical psychologists which forms the focus of this dissertation.

3.2 General Practice

“General Practice forms the heart of Australian health care and for almost all of us, GPs represent the familiar and public face of medicine in this country. General Practice is also as diverse as Australia.”

(The Hon. Michael Wooldridge, Minister for Health & Ageing, 1998.)
3.2.1 Annual survey of Divisions of General Practice

The Primary Health Care Research and Information Service (PHC RIS) has, since 1997-1998, conducted an Annual Survey of Divisions (ASD) on behalf of the Australian Government Department of Health and Ageing. Since “Divisions report this information for all GPs in their catchments (regardless of Division membership) ... it is a reasonably accurate account (of GP numbers and trends) aligning with other measures” (email communication from PHC RIS, 27.3.08). Findings from the latest Report, “Making a difference” (Hordacre, Howard, Moretti & Kalucy, 2007) are outlined below.

At 30 June 2006, it was estimated that 22,564 GPs work in Australia, an increase of approximately 500 GPs since 2001-2002 (see Figure 3.1).

Approximately 36% of GPs were female (surprising, since more than 50% of the intake in most medical schools has been female for over a decade now) with most of these being more likely to practice in metropolitan areas (ie. “Metro” or
“Metro/Rural” RRMA categories). Eighty-two percent of GPs were found to be working in urban areas (ie. “Metropolitan” or “Metropolitan-Rural”) whilst 18% were in “Rural”, “Rural/Remote” and “Remote” RRMA classifications (PHC RIS, 2007) – see Figure 3.2 below and Chapter 4 for further details on rural and remote distribution of GPs.

Data indicate that GPs are located in 7,525 practices (for the 2005-2006 year) – slightly lower than the number (approximately 7,800 practices) estimated in 2004-2005 and 2003-2004 (Hordacre et al., 2007). This may be due to the “engineered” decline in solo practices outlined below. Figures indicated a total of 6,151 practice nurses (a numeric increase of 25% since 2004-2005, representing a 20% increase in practices having a practice nurse to 3,296 – ie. 44% of all practices). A total of 8,518 other practice staff was also found (Hordacre et al., 2007).

Latest figures suggest that the number of GPs in solo practices has declined significantly in the past 20 years with 12.3% of all GPs Australia wide currently in solo practice (ie. approximately 2,775). This indicates a decrease of approximately 17.5% (based on data from South Australia, the only state in which pre- and post-
Chapter 3: Mental Health Services in Australia

figures are available, where numbers fell from approximately 29% in 1988 to 11.5% in 2006). The decline represents Australian Government policy to reduce the number of solo practices and support amalgamations in an attempt to increase quality of and access to health services for patients (Hordacre et al., 2007). Interestingly, the highest proportion of solo practices exists in “Rural/Remote” and “Remote” RRMA categories (189/380: 49.7% of practices and 61/110: 55.5% of practices in these categories respectively) with the proportion reducing to 37% (ie. 1,933/5,212 practices) in “Metro” practices and 31% in “Metro/Rural” practices – see Figure 3.3. (practice sizes in the “other” categories vary from 2-5 GPs up to 6+ GPs – see Hordacre et al., 2007.)

Figure 3.3: Number of practices in Division catchment by RRMA, 2005-2006

In addition to encouraging amalgamations to improve the quality of care, the Australian Government (via Division policy) have also been active in facilitating collaborative care arrangements, particularly in the mental health arena. In the latest Annual Survey, Divisions clearly continued their focus on mental health care with 94% indicating that they were running mental health programs (in contrast to 81% in 2004-2005). Allied health professionals (most being psychologists) were employed in 88% of Divisions, with 1,813 being contracted – a 10% increase on the 1,641 employed during 2004-2005. Findings from 2005-2006 indicated that 30% of the 604 Full-Time Equivalent staff (ie. 179) were funded through More Allied Health Services (MAHS) and 23% (ie. 138) through Better Outcomes in Mental Health Care.
Chapter 3: Mental Health Services in Australia

(BOMHC) (Hordacre et al., 2007). These data preceded the advent of Medicare funding for psychological services in November 2006. It will therefore be intriguing to see how patterns of employment via Divisions alters in relation to alternative COAG funding now being available. These findings, however do indicate that collaborative care and mental health specialist support of GPs in treatment of mental health issues is a priority of Divisions and has emerged successfully over the past few years. Additionally, the number of non-GP members of Divisions has almost tripled in the last year with 54% of Divisions reporting 5,277 non-GP-members in 2005-2006, up from the 1,850 reported by 42% of Divisions in 2004-2005 (Hordacre et al., 2007), suggesting a move towards the often discussed concept of “Divisions of Primary Care” as an alternative to “Divisions of General Practice”.

<table>
<thead>
<tr>
<th></th>
<th>% of Divisions</th>
<th>Number of Division members</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Median</td>
<td>Maximum</td>
</tr>
<tr>
<td>Total Division members (estimated)</td>
<td>99</td>
<td>158</td>
</tr>
<tr>
<td>GPs (not including IMGs or registrars)</td>
<td>99</td>
<td>113</td>
</tr>
<tr>
<td>International medical graduates</td>
<td>50</td>
<td>15</td>
</tr>
<tr>
<td>Registrars</td>
<td>71</td>
<td>6</td>
</tr>
<tr>
<td>Allied health professionals</td>
<td>24</td>
<td>9</td>
</tr>
<tr>
<td>Practice nurses</td>
<td>29</td>
<td>35</td>
</tr>
<tr>
<td>Practice staff</td>
<td>26</td>
<td>22</td>
</tr>
<tr>
<td>Medical specialists</td>
<td>24</td>
<td>4</td>
</tr>
<tr>
<td>Others</td>
<td>28</td>
<td>4</td>
</tr>
</tbody>
</table>

Table 3.2: Number of Division members, 2005-2006

Note: Divisions with ‘unknown’ or zero responses are not included in calculations for proportions or medians

There are 119 Divisions of General Practice providing information and support to general practices across the country throughout the year. They vary enormously in terms of numbers of GPs they represent, with a range from 17 to 797 GPs per Division, and a median of 153 GPs. The number of Divisions again varies by state, with NSW having 37 Divisions; Queensland 18; Victoria 30; South and Western Australia 14 each; Tasmania 3; Northern Territory 2; and the ACT 1. Most Divisions are located in: “Metro” areas 54; “Metro-Rural” 12; “Rural” 34; “Rural/Remote” 14; and only 5 in the “Remote” category (Hordacre et al., 2007).
<table>
<thead>
<tr>
<th>Number of Divisions unable to report</th>
<th>Number of practices</th>
</tr>
</thead>
<tbody>
<tr>
<td>Median</td>
<td>Minimum</td>
</tr>
<tr>
<td>NSW (n=37)</td>
<td>0</td>
</tr>
<tr>
<td>Vic (n=30)</td>
<td>0</td>
</tr>
<tr>
<td>Qld (n=18)</td>
<td>0</td>
</tr>
<tr>
<td>SA (n=14)</td>
<td>0</td>
</tr>
<tr>
<td>WA (n=14)</td>
<td>0</td>
</tr>
<tr>
<td>Tas (n=3)</td>
<td>0</td>
</tr>
<tr>
<td>NT (n=2)</td>
<td>0</td>
</tr>
<tr>
<td>ACT (n=1)</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>0</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Number of solo practices</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>NSW (n=37)</td>
<td>3</td>
</tr>
<tr>
<td>Vic (n=30)</td>
<td>0</td>
</tr>
<tr>
<td>Qld (n=18)</td>
<td>1</td>
</tr>
<tr>
<td>SA (n=14)</td>
<td>0</td>
</tr>
<tr>
<td>WA (n=14)</td>
<td>0</td>
</tr>
<tr>
<td>Tas (n=3)</td>
<td>0</td>
</tr>
<tr>
<td>NT (n=2)</td>
<td>0</td>
</tr>
<tr>
<td>ACT (n=1)</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>5</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Number of practices with 2-5 GPs</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>NSW (n=37)</td>
<td>3</td>
</tr>
<tr>
<td>Vic (n=30)</td>
<td>0</td>
</tr>
<tr>
<td>Qld (n=18)</td>
<td>1</td>
</tr>
<tr>
<td>SA (n=14)</td>
<td>0</td>
</tr>
<tr>
<td>WA (n=14)</td>
<td>0</td>
</tr>
<tr>
<td>Tas (n=3)</td>
<td>0</td>
</tr>
<tr>
<td>NT (n=2)</td>
<td>0</td>
</tr>
<tr>
<td>ACT (n=1)</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>5</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Number of practices with 6 or more GPs</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>NSW (n=37)</td>
<td>3</td>
</tr>
<tr>
<td>Vic (n=30)</td>
<td>0</td>
</tr>
<tr>
<td>Qld (n=18)</td>
<td>1</td>
</tr>
<tr>
<td>SA (n=14)</td>
<td>0</td>
</tr>
<tr>
<td>WA (n=14)</td>
<td>0</td>
</tr>
<tr>
<td>Tas (n=3)</td>
<td>0</td>
</tr>
<tr>
<td>NT (n=2)</td>
<td>0</td>
</tr>
<tr>
<td>ACT (n=1)</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>5</td>
</tr>
</tbody>
</table>

With regard to population served by each Division, at 30 June 2005 the estimated population of Australia was 20,339,759 (Australian Bureau of Statistics, 2006) leading to a median population for Divisions of 162,217 people – an increase of 7,500 from the previous 2003-2005 median of 154,545 (Hordacre et al., 2007; see also Figure 3.5 below). However, Divisions vary widely in terms of population served, from more than half a million (592,881) in the largest Division in Queensland to 16,971 in the smallest Division (NSW Outback Division). Rural and remote Divisions are usually the smallest with most of the 11% of Divisions with less than 50,000 populations being in these regions (Hordacre et al., 2007) – see Figure 3.5.
3.2.2 Annual BEACH Surveys

In addition to the ASD run by PHC RIS (see above), another consistent and detailed source of information on general practice activity in Australia is BEACH - “Bettering the Evaluation And Care of Health” (Australian Institute of Health & Welfare, 2007). The BEACH Program “continuously collects information about the clinical activities in general practice in Australia including: characteristics of GPs, patients seen, reasons people seek medical care and problems managed”. This well known “General Practice Series” which documents nearly ten years of continuous analysis of primary care data (from April 1998-1999 to 2006-2007) in 21 key publications, is jointly produced by the Australian General Practice Statistics and Classification Centre, part of the Australian Institute of Health and Welfare, and the University of Sydney. It provides a continuous randomised/cross-sectional national study of general practice activity in Australia. Its latest report is based on a survey of 930 GPs and covers 93,000 patient encounters and presents characteristics of GPs and their patients, reasons for GP consults, issues managed and the techniques used to do so (Britt, Miller, Charles, Bayram, Pan, Henderson, Valenti, O’Halloran, Harrison & Fahridin, 2008). Providing a comprehensive coverage of current activity, the Reports also
outline trends and changes that have occurred over the nine years of the BEACH study. Key findings of the latest survey (Britt et al., 2008) suggest that:

- the general practice workforce is ageing (in 2006-2007 one in three practitioners were aged 55 and over, an increase of approximately 40% since 1998-1999);
- there is a trend towards more women joining the profession (increasing from 30% in 1998-1999 to 34.1% in 2006-2007); with consequent choice of a better work-life balance amongst practitioners: more women work part-time than men and many GPs are working fewer hours. The proportion working less than 6 sessions per week has increased from 12-17%, whilst those working 11 or more sessions has halved from 19.0% to 9.6% between 1998-1999 and 2006-2007. There has also been a 20% decline in the proportion of GPs providing their own cooperative after hours services (since 2000-2001);
- solo practices have halved (amongst the randomised respondents) since 1998-1999 to about 8% in their sample; with larger practices (5 or more GPs) accounting for more than half of the GPs (as has been outlined by PHC RIS).

Changes were also found both in patients consulting and problems managed by GPs as follows:

- an increase in consulting by “baby boomer” (45-64 yrs of age – a 15% increase since 1998-1999) and the aged (75 yrs and over – a 30% increase) patients, with children making up a decreasing proportion of consultations (with a seen-to-be-linked decrease in frequency of management of acute respiratory conditions);
- more frequent management of chronic problems such as diabetes, cancer, cardiovascular disease and mental disorders (partly consequent upon the above change in population distribution of patients) – with a 5.4million increase in the number of GP consults related to chronic disease in less than a decade (the management rate of chronic problems has increased from 46.5 to 52.1 per 100 encounters between 1998-1999 and 2006-2007);
policy initiatives have had a significant impact on the management of Type 2 Diabetes, but a lesser effect on the management of depression in general practice in which no significant change in identification or management rates were found between 1998-1999 and 2006-2007; and no increase in “in-house” provision of counselling for depression since 2000-2001 (after an initial increase from 1998-1999). Interestingly, referrals to psychologists had increased significantly whilst those to psychiatrists had decreased;

- analysis of risk factors such as being overweight and obese, smoking and alcohol consumption indicated a considerable increase in percentages in both sexes in the overweight or obese ranges with only four in 10 patients in the normal BMI range; a significant decrease in reported daily smoking in adults of both sexes; and a constant prevalence of reported “at risk” consumption of alcohol – remaining at 27% of patients since first measured in 1998-1999;

- patients were found to be consulting with more “reasons for encounter” (RFE’s): increasing from 146.3 to 150.8 reasons per 100 encounters from 1998-1999 to 2006-2007, with visits to obtain results of tests doubling from 3.4 to 6.9 per 100 encounters and administrative procedures (such as medical certificates) up from 1.1 to 1.9 per 100 encounters;

- there has been a significant increase in longer surgery consults. However, despite this, average length of Medicare/DVA consult has remained constant at approximately 15 minutes (since 2000-2001). GPs were also found to be doing fewer home visits.

It is amongst this diverse role description that collaborative care needs to fit – making a difference without adding further burden.

### 3.3 Psychiatry

A psychiatrist is defined as “a medical practitioner who identifies as being a specialist i.e. holds a qualification awarded by a specialist college; for example, the Royal Australian and New Zealand College of Psychiatrists (RANZCP) – and whose main specialty of practice is psychiatry” (AIHW, 2005). Psychiatrists may work as clinicians or non-clinicians, in the public or private sectors or both (MHWAC,
A major study into the supply and distribution of psychiatrists in Australia - one year after, and instigated by the introduction of the National Standards for Mental Health Services (1995), found both an undersupply and unequal geographic distribution of psychiatrists across Australia (McKay & Associates, 1996). These issues were of particular concern as, at the time, psychiatry was the only public-funded mental health specialty in the country. It was disputed whether there was in fact an undersupply, given that the Australian data indicated an average of 5.8 psychiatrists per 100,000 population as compared with 3.6/100K in the UK (Goldberg, 2000 as quoted in Groom, 2002). What was not disputed, however, were McKay and Associates (1996) conclusions that changes were needed in the way psychiatrists, and particularly those in private practice, worked - with a range of strategies recommended. It was suggested that psychiatrists should “practice more as consultants (to GPs) and less as specialists providing long term personal care for patients” (McKay & Associates, 1996).

The Australian Medical Workforce Advisory Committee study of “The Specialist Psychiatry Workforce in Australia” (AMWAC, 1999a, 1999b) endorsed the earlier findings of McKay and Associates (1996) and found little change had occurred in relation to the key issues of supply, distribution and work practices of the profession. Both studies highlighted gross problems in access due to the high concentration of practitioners in urban areas, which left “the bush” largely under/serviced, with a severe shortage of specialists in rural and remote areas. Figures indicated concentration of the majority of practitioners in the capital cities (86.1%) with only 4.9% of psychiatrists working in large rural areas and only 3.5% provided care in “other” rural and remote locations (AMWAC, 1999; see also Chapter 4 Rural Areas and Equity). Unmet need for and difficulty in accessing these services was also found in urban and urban fringe areas (AMWAC, 1999), attributed to the majority of psychiatrists being in private practice (in the “leafy suburbs”) which, despite government support, was found to be expensive (due to fee gaps charged) and waiting lists long. Consumers were found to have an average waiting time of 33.6 days for a standard first consultation with a private psychiatrist, with a similar consultation with a public psychiatrist being slightly better at 19.6 days (AMWAC, 1999). These patterns have long caused concern in light of psychiatry being until very recently, as mentioned above, the only mental health speciality under the public health system (ie.
Medicare) – and therefore supposedly accessible to those not in a position to pay for alternative services.

In contrast with the approximate 23,000 GPs practicing in Australia at the time of the AMWAC (1999) study, the 1,960 psychiatrists were deemed (by Divisions of General Practice, consumers and GPs) to provide “inadequate” coverage and access due both to the maldistribution mentioned above and the continuing lack of consultant support to GPs (the majority of psychiatrists were still found to be in an ongoing direct service provision role, despite recommendations from McKay & Associates (1996) to depart from this model). Very few psychiatrists, then or now, work collaboratively with GPs in Australia (in contrast to Canada where the collaborative care model established by Nick Kates has worked for many years, at the exclusion of clinical psychologists and psychologists – see Kates, Craven, Crustolo, Nikolaou & Allen, 1997; Kates & Craven, 1998). Little collaboration was also found between the private and public systems of psychiatry which function in parallel but cater to different groups of people (Paton, 1999), having different remuneration systems which act as disincentives to collaboration (Groom, 2002). Those in the salaried public sector earn considerably less than those in the private sector (in 1999 figures: approximately $140,000 per annum for those in the public system compared to upwards of $200,000 in private practice - see Henderson, 2000), and referrals to the public sector can steer patients away from the lucrative private sector. Estimates vary as to the proportion of those in private practice: the RANZCP estimating that approximately 41% of psychiatrists (ie. 1,062.9 FTE’s) work exclusively in private practice, 23% completely in the public sector, and 36% in both sectors (MHWAC, 2008); whilst Henderson (2000) suggests “private practice is where some 80% of our psychiatrists are working”. The drift from salaried/public to private sector positions has been attributed to “tensions between psychiatrists and the other health professionals” – and the suggestion made that ...“As in any conflict among higher primates, this is inevitably about dominance hierarchies, territory and scarce resources” (Henderson, 2000). In addition “introduction of managers from industry, the public (civil) service or the non-medical health professions to senior appointments in regional authorities” has resulted in “many psychiatrists hav(ing) found this a toxic experience and have given up in their attempts at conflict resolution, entering private practice” instead (Henderson, 2000). It is suggested that there is an ethos in Australia of “What is a
good doctor like you doing in a salaried job?” in stark contrast to what applies in Scotland/the UK under the NHS (Henderson, 2000). It has been stated that private and public psychiatrists are isolated from each other not only in their clinical work but also in their professional ideology with public psychiatrists (and others) claiming that many Australians cannot access private psychiatric care because they cannot afford the gap (between the 85% of the scheduled fee paid by Medicare and the total fee charged per consultation). As has been stated, “social equity is a concern, but only to some” (Henderson, 2000).

Locally trained psychiatrists are poorly represented in the public sector which (having difficulty in recruiting local graduates who prefer to work in private practice) has become reliant on recruitment from overseas (particularly in rural areas). In recent years, the proportion of trainee psychiatrists (ie. medical practitioners who have been accepted by the RANZCP and supervised by a member of the College prior to gaining entry) whose original qualification was obtained overseas, has increased significantly from 14.8% in 2000 to 27.6% in 2004 (MHWAC, 2008).

Latest figures reveal that between 2000 and 2004 the number of FTE (full time equivalent) psychiatrists and psychiatrists-in-training has increased by 9.8% (an average increase of 2.4%) from 3,089 to 3,392, making up 5.4% of all employed medical practitioners and 11.4% of all medical specialists in Australia (AIHW, 2007; see table below for distribution of fully qualified psychiatrists by state). In 2004, 64.1% (ie. 2,020) were male, 35.9% (ie. 1,131) were female; with women making up 56% of psychiatrists-in-training, up from 42% in 1999. The relatively higher number of women was attributed to the possible effect of controllable work hours in the profession ie. a better “work life balance”. The majority of practitioners (approximately 55%) were aged between 35 and 54 years, with a sizeable proportion (31%) being older than 55 (MHWAC, 2008). A 2005 workforce survey undertaken by the RANZCP indicated that 17% of the psychiatric workforce was planning to retire in the next five years, with another 1/3 planning to reduce their hours.
Table 3.4: 2004 distribution of fully qualified psychiatrists by state

<table>
<thead>
<tr>
<th>State</th>
<th>No.</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACT</td>
<td>31</td>
</tr>
<tr>
<td>NT</td>
<td>10</td>
</tr>
<tr>
<td>NSW</td>
<td>679</td>
</tr>
<tr>
<td>QLD</td>
<td>337</td>
</tr>
<tr>
<td>SA</td>
<td>208</td>
</tr>
<tr>
<td>TAS</td>
<td>45</td>
</tr>
<tr>
<td>VIC</td>
<td>644</td>
</tr>
<tr>
<td>WA</td>
<td>182</td>
</tr>
<tr>
<td>Total</td>
<td>2,136</td>
</tr>
</tbody>
</table>

Relative to population, there is now one RANZCP Fellow to every 8,919 people in Australia (higher than the WHO recommended 1:10,000 psychiatrist: population ratio), with the highest ratios existing in Victoria and South Australia (1:7,433 and 1:6,701 respectively) and the lowest ratios in the Northern Territory, Tasmania, Queensland and Western Australia, where the recommended 1:10,000 is exceeded (respectively 1:20,670; 1:12,865; 1:10,723 and 1:10,306) – see MHWAC, 2008). As outlined above (and in Chapter 4), they are, like most medical specialists, unevenly distributed, concentrated in capital cities, and inadequately accessible particularly in rural areas. In February 2008 a paper commissioned for the Medical Workforce Advisory Committee again cited the following reasons for this inadequate access: insufficient supply, inability to fill funded vacancies in the public sector workforce, maldistribution, unacceptably long waiting times and work practices still focusing on individual patient servicing rather than collaborative consulting in the community (MHWAC, 2008).

Studies indicate that, in the short and medium term, demand for psychiatrists is likely to exceed supply (AMWAC, 1999) and that the psychiatric workforce is moving towards a situation of escalating undersupply, with training rates insufficient to meet expected requirements. The distribution of psychiatric workforce is likely to remain skewed to metropolitan areas, a significant percentage of practitioners are approaching retirement and more are choosing to work fewer hours – whilst the Australian population grows.
For many years, in both the specialist and primary health care sectors, the Australian Government has used changes in payment schedules as a way of engineering change in work practice patterns amongst doctors. In the five years following the McKay and Associates (1996), and the three years following the AMWAC (1999) Reports, no financial incentives were put in place to encourage psychiatrists to become more involved in collaborative work with GPs (Groom, 2002). The first attempts were made under the Better Outcomes in Mental Health Care Scheme (Commonwealth Department of Health & Aged Care, 2008c) to encourage collaboration between GPs and psychiatrists via multidisciplinary case conferencing. Later incentives for collaborative work by psychiatrists in the form of initial assessments and provision of management advice to consumers’ GPs, have been established under new National Action Plan on Mental Health: 2006-2011 (COAG, 2006). However, it remains unclear at time of writing whether these incentives have achieved the desired changes.

It is difficult to gain a picture of practice trends in psychiatry as total HIC/Medicare data (beyond, but inclusive of, recent Better Access figures which are only a small percentage of psychiatric practice) are not in the public domain. However, the known pattern of psychiatrists seeing patients for ongoing, often long-term/psychodynamic treatment (although they have been “cut-back” in recent years to 50 rebateable sessions per year under Medicare); their infrequent consultation and liaison with GPs; the known tendency to charge large fee gaps for patients who may not be able to afford them (Commonwealth Department of Health and Ageing, 2008c), remains undesirable. Henderson (2000) claims that this has shifted with psychotherapy now rarely being long-term; the average number of visits per patient per year being 7.2 (still large given that many may only come for 1-2 sessions), and that “psychological treatments (being used) are directed at current problems rather than achieving psychodynamic insights” (as in the past when psychoanalytic modes of treatment were emphasized in training). However, until transparent figures (HIC/Medicare statistics) are made available providing information on: numbers and diagnostic codes of patients seen, the range and median of total sessions (by disorder category) seen for, how many patients are still consulting psychiatrists under a 50-session-a-year model, what fee gaps (range, extremes and median/average) are charged, can conclusions be drawn as to what current workplace practices are and whether these have changed.
3.4 The psychological workforce

There is a two tiered approach to formal accreditation for psychologists in Australia, one building upon the other. The first of these is via compulsory registration as a Psychologist with state and territory Psychologists Registration Boards (this allows practice as a psychologist and enables recognition as a Medicare-funded “allied health worker” under the new Better Access to Mental Health Care program, ratified by the Council of Australian Governments in July 2006 and operative from November, 2006). The second is via a process of recognition (after registration) as a specialist Clinical Psychologist. Eligibility for the APS College of Clinical Psychologists is the formal criterion set by the Commonwealth for registration as a “clinical psychology provider” under the Health Insurance Commission and delivery of MBS/Medicare-rebateable services in clinical psychology (MHWAC, 2008). Specialist registration provides higher Medicare rebates than are reimbursed for generic “allied health” worker status accorded to registered psychologists.

A “psychologist” is therefore defined as “a person who is on the register maintained by a state or territory psychologists board or council to practice psychology in that state or territory” (MHWAC, 2008). The minimum qualifications/educational requirements for this are as follows:

a) a four year degree in a course approved by a state or territory registration board plus two years supervised training; or

b) a four year degree plus a two year full-time masters degree accredited by the Australian Psychology Accreditation Council (APAC).

Registration requirements vary slightly between different state/territory-based jurisdictions - shortly to change with the forthcoming move to a national system of registration.

A “clinical psychologist” is a “specialist in the assessment, diagnosis and treatment of psychological problems and mental illness” (MHWAC, 2008), and requirements entail a minimum of six years university training, including an accredited
postgraduate clinical degree and placements in psychiatric settings, plus one year of supervised experience in the clinical field (Australian Psychological Society, 2000).

Full membership of the Australian Psychological Society (APS), the largest and “peak professional association” for psychologists in Australia, requires a minimum of a four year degree and an approved two year postgraduate qualification - representing a dysfunction from Psychologists Registration Board requirements (see above). The APS represents more than 16,000 members and supports nine specialist colleges including: clinical, clinical neuro, health, counseling, community, forensic, educational and developmental, organizational and sport psychology. Some of these specialist areas are more relevant to the mental health workforce than others, with not all psychologists forming part of the mental health workforce (MHWAC, 2008). Latest APS membership figures indicate a total membership of 16,363 with category of membership breakdown as follows: 11 Honorary Fellows; 192 (1.2%) Fellows; 10,494 (64%) Members; 3,694 (22.6%) Associate Members; 257 (1.6%); 1,651 (10%) Student Members; 18 Foreign Affiliates; 17 Teacher Affiliates; 29 Professional Affiliates. Geographic distribution is discussed in Chapter 4 Rural Areas and Equity (provided by the APS; as at 2 May 2008; annual report figures are based on 31 May statistics).

3.4.1 Registered psychologists

Accurate and current information regarding the psychology labour force is hard to come by, although from figures available it seems that Australia is “largely self-reliant” ie. does not currently have a workforce shortage (see below). According to the Mental Health Workforce Advisory Committee (2008) there are two key published sources: the Australian Bureau of Statistics Labour Force Survey and the Australian Institute of Health and Welfare survey (AIHW, 2006a). The latter was carried out in 2003 and targeted psychologists via registration board records, but was subject to non-response errors. The AIHW estimate of the total number of psychologists across the five states and territories in 2003 was 16,094 psychologists. However direct enquiry of the different State Registration Boards revealed a different figure of 19,143 (see below), varying upwards to 20,105 if probationary and provisional registrants were included. Whatever the figures, the psychology
workforce is estimated to have increased (eg. in NSW by 21.4% between 2001 and 2003 – see NSW Health Workforce Development and Leadership Branch, 2003). Recent figures (from state and territory registration boards via Annual Reports and email enquiry) are as follows (reflecting full registration and excluding probationary/provisional registration).

### Table 3.5: Registered psychologists in Australia by state

<table>
<thead>
<tr>
<th>State</th>
<th>Reg at 30.6.03</th>
<th>Current Registration</th>
<th>Comments/Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACT</td>
<td>615</td>
<td>773</td>
<td>(30.6.08) Email and website</td>
</tr>
<tr>
<td>NSW</td>
<td>7,655</td>
<td>8,140</td>
<td>+ 1,399 prov. (30.6.07) Email &amp; website.</td>
</tr>
<tr>
<td>NT</td>
<td>178</td>
<td>155</td>
<td>+32 prov (31.12.06) Email &amp; website</td>
</tr>
<tr>
<td>QLD</td>
<td>2,593</td>
<td>3,416</td>
<td>+953 prob/prov. (30.6.07) Annual Report</td>
</tr>
<tr>
<td>SA</td>
<td>922</td>
<td>1,145</td>
<td>(24.1.08) Email from SA Board</td>
</tr>
<tr>
<td>TAS</td>
<td>364</td>
<td>492</td>
<td>(24.1.08) Email from Tas Board</td>
</tr>
<tr>
<td>VIC</td>
<td>4,793</td>
<td>5,972</td>
<td>(3.5.08) Email from Vic Board &amp; website</td>
</tr>
<tr>
<td>WA</td>
<td>2,184</td>
<td>2,307</td>
<td>(7.2.08) Email from WA Psych. Reg. Bd. (7.2.08)</td>
</tr>
<tr>
<td>Total</td>
<td>19,143</td>
<td>22,400</td>
<td></td>
</tr>
</tbody>
</table>

Latest registration board figures indicate a total registered psychologist workforce of 22,400. It remains unclear why these figures differ from those provided by MHWAC (2008) which indicates an estimated total workforce/fully registered psychologists as 20,774 as follows: NSW 7,716; NT 143; QLD 3,148; SA 1,070; VIC 5,370; WA 2004 (ACT and TAS are 719 and 448 respectively, inclusive of both full and provision registration). The 2005 ABS estimate of the number of employed psychologists was 13,900 (MWHAC, 2008) ie. considerably discrepant from those actually registered to practice. The most accurate data reflecting those registered and practising lies in the number registered as psychologists with Medicare. However, this figure is not publicly available (MHWAC, 2008).

Recent data indicates that the number of people completing both undergraduate and postgraduate courses in psychology has shown a steady increase between 1998 and 2005. Completion of postgraduate courses is the more accurate predictor of rates of
registration, moving into the workforce and pursuing a career as a practising psychologist, as students may complete an undergraduate degree but never pursue registration or a career in psychology (MHWAC, 2008).

### 3.4.2 Clinical psychologists

Western Australia is the only state in which specialist registration applies, although moves have been made over many years to establish this nationally and to bring state-based registration requirements in line with those used for APS membership (ie. phasing in postgraduate qualifications as the minimum criterion for professional registration and practice – see MHWAC, 2008). Of the 2,307 registered psychologists in W.A., 741 (approximately 32%) hold a specialist title, 591 (ie. approx. 26%) are registered as clinical psychologists (with some registrants holding more than one specialist title). Table 3.6 below.

Table 3.6: Specialist registration amongst Western Australian Psychologists

<table>
<thead>
<tr>
<th>Specialisation</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical</td>
<td>591</td>
</tr>
<tr>
<td>Counselling</td>
<td>71</td>
</tr>
<tr>
<td>Educational</td>
<td>13</td>
</tr>
<tr>
<td>Educational &amp; Developmental</td>
<td>15</td>
</tr>
<tr>
<td>Clinical Neuropsychological</td>
<td>14</td>
</tr>
<tr>
<td>Organisational</td>
<td>21</td>
</tr>
<tr>
<td>Sport</td>
<td>3</td>
</tr>
<tr>
<td>Forensic</td>
<td>29</td>
</tr>
</tbody>
</table>

(Source: Information provided by the Psychologists Board of Western Australia, 7 February 2008.)

Figures on numbers of clinical psychologists across the country vary, with ABS and AIHW data based on self-reports of those working as psychologists (13,900 – as mentioned above). Most accurate/“hard” figures are based on those now registered for delivery of MBS-rebateable services in clinical psychology (the criterion for which is “eligibility for the APS College of Clinical Psychologists”). As of September 2007, those eligible to provide these specialist services was 1,904 (MHWAC, 2008).
3.4.3 Characteristics of the psychology workforce

As there still are no cross-national data (given that registration is state and territory based) it remains difficult to accurately establish characteristics of the psychology workforce across the country. Queensland registrants are found to be 74.5% female and 25.5% male, with age ranges as follows: 4% under the age of 25; 30% between 25-34 years of age; 25% between 35–44; 23% between 45–54; and 18% over 55 years - figures which may be indicative of gender and age trends nationally (Psychologists Board of Queensland, 2007). The recent Mental Health Workforce Advisory Committee report endorses these findings stating that psychologists are predominantly female (with recent course completions showing little sign of this changing) with the average age in 2003 being 44.2 years with female psychologists: at average 43.2yrs, younger than their male counterparts: 48.5 years old (MHWAC, 2008). The AIHW survey (AIHW, 2006) found the majority of those surveyed who were working in the profession described themselves as working mainly as “clinicians”, with the proportion working in private practice (usually as clinicians, educational or organisational psychologists) varying from state to state as follows: Victoria 34.6%; South Australia 31.7%; ACT 27.1%; NSW 24%; and Queensland 22.9%. The majority were found at the time (2003) to be working in the public sector with the overall ratio of public sector to private sector employment being 60:40 in NSW, Queensland, SA, and the ACT (MHWAC, 2008). This differed in Victoria where only 47.1% (ie. under half) reported working mainly in the public sector. On average, in all states, those in the public sector were younger, worked longer hours and were less likely to work part-time than those in the private sector. As outlined in the Mental Health Workforce Advisory Committee Report, the advent of MBS rebates in November 2006 (which has enhanced security of work and income in the private sector) is likely to have had a significant impact on these ratios, with a greater proportion moving to the private sector. However, the exact impact on the labour force is not yet clear.

The majority of those employed as psychologists in Australia are Australian citizens and Australian born with only approximately 28%, 24% and 25% in NSW, Victoria and Queensland respectively having an alternative country of birth, the most common
of which are the UK/Ireland, other European and then Asian countries (MHWAC, 2008).

Relative to population, figures again differ from state to state: FTE (full time equivalent) rates for those working as “clinicians” varying from 35:100,000 population in South Australia to 61:100,000 in NSW and 103:100,000 in the ACT (MHWAC, 2008). Whilst there does not appear to be a current workforce shortage, uptake of psychological services under Medicare has been very high and suggests that overall demand for psychologists (and particularly for clinical psychologists) may increase – thereby putting “pressure on supply” (MHWAC, 2008). Future trends are not yet clear.

3.5 Mental Health Nursing in Australia

3.5.1 Workforce issues

In contrast to psychology, there is a definite workforce shortage in mental health nursing in Australia (MHWAC, 2008 – unpublished document). Whilst generally better distributed than other health professionals (see Chapter 4), mental health nurses (MHNs) “are in workforce shortage and appear on the current DEWR lists (Department of Employment & Workplace Relations’ Skills in Demand Lists)” (email communication from MHWAC, May 5, 2008). Analysis of nursing workforce reports between 2001-2004 indicate that the current supply of MHNs is insufficient to meet future demand, with a combination of factors determining this (ageing workforce, changing labour patterns, fewer people choosing to work in mental health, combined with increasing demand/service need). Numbers entering nursing training are too few overall (enrolments/new commencements in 2003 were 9,382) to meet projected demand (at the time, it was estimated that by 2006 between 10,182 and 13,408 new graduates would be needed) – with any shortage in nursing personnel being greater in mental health due to the issues outlined above (MHWAC, 2008 – unpublished paper).

Nurses in Australia must be either “registered” or “enrolled” with the appropriate state or territory nursing, midwifery or health practitioner board, with registration now requiring a minimum three year bachelor or postgraduate degree in nursing. “Nurse
practitioners” undertake additional education and training at an advanced level in specialty areas including mental health (MHWAC, 2008). Less well qualified enrolled nurses require only a one-year Certificate IV or Diploma (Certificate V) and usually work under the direction of registered nurses in providing care. Registered nurses are in the majority in the Australian nursing workforce as a whole; however, this differs in mental health nursing where nurses are less likely to be registered (ie. more likely to be enrolled nurses: “ENs”, are on average slightly older, and much more likely to be male than female - 33% of mental health nurses in 2004 were male compared to 7.7% of the general nursing workforce). Whilst overall employed nursing numbers increased by 11% between 1999 and 2004, the number of mental health nurses declined by 2.6% (from 14,497 to 14,123 – see figures below), the decline being offset by an 8.2% increase in average weekly working hours for MHNs from 34.1 to 36.9 hours per week (see MHWAC, 2008 – unpublished paper). This represented a slight increase in full-time-equivalents, with growth predominantly among enrolled (14.9% growth) rather than registered (2.8%) nurses.

3.5.1.1 Definition

In contrast to general nurses and midwives where role definitions are clear, the definition of “mental health nurse” is contested and varies. Some definitions are broad and encompass “nurses who indicate that their main area of nursing is in the psychiatric or mental health field, and includes both registered and enrolled nurses” (MHWAC, 2008) ie. the mental health nursing workforce contains a number of nurses who do not have this specialist education and preparation. Accurate figures in relation to MHN workforce are hard to come by. However, using this broad definition, the January 2008 Australian Institute of Health and Welfare report on the nursing workforce in 2005: “Nursing and midwifery labour force 2005 (AIHW, 2005b) indicated the following.
Table 3.7: Profile of 2005 Mental Health Nurse workforce across Australia

<table>
<thead>
<tr>
<th>State</th>
<th>NSW</th>
<th>Victoria</th>
<th>Qld</th>
<th>WA</th>
<th>SA</th>
<th>Tasmania</th>
<th>ACT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number</td>
<td>4,315</td>
<td>3,869</td>
<td>2,317</td>
<td>1,937</td>
<td>1,153</td>
<td>343</td>
<td>221</td>
</tr>
<tr>
<td>Average age</td>
<td>44.7</td>
<td>46.3</td>
<td>48.2</td>
<td>46.8</td>
<td>48.2</td>
<td>48.1</td>
<td>48.4</td>
</tr>
<tr>
<td>% male</td>
<td>33.4</td>
<td>29.1</td>
<td>31.8</td>
<td>30.1</td>
<td>32.2</td>
<td>34.8</td>
<td>28.5</td>
</tr>
<tr>
<td>% Registered</td>
<td>86.3</td>
<td>75.7</td>
<td>85.7</td>
<td>83.0</td>
<td>80.6</td>
<td>85.6</td>
<td>85.2</td>
</tr>
<tr>
<td>% postgraduate quals</td>
<td>52.6</td>
<td>50.7</td>
<td>50.1</td>
<td>41.9</td>
<td>46.6</td>
<td>49.1</td>
<td>59</td>
</tr>
<tr>
<td>Average hours per week</td>
<td>37.8</td>
<td>36.4</td>
<td>37.0</td>
<td>36.5</td>
<td>36.8</td>
<td>37.6</td>
<td>37.1</td>
</tr>
<tr>
<td>% part-time</td>
<td>25.6</td>
<td>34.5</td>
<td>29.9</td>
<td>31.1</td>
<td>28.2</td>
<td>28.1</td>
<td>32.2</td>
</tr>
<tr>
<td>Total</td>
<td>4,315</td>
<td>3,869</td>
<td>2,317</td>
<td>1,937</td>
<td>1,153</td>
<td>343</td>
<td>221</td>
</tr>
</tbody>
</table>

(Source: Data from AIHW, 2008, p. 24-37.)

The data suggested a total mental health nursing workforce of 14,155 of whom on average only 50% had post-registration/enrolment qualifications (as is required for membership of the AMHNC) and only approximately 83.2% were fully registered (many work in the state-based public sector and accurate figures on distribution are hard to come by). The Mental Health Workforce Advisory Committee March, 2008 reported slightly different figures of 14,123 MHNs in Australia, with only approximately 29% reporting completion of a post-registration or post-enrolment course of more than six months’ duration in mental health (MHWAC, 2008 – unpublished document provided for review).

3.5.1.2 ACMHN membership

The Australian College of Mental Health Nursing (ACMHN – see details below) has approximately 2,000 full members (email communication from the President, May 14, 2008) but, despite the College defining “a mental health nurse as one prepared in the specialty of mental health nursing” it is not clear how many of these members actually have formal mental health qualifications (ie. membership is therefore not necessarily a criterion of specialist training as it still does not require specialist qualifications as a mental health nurse).
3.5.1.3 Credentialing for Medicare

Fully qualified MHNs can currently provide limited Medicare services in areas such as “allied health” and “psychological services” if “credentialed”. Full credentialing by the College to practice in the Mental Health Nurse Incentive Program (MHNIP) and under Medicare is therefore the most accurate estimate of full qualifications. Requirements for some other programs such as the Better Outcomes in Mental Health Care are inconsistent and not as stringent; however, consistent criteria do apply for eligibility for MHNIP and a Medicare provider number to work with psychiatrists and general practitioners under the New Funding for Mental Health Nurses Initiative (COAG, 2006). These are set by the College’s “Credentialing for Practice Program” (MHPA, 2007) which is a separate process from application for membership (as mentioned above, the ACMHN does not require an applicant to have full specialist qualifications as a mental health nurse and hence membership does not imply automatic eligibility for a Medicare provider number: ie. “you don’t have to be credentialed to be a member and visa versa” and “you don’t have to be a member of the ACMHN to be credentialed to register with Medicare and/or take up positions in the Mental Health Nurse Incentive Program” – email communication, ACHMN, May 5, 2008). The credentialing program accredits those nurses who can “provide evidence of specialist qualifications, recency of practice and evidence of ongoing education and professional development” (email communication, ACMHN, May 14, 2008). Credentialing is voluntary, unlike with GPs or psychiatrists where training under the aegis of their Colleges is required in order to offer patients services eligible for Medicare reimbursements. ACMHN membership is not “credentialing” (ie. is not the same as medical college membership, or indeed membership of the APS College of Clinical Psychologists where membership implies endorsement of qualifications and competence to practice). Credentialing is purely voluntary and undertaken by mental health nurses to gain recognition of qualifications and as part of their professional development. It is, however, the standard that has been chosen if nurses choose to register for Medicare under allied health benefits or want to take up a position under MHNIP (which was implemented 2007).

Current figures on credentialing again vary, with the ACMHN estimating that there are 220 credentialed mental health nurses (email communication from the ACMHN,
May 6, 2008), whilst the MHWAC Report estimates only 203 nationally in March 2008 (MHWAC, 2008 – unpublished paper). The number of credentialed mental health nurses does not necessarily reflect the number who have registered with Medicare or who are working under other initiatives, as not all of those credentialed take up work options related to Medicare. Numbers practising under Medicare may therefore be even smaller than the extraordinarily small numbers who are credentialed.

3.5.2 The Australian College of Mental Health Nurses

The ACMHN is the peak professional body for mental health nurses in Australia and the only organisation representing mental health nurses and the profession of mental health nursing. The College was established as a congress in 1975, is governed by a Council, has branches in each state of Australia and “works with local stakeholders to promote mental health and mental health nursing” (MHPA, 2007). The aims of the College are to: “promote public confidence in and professional recognition of mental health nursing; set professional practice standards and encourage accountability, autonomy and partnership; provide a forum for quality education, professional development and networking; and develop and facilitate research and policy development in relation to the profession and mental health care delivery” (ACMHN, 2008). Criteria for membership of the ACMHN are as follows:

- a current licence to practice as a registered nurse in Australia;
- a specialist or postgraduate mental health nursing qualification, or demonstrate equivalence;
- minimum of three years experience as a registered nurse in mental health or 12 months experience since having undertaken a specialist/postgraduate qualification;
- recency of practice;
- continuing professional education and practice development in the preceding three years.

As outlined above, membership does not imply full credentialing.
3.5.3 Training

In relation to undergraduate training, the Mental Health Nurse Education Taskforce (MHNET), responsible for the mental health component of pre-registration nurse education across Australia, found in a series of consultation sessions with relevant nurse training universities in late 2006 that there is huge variation nationally in the amount of compulsory mental illness/disorder theory and clinical placement hours from course to course – varying from 15-359 hours (overall mean: 105.5 hours) spent on mental illness theory. Eighty percent of universities reported difficulty in obtaining sufficient mental health placements and some therefore have ceased to expect compulsory placements in this area (MHNET, 2007). Common themes of concern in the discussions (also held with state and territory nursing boards) included: therapeutic communication, supportive clinical placements, balancing mental health promotion content with illness/acute care content, university and service partnerships, cultural diversity, consumer and carer participation, recover and family inclusion, peer support and learning. From these discussions came agreement (December 2006) about the need to improve mental health content of pre-registration nursing content. Three key principles were identified as necessary in the mental health content of pre-registration curricula:

- mental health is an essential foundation for all practice nurses.
- thinking should be beyond the illness paradigm (eg. encompassing a recovery focus and illness prevention).
- a strong relationship should exist between theory, evidence and practice (MHNET, 2007).

Further, the following core values underpinning the learning and teaching of mental health nursing were articulated as follows:

a) consumers and carers have a right to participate in treatment and recovery processes;

b) stereotyping and negative images of mental illness are detrimental to treatment and recovery;

c) a therapeutic relationship is paramount to treatment and recovery;
Ch. 3: Mental Health Services in Australia

3.5.4 Overview/Summary

In light of the credentialing issues outlined above, the current mental health nursing workforce has some way to go to reach desired/specifed criteria. Given the extent to which mental health nursing has already been included as a mental health specialty under both the state (especially in NSW where there is heavy dependence on the profession) and Commonwealth sectors, the above formulation of generic principles underlying the objective of consistent, quality controlled training for registered nurses seems both extraordinarily late and generic. It may therefore be that mental health nurse training is not yet subject to the advanced “TQM” (total quality management)/evidence-based criteria established and already applying in the areas of general practice, psychiatry and clinical psychology.

3.6 New directions in collaborative care

Since 1998, and particularly in the last five years following completion of the Second National Health Plan (1998-2003), there has been an increasing emphasis on collaborative mental health care in Australia. The National Action Plan on Mental Health (2006-2011) - arising out of the Australian Government’s and the Council of Australian Governments’ (COAG) deliberations in February and July 2006, and including the Better Access Initiative – has created a new climate of (and incentives for) “team-based mental health care in the community, with allied health professionals
working alongside GPs, psychiatrists, and mental health nurses” (MHPA, 2007). Interdisciplinary collaborative mental health care involving “good communication and coordination of care to achieve best possible outcomes for the patient” is the key focus of The Better Access Initiative and indeed of much of the new Mental Health Plan. How these new initiatives (which occurred after the research outlined in this dissertation) are working “on the ground” is the focus of Chapter 8 “Further Developments”. However, it is important to emphasise that the aim of much of the recent developments in mental health policy has been to get the above four professions (psychiatrists, general practitioners, psychologists and mental health nurses) to work more closely together, to establish better liaison and communication and to ensure that the patient gets the most appropriate, early intervention for their condition. How this collaboration is to be ensured is still an open question. The Mental Health Professionals Association (MHPA) was convened in early 2006 as a way of supporting collaboration and coordination between the four key professional groups and, additionally, the appropriate use of the new (and existing) MBS/Medicare items to facilitate patient care. In 2007, the Mental Health Interdisciplinary Networking Workshop (MHINH) Project was established under MHPA to facilitate the development of interdisciplinary networks enabling general practitioners (the core of mental health care in Australia) and psychiatrists to make increasingly effective referrals to psychologists, paediatricians, social workers and occupational therapists (MHPA, 2007). After an initial seeding grant to run four pilot workshops across the country, the Commonwealth have allocated an extra $15million to the project to ensure continued focus on collaboration. The dilemma is, however, that the funding has been split/allocated four-way between all four participating professions – perhaps a process issue which might enhance, rather than diminish the “silo” phenomenon which still operates.

The project outlined in this thesis exemplifies one approach to collaborative care aimed at facilitating the best interest of both the patient and the general practitioner.
Chapter 4

RURAL AREAS AND EQUITY

Given the overall reliance of Australia on the productivity of Australia’s rural regions, the mental health needs of those located outside the metropolis is crucial to the overall wellbeing and survival of the country. There are large inequities in service provision across the country and enormous difficulty in recruiting and retaining mental health practitioners in rural, and particularly remote areas. Rural and remote mental health has therefore become a national priority. The Minister for Health, the Hon. Nicola Roxon highlighted this recently: “It’s a sign of (the new) Government’s commitment on this issue that (an) audit (of health workforce shortages in rural areas) was ordered by the Prime Minister within the first fortnight of the Government being formed” (Commonwealth Department of Health & Ageing, 2008b).

4.1 Measuring “rurality”

Definitions of rurality are complex (Jackson, Judd, Komiti, Fraser, Murray, Robins, Pattison & Wearing, 2007), with a number of authors indicating that there are dangers in attempting to study the seemingly straightforward “effects of rurality” (Judd, 2006; Roufeil & Lipzker, 2007). As rural people indicate “no two rural communities are alike” or “if you’ve seen one country town, you have seen only one country town” (Roufeil & Lipzker, 2007).

There has been considerable conceptual confusion in thinking about the dimension of “metropolitan vs. regional-rural-remote” distribution of population and “advantage/disadvantage” in Australia (Hugo, 2002). The Australian Institute of Health and Welfare defines rural and remote as “living outside cities with populations greater than 250,000” (AIHW, 2006b), but there remains dispute as to the best ways of defining and categorising “rurality” whilst recognising its variations – particularly since there are often large differences between and even within broad geographical areas.
4.1.1 RRMA vs. ARIA

Discussion of “rurality” as a concept has been confounded by two conceptually distinct aspects: “urban vs. rural” and “accessibility vs. remoteness”. Methodologies for measuring “remoteness” in Australia have therefore advanced from the earlier RRMA Classification (Rural, Remote and Metropolitan Areas), a seven-scale classification of remoteness which relies totally on population size (ie. the Statistical Local Area (SLA)). The newest system/method of classification is known as ARIA (Accessibility/ Remoteness Index of Australia), a measure which derives from the road distance between populated localities and their closest service centre and generates a “remoteness” score (see GISCA 1). ARIA therefore interprets “remoteness” as “accessibility” of urban service centres to the 11,879 inhabited towns/localities across Australia. The total of 730 service centres with populations of more than 1,000 people are categorised on the basis of initially four levels (later five and six – see below) of increasing population size.

The ARIA index has distinct advantages over the RRMA measure including “flexibility, clarity, precision and stability over time” (GISCA 1). It is now widely accepted as Australia’s “most authoritative and preferred geographic measure” of remoteness and is the current standard Australian Bureau of Statistics/ABS-endorsed measure of remoteness (GISCA 1). Road distance to service centres is the basis of classification, overcoming the lack of precision in terms such as “rural”, “remote”, “the bush”, “the outback”, etc. The earlier version of ARIA (based on four service centre levels with scores ranging from 0-12) has been superseded twice since a review in late 2003 in which population figures and spatial boundaries from the Australian Bureau of Statistics 2001 Census of Population and Housing were used. The initial ARIA has been superseded by ARIA+ (based on five service centre categories with values ranging from 0-15) and ARIA++ (based on six service centre levels, scores ranging from 0-18).

As outlined below, however, despite endorsement as the methodology of choice, use of this measure varies across profession and project making both interpretation of differing regional statistics and comparison across professions difficult. The Department of Health and Ageing (DoHA), the Royal Australian College of General
Practice (RACGP), PHC RIS (Primary Health Care Research Information Service) and others continue to use the traditional RRMA classification system despite its shortcomings.

### 4.2 An overview of rural mental health issues

Australia is an island continent of approximately 8 million square kilometres. It is a huge country - the sixth largest in the world; bigger than Western Europe (Rajkumar & Hoolahan, 2004). With a population of approximately 21½ million people (Australian Bureau of Statistics, 2008) it ranks 54th in terms of population size, below many other geographically smaller nations. It is relatively sparsely populated compared to the rest of the world - approx. 20,606,000 total population compared to a world total of approx. 6.65 billion (ABS, 2007) - and is densely urbanised, with approximately 1% of the continent containing 84% of the population clustering mainly in the key capital cities, major metropolitan, outer-metropolitan and large regional areas (Australian Bureau of Statistics, 2002). In contrast, the widespread regional, rural and remote areas (commonly referred to as “the bush” or “the outback”) have a low population density of approx. 30% ie. about 6.7 million (Australian Institute of Health & Welfare, 2006; Cresswell, 2008), unlike countries such as India and China which have huge rural populations (Rajkumar & Hoolahan, 2004). National trends have consistently highlighted the shift of people and services from rural to metropolitan areas. In 1911, 43% of Australians lived in rural areas but in 1976, the corresponding population was only 14%. The 1996 census shows that the rural population again decreased as a proportion of the total population (Australian Bureau of Statistics, 2002), although the exact proportion varies from state to state. In NSW, the most populous state of Australia, there is a sizeable proportion of people (1,427,335 – ie. 22.4% of total population) in rural areas - excluding the regional centres of the Hunter and Illawarra.

### 4.3 Risk factors and needs of rural people

Australia’s rural and remote populations have poorer health than their metropolitan counterparts, with life expectancy generally declining with increasing remoteness (more so amongst men than women). The gap is widening between urban and rural
people, with life expectancy increasing more than 20 per cent faster for residents of metropolitan local government areas, compared to rural LGAs (Cresswell, 2008b). In some parts of rural Australia, life expectancy rates actually fell during the four years to 2005, compared with average increases in that time of three years for men (to 79.8 years) and two years for women (to 84.3 years) (Cresswell, 2008b). Specifically, in NSW, it has been found that Sydney men have a life time expectancy of almost two years longer than men in outer-regional areas, a four-year difference than those in remote areas, and almost a 17 year difference for those in very remote areas. These estimates are affected by higher overall Indigenous mortality rates (on average, 17 years less than the rest of the population) as well as a possible drift/migration of the frail aged to some regional and rural areas (AMWAC, 2005).

National figures indicate that people are significantly more likely to die of heart disease if they live in rural areas with rural patients having overall poorer health as well as being disadvantaged in relation to access to new investigation technologies and treatment techniques (RDAA, 2008c). People living in rural and remote communities also have particular risk factors and mental health needs associated with isolation and exposure to environmental hazards such as drought, flood and fire. The impact of drought alone, and the consequent enormous financial stress on farming families, has been found to lead to anxiety, depression, family breakdown, grief and anger (Commonwealth Department of Health & Aged Care, 2000a). In addition, rural environments are often characterised by distance and are difficult to access and adequately service. Other stresses endemic to rural locations, apart from the unpredictability of weather (ie. deriving from the intrinsic characteristics of rural life) include: working with dangerous machinery, farming accidents, equipment breakdowns, exposure to dangerous chemicals, changing government regulations/legislation, lack of leisure time/long hours, difficulty for couples in balancing roles with necessary off-farm work increasing, etc. (Roufeil & Lipzker, 2007). There are numerous additional factors which make rural and particularly remote communities different: small groups of people, enormous areas, unpredictable socio-economic and ecological circumstances (eg. drought, flood, salinity and fire), “out-migration” of young people to cities for education and in search of work, and declining public infrastructure (eg. through bank closures). These all affect people’s lives adversely (Rajkumar & Hoolahan, 2004). Occupational hazards specific to rural
areas, sparse infrastructure (including lack of health services) and risk-taking attitudes to health, illness and behaviour are known to be more prevalent in “the outback” (for example, rural people have been found to be more prone to addictive behaviours, they consume relatively more alcohol and drink at risky levels, are more likely to smoke, be overweight and unfit - Australian Institute of Health & Welfare, 2006). These factors are also associated with lower levels of education and lower income/socioeconomic status, hardship, less access to work, high levels of stress and job insecurity (when work is available), greater exposure to possible injury in early life, low social support, ill health, unhealthy food choices and other risky practices (eg. dangerous driving). As mentioned above, on average, Australian rural people are poorer and attain lower levels of education than people in urban areas: 56% of rural households fall into the two lower income quintiles, compared to 36% of capital city households and 45% of “other urban” households (Australian Bureau of Statistics, 2002). In rural and remote communities the cost of basic food is often up to at least 10% higher than in metropolitan and regional centres, giving a “double deprivation” effect, resulting from lower levels of income combined with higher basic costs. Lower levels of education and higher levels of poverty are reflected in poor physical and mental health status (Wainer & Chesters, 2000).

4.3.1 Social exclusion

The factors outlined above combine to create what is termed ‘social exclusion’ within a community, a shorthand term to describe what can happen when people (or areas) suffer from a combination of linked problems such as unemployment, poor skills, low incomes, poor housing, high crime, bad health and family breakdown. Such social exclusion disadvantages communities in many ways and rural communities are considered to be the most socially disadvantaged in relation to any global index (Saunders, 2003; Shucksmith, 2008; ASU, 2007).

It remains unclear, therefore, whether the “rural-urban” health status differential and the determinants of ill health in rural areas are due to characteristics intrinsic to rural locations, environments, lifestyles and occupations, or whether they are shared with urban residents from similar demographic, occupational, ethnic/racial, socioeconomic or educational backgrounds (Smith, Humphreys & Wilson, 2008), ie. whether it is
largely due to poverty or to geographic location. The World Health Organisation indicates that poverty is a major contributor to illness stating “ill health is both a cause and a consequence of poverty. Illness can reduce household saving, lower earning ability, reduce productivity and lead to a diminished quality of life – thus creating perpetuating poverty” (World Health Organisation, 1999). It is an open question as to whether the effects are due to socioeconomic disadvantage or to “rurality” per se.

4.4 Indigenous Australians

It is well known that indigenous Australians have considerably higher general health mortality rates and, specifically, a significantly higher incidence of serious mental health problems associated with social disadvantage (Hunter, 2007). Indigenous men and women are hospitalised for mental health disorders at 2 and 1.5 (respectively) times the rate of non-indigenous people (AIHW, 2006b). Health, education and employment have recently been made the Government’s “No. 1 focus” in Aboriginal affairs (Franklin, 2008), including an emphasis on urban Aboriginal poverty whilst also continuation of the “Northern Territory intervention” which focused purely on the plight of indigenous people in remote areas (and particularly the “alcohol-fuelled sexual and physical abuse of children” (Franklin, 2008)). Recent figures have indicated that levels of Aboriginal disadvantage and poverty in the cities and remote areas are not dissimilar (Franklin, 2008). However, educational standards in remote indigenous populations are poorer than those in urban areas, and both are well below those in the general community. Jenny Macklin, the Indigenous Affairs Minister, has recently indicated that “the gap (between indigenous and other sectors of the community) in health, education and other social standards is very serious in cities and extremely serious in remote areas”. What is not clear is the extent to which indigenous health statistics influence the overall picture of health disadvantage in rural Australia. It is therefore important to attempt to isolate and separate out issues specific to indigenous people whose population is relatively concentrated in rural areas.

Australia ranks bottom in relation to first world nations working to improve the health and life expectancy of their indigenous people (Oxfam, 2007), and the gap between outcomes for indigenous peoples and other Australians is wide (Productivity
Commission, 2005). It is, however, still difficult to gain accurate data on indigenous communities and populations in Australia. At the 2001 Census, approximately 2.4% of Australians identified themselves as Aboriginal or Torres Strait Islander (Australian Bureau of Statistics, 2001), however, others suggest that their numbers have steadily reduced to only 1.5% of the population (Henderson, 2000). They are not evenly represented across Australia, tending to make up a larger proportion of the population in rural and remote areas (Hordacre et al., 2007). The median age of the aboriginal population (21 years) is significantly younger than the non-indigenous population (36 years), with key national health data indicating that Aboriginal and Torres Strait Islanders die nearly 20 years younger than non-indigenous Australians (unlike the USA, Canada and New Zealand where the gap is 7 years). Infant mortality rate is three times the rate of non-indigenous Australians and more than 50% higher than similar statistics in the USA and New Zealand (Oxfam, 2007). Specific diseases, neoplasms/tumors, ischaemic heart disease, cerebrovascular disease, diseases of the lung and respiratory tract, pneumonia and influenza, diabetes, intentional self-harm and assault are all significantly higher than in the non-indigenous population (ranging from 1.27 times higher for tumors to 5.57 times higher for assault and 9.8 for diabetes – see Oxfam, 2007 for specific health indicators). Socioeconomic and environmental factors contribute to the lower life expectancy and health status, with indigenous Australians also having a higher incidence of risky behaviours (such as smoking and alcohol consumption) and greater prevalence of chronic diseases - as mentioned above (Hordacre et al., 2007).

It is difficult to factor out aboriginal health issues when looking at overall averages in relation to poor health mortality rates in rural areas. What is clear however, is that the psychological and behavioural problems emerging in response to indigenous poor social conditions are often compounded by inadequate, often culturally insensitive, narrowly focused mental health services (Hunter, 2007), with children being a particularly vulnerable target group for whom specialist mental health services are under-resourced, if not unavailable (O’Kane & Tsey, 2004). Their plight illustrates a stark exacerbation of the disadvantage experienced by the rural, remote and very remote population in general, whilst having its own unique features specific to indigenous circumstances. The higher proportion of indigenous Australians living in
remote areas contributes to but does not completely account for the generally poorer health of Australia’s rural and remote population (AIHW, 2008b).

4.5 Incidence of mental (and other) health issues in rural communities

As outlined in Chapter 1, the National Survey of Mental Health and Wellbeing of Adults (Australian Bureau of Statistics, 1997) indicated that mental health is a significant health issue in Australia with almost 1 in 5 people suffering from a mental disorder in a 12 month period. One of the key limitations, however, of the survey was that rural, remote and indigenous groups were not included (Henderson, 2002; Whiteford, 2000). Accurate data on the distribution and determinants of mental health and wellbeing in rural and remote populations in Australia is therefore unavailable. Research findings, however, do suggest that there is a significant “rural-urban” health status differential and that a number of key/focal health issues in rural and particularly remote areas require special attention and intervention: comorbid mental health and A&OD disorders (Commonwealth Department of Health and Family Services, 1997; Bryce, Rowse & Scrimgeour, 1992), higher levels of attempted and completed suicide (Wainer & Chesters, 2000), unique pressures amongst farming communities (Larson, 2002; Rajkumar & Hoolahan, 2004) and indigenous mental health issues. There are more indigenous people residing in rural areas than in cities and, as is well known, consistent evidence suggests that the health of indigenous people is significantly poorer, with higher rates of serious mental disorders/mental health problems and A&OD disorders than in the non-indigenous population (Hunter, 2007; Roufeil & Lipzker, 2007). Research findings also indicate that rural women in remote areas are more exposed to violence in personal relationships than urban women (physical and sexual violence against women are well documented as determinants of poor mental health) and many are isolated without public transport. Both females and males aged 20-29 in rural/remote areas are twice as likely to consume alcohol in hazardous or harmful quantities (Commonwealth Department of Health & Family Services, 1997) when compared to their metropolitan counterparts (alcohol has been implicated in up to 50% of all suicides in Australia). Suicide rates amongst rural communities are known to be consistently higher than in urban communities, research findings indicating between 1988 and 1998 a rate of 17 per 100,000 in rural and remote communities compared to 13 per 100,000 in urban localities. Risk factors for suicide
include higher levels of alcohol and other drug (A&OD) consumption, social pressures unique to the bush (eg. higher rates of unemployment); changes in community infrastructure (eg. bank closures); decline in prosperity and economic collapse of farms in Australia (a 25% reduction in farm numbers has occurred in the past 25 years). A combination of drought and financial burden saw 15 families walk off their farms every week in 2001-2002 with 20% of families surviving on less than $10,000 a year (Central Western Daily, 2002). In addition; higher levels of gun ownership in rural and remote regions impact on suicide method and completion rates (male farm managers and agricultural labourers have been found to have higher suicide rates, particularly later in life (Wainer & Chesters, 2000; Page & Fragar, 2002).

### 4.6 Equity of access to services

As outlined above, and contrary to myth, people living in rural and remote areas have generally worse health than those living in metropolitan areas. On average, rural Australians live three years less than those living in cities. Indigenous Australians are particularly afflicted having higher rates of chronic disease and living on average 17 years less than city dwelling Australians (Rural Doctors Association, 2008a). They generally manifest higher levels of disability and mortality and score lower on a number of different health indices (AIHW, 2006b). In addition, distance and difficulties in communication have led to inequities in health service provision for those outside cities, many of whom are Aboriginal and Torres Strait Islanders (Rajkumar & Hoolahan, 2004). Recruitment to and retention of health-professionals (GPs, medical specialists, psychologists and others) in regional, rural and remote communities in Australia are major challenges, with the majority of health service providers residing and working in the large cities. Access to appropriate specialist mental health professionals, in particular, is extremely limited once one moves beyond the main metropolitan centres and rural residence has been found to be negatively associated with frequency of use of both psychologists and psychiatric services (Parslow & Jorm, 2000). In addition, the incidence of psychological/mental health problems managed by GPs per 1,000 population decreased significantly outside the major capital cities (Caldwell, Jorm & Dear, 2004) suggesting either a lack of presentation or unwillingness to deal with these complex issues, for which little help
is available. Both help-seeking and service utilisation rates (ie. actual presentation to treatment and use of mental health services) for mental health issues are lower in rural areas (Jackson et al., 2007), with those suffering from mental health difficulties facing more barriers to help-seeking than their metropolitan counterparts. These include, as outlined: poor availability and accessibility of services as well as a number of different characteristics specific to rural communities such as lack of choice amongst health providers, high workload of available GPs, geographic distance (as mentioned above), lack of knowledge about and negative view of mental health problems (and/or practitioners) by those living in rural areas and amongst their social network (Jackson et al., 2007). The self-sufficiency, self-reliance and stoicim known to be characteristic of rural communities (Griffiths & Christensen, 2007), strict boundaries on self-disclosure (eg. “what is considered family is private business” (Roufeil & Lipzker, 2007)), and the limited anonymity present in smaller towns – all act as disincentives to help-seeking (Boyd et al., 2008). The small size of country communities (ie. the “small town” phenomenon) impacts both on client privacy and on “boundary issues” for practitioners, with concerns about confidentiality acting as a further disincentive to accessing help. The issue of stigma in relation to mental health issues remains a key factor in people’s postponement or avoidance of getting help, particularly in small rural communities where it is thought that “everyone knows everyone else’s business”. Sensitivity to such common belief systems and knowledge of “rural culture” is crucial in successfully providing help, whilst remaining aware of dangers inherent in false stereotyping of this population.

Most people, both in rural and metropolitan areas, have been found to be more likely to seek help from a GP than a mental health professional, particularly amongst those with lower educational levels (Tijhuis, Peters & Foets, 1990), with consultation rates amongst women being considerably higher than those of men. Gunnell and Martin (2004) found that rural male subjects were 30% less likely to consult a GP than their urban counterparts and rural female subjects 16% less likely to do so. They attribute the difference to a greater perceived stigma associated with help-seeking amongst men than amongst women. (Gunnell & Martin, 2004).
4.7 Mental health specialities

The Australian rural experience indicates that there has been a long term problem in attracting medical practitioners to rural areas (AMWAC, 1996), with access to psychiatrists a uniformly major problem (AMWAC, 1999b). Overall, professions such as psychiatry, psychology, and even general medicine are largely absent in non-metropolitan areas of the country. Some research indicates that only approximately 4% of psychiatrists practice in rural and remote areas (McEwin, 1997; Fraser, Judd, Jackson, Murray, Humphrey & Hodgins, 2001; Australian Institute of Health & Welfare, 2003), and other mental health specialties are similarly under-represented. The establishment of a network of University Departments of Rural Health and Rural Clinical Schools across Australia (eg. the Monash University Department of Rural and Indigenous Health; the University of Newcastle’s Rural Mental Health Unit: the Centre for Rural and Remote Mental Health) has been one of a number of initiatives to remedy this imbalance. Amongst these are specific local actions, such as at Latrobe Regional Hospital, Gippsland, where recruitment systems have been improved (by providing proper orientation; individual and family support and ongoing educational initiatives, etc.) to the extent that recruitment/retention rates for psychiatrists have increased dramatically. In this specific situation recruitment increased between 1994 and 2006 from 1 to 11 full-time psychiatrists; with retention improving from an average of 18 months to 4 years (Wilks, Oakley-Browne & Jenner, 2008). However, despite these pockets of success, in practice, availability of appropriately qualified and skilled personnel and services remains woefully inadequate.

Despite rural health, and specifically mental health, having been a key national priority for a number of years, there is still no coherent map of how and where services are distributed and provided. Data are dispersed and, for a number of the key professions old (eg. despite recent release/publication of information on the “nursing and midwifery labour force” - AIHW, 2008a - figures used are at least three years old - 2005 data form the basis of the Report). There is little accurate analysis of data across professions enabling easy comprehension (and comparison) of the spread of practitioners in rural areas. The emergence of MHPA (Mental Health Professionals’ Association of Australia) in early 2006, (following the advent of “Better Access”, a new initiative developed after mental health was identified as an issue of national
significance by the Council of Australian Governments (COAG) in February 2006), was proposed as a way of supporting coordination and collaboration between the four key professional groups involved in mental health care: psychiatry, general practice, psychology and mental health nursing (MHPA, 2007). At least two years later, however, there is little indication of an understanding of the real relative distribution of these four professions, and the key initial project of MHPA: MHINP (Mental Health Interdisciplinary Networks Project) seems to have been slow to progress after four initial pilot workshops run in different locations across the country in late 2007 (see http://mhpa.org.au/content/view/17/1/#4). It is clear that a “systemic understanding” of collaborative, cross-professional mental health service delivery in rural (as well as metropolitan) areas is still some way off.

To find data relating to distribution of mental health practitioners in regional, rural and remote Australia still requires independent study of each of the four key mental health specialities. What becomes clear in doing this is that: most professions still do not consistently/systematically track “RRR distribution” (eg. the Psychologists Registration Boards across Australia do not implement any form of ARIA or even RRMA breakdown of registrands); data are dispersed across a number of different locations/organisations (eg. AMWAC, MHWAC, AIHW, PHC RIS – amongst others); and that, when geographic distribution is considered, professions vary in their use of new ARIA frameworks (eg. RRMA mapping is still used by some within the National Rural Faculty of the RACGPs (Lawrance, 2008); and indeed by PHC RIS in its Annual Survey of Divisions of General Practice (Hordacre et al., 2007). Those responsible for coordinating figures within specific professions indicate for example (amongst others), “the tricky and confusing situation regarding figures on GP distribution” (email communication from PRC RIS – Primary Health Care Research and Information Service, March 25, 2008); “the figures are somewhat old but unfortunately that’s what we have to deal with – stats that are 3 or 4 years old by the time they’re published” (email communication, RCNA (Royal College of Nursing, Australia), March 11, 2008); “there are no statistics available regarding metropolitan vs rural psychologists” (email communication, SAPRB (South Australian Psychologists Registration Board), January 24, 2008); “we are not able to provide any of the further information you require” (email communication, PRBT (Psychologists Registration Board of Tasmania), January 24, 2008), and “I am unable to break this
figure down into metro/regional/rural/remote locations” (email communication, PBWA (Psychologists Board of Western Australia), February 6, 2008).

Information in relation to each of the four mental health specialities follows:

4.7.1 Psychiatry

As outlined in Chapter 3, the psychiatric workforce is unevenly spread in Australia with undue concentration in capital cities and vastly inadequate access in rural areas (AMWAC, 1999b; MHWAC, 2008a). Analysis of postcodes of practising psychiatrists and their patients from 1999 and 2002 Health Insurance Commission data has indicated that most psychiatrists practising under Medicare are located in the “leafy” (ie. well to do) suburbs of Sydney, Melbourne and Adelaide. Patients accessing these services were also found to be similarly concentrated in the higher socioeconomic areas of metropolitan centres. In 2004, it was estimated that 3,151 psychiatrists were employed in Australia (or 3,392 FTE’s based on a 38 hour week). The majority (90.1%) were found to work in a major city where a psychiatrist population ratio of 22 FTE (employed psychiatrists and psychiatrists-in-training) per 100,000 was indicated, in comparison with figures of 6, 3 and 3 per 100,000 population in “inner regional”, “outer regional” and “remote and very remote” areas respectively (MHWAC, 2008). Approximately 5% of those residing in capital cities were found to provide services, at least part-time, in outer regional, remote or very remote areas (RANZCP, 2007). However, people outside major cities clearly have less access to psychiatric services, and those who do see psychiatrists. This pattern is disturbing in light of psychiatry being, until very recently, the only mental health specialty publicly funded under Medicare.

It is hard to produce accurate data on the rural psychiatry workforce, as numbers are extremely hard to come by and continually change. In the late 1990’s it was estimated (as mentioned above) that approximately 4-8% of the nation’s approximate 1,800 psychiatrists (this figure varies from study to study) lived and practiced in rural areas, with the ratio of psychiatrists to population in rural NSW being found to be 1:10,000 (McEwin, 1997). The recommended number of available psychiatrists in rural NSW was 143 whilst the actual number was 41 (McEwin, 1997).
In 2003, the total number of psychiatrists based in rural Australia was estimated at 114 (Vines, Tonna, Merrell & Martin, 2004, p.4) with data from South Australia indicating only one rural resident psychiatrist living outside the metropolitan area and in Tasmania, three rural resident psychiatrists based at Burnie, with three additional vacant positions which had been previously occupied.

Data from NSW were as follows (Earle, 2003).

<table>
<thead>
<tr>
<th>AREA</th>
<th>Resident Psychiatrists</th>
<th>Outreach Psychiatrists</th>
<th>Area of Need Psychiatrists</th>
<th>Rural Trainees</th>
<th>Trainees on rotation</th>
<th>CMOs</th>
<th>RMOs</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Northern Rivers</td>
<td>12</td>
<td>4</td>
<td>1</td>
<td>3</td>
<td></td>
<td></td>
<td></td>
<td>20</td>
</tr>
<tr>
<td>Mid North Coast</td>
<td>11</td>
<td>15</td>
<td>3</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>29</td>
</tr>
<tr>
<td>New England</td>
<td>2</td>
<td>8</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td></td>
<td>13</td>
</tr>
<tr>
<td>Macquarie</td>
<td>9</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>10</td>
</tr>
<tr>
<td>Mid West</td>
<td>6</td>
<td>7</td>
<td>2</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td></td>
<td>19</td>
</tr>
<tr>
<td>Far West</td>
<td>1</td>
<td>9</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>10</td>
</tr>
<tr>
<td>Southern</td>
<td>14</td>
<td></td>
<td>1</td>
<td>3</td>
<td></td>
<td></td>
<td></td>
<td>18</td>
</tr>
<tr>
<td>Greater Murray</td>
<td>6</td>
<td>11</td>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td>18</td>
</tr>
<tr>
<td>TOTAL</td>
<td>38</td>
<td>77</td>
<td>1</td>
<td>6</td>
<td>6</td>
<td>8</td>
<td>2</td>
<td>138</td>
</tr>
</tbody>
</table>

(Table supplied by RANZCP – NSW Branch Rural Psychiatry Projects to the “Support Scheme for Rural Specialists Project: July 2003-March 2004”; NB Numbers approximate only, subject to change.)

Data from other states were not readily available in 2003 (apart from South Australia and Tasmania – as above), although information suggested distributions similar to NSW at the time with the vast majority of psychiatrists living in metropolitan areas.
Recent figures, however, from the RANZCP indicate that:

“In 2007, the College had approximately 440 Fellows (out of 2,310) with either a rural/regional postcode (188 – ie. 8.1%) in Australia or who provided outreach services but did not live in the rural area (252 – ie. 10.9%). At any time there are up to 60 trainees across 33 rural/regional sites that might be performing a rural rotation which lasts for 6 months but these fluctuate from month to month. Currently the College has approximately 150 registered overseas trained psychiatrists that are attempting to become a College Fellow; on average approximately 20-30% are in rural or regional areas but again are a mobile bunch and the numbers fluctuate. Again this does not include overseas trained psychiatrists that are here on business visas and do not intend to stay in the country” (email communication, RANZCP, March 27, 2008).

Most recent findings (MHWAC, 2008a) suggest that rural residents are less than half as likely to receive services from a private psychiatrist than those residing in a capital city and that, when they do see a psychiatrist, they have approximately 1/3 less consultations (Department of Health & Ageing, 2005). As with GPs (see below), Overseas Trained Psychiatrists (OTPs) provide some psychiatric services in Australia, and may be disproportionately represented in rural areas to redress the imbalance (MHWAC, 2008a). However, accurate figures on this are not readily available.

Recent findings also indicate that the maldistribution of psychiatrists between urban and rural areas varies between and within states and territories, with South Australia, WA and Victoria being most heavily skewed to the cities (MHWAC, 2008a), unlike NSW and Queensland which have relatively larger regional workforces (despite the findings above). Victoria, with approximately 25% of the Australian population has 29% of RANZCP members who generate approximately 1/3 of all Medicare psychiatric services – indicating a higher (over?) level of servicing relative to other states; whereas in NSW the proportion of College members residing and practising in the state corresponds closely with the proportion of the Australian population, with level of Medicare services being proportionately slightly less (MHWAC, 2008a).

The consequences of such low numbers of the profession based in rural areas are numerous and include: enormous pressure on those in the profession outside the metropolitan context; long waiting lists for patients to access services; and little time
or opportunity for professional development and networking; factors found to be associated with retention of the rural health workforce. De-skilling can result from ongoing practice without access to evidence-based training, and lack of up-to-date knowledge of clinically relevant research specific to the rural context can place the practitioner at ethical and professional risk. A key task therefore, with both recruitment and retention in mind, is to provide professional development support structures for psychiatrists practising outside the mainstream metropolitan context. The trial at Latrobe Regional Hospital (Wilks, Oakley-Browne & Jenner, 2008) and the Support Scheme for Rural Specialists RANZCP Tutorial Supported Refresher Program for Rural Psychiatrists (Vines, Tonna et al., 2004) provide examples.

As indicated in the table, a considerable number of psychiatrists (in NSW and elsewhere), provide outreach services on a “fly-in fly-out” basis to rural areas where the majority of their case load is located, whilst still living in a metropolitan area. (Earle, 2003; RANZCP- NSW Branch Rural Psychiatry Project). Many people located in regional and rural areas indicate that this model of mental health service delivery is inadequate, as there is often little understanding of local issues, dynamics and needs, frequent lack of availability (ie. between visits) and poor service continuity. Relative effectiveness needs to be evaluated.

4.7.2 Psychology

In 2000, the estimated psychologist workforce in NSW was 4,785.4 FTE (full-time equivalents), approximately 85.3% of whom were found to be located in metropolitan areas, with only 14.2% (ie. approx. 680) reporting their main job-location in regional, rural and remote areas of the state. Later figures suggest an increase, with the 2004 National Allied Workforce Report (citing 2003 figures) indicating that approximately 20.5% of psychologists work in rural and remote regions, equating to 0.83 psychologists per 10,000 population in very remote areas, as compared to 3.44 per 10,000 in inner regional centres, and 5.92 psychologists per 10,000 in major capital cities (National Rural Health Alliance, 2004). Current figures from the Australian Psychological Society (the national peak professional body) indicate that from a total membership of 15,536 in 2007 (membership has expanded to over 16,000 at time of writing, 2008), approximately 20.13% (ie. 3,128) reside and practice outside the
“major metropolitan”, “suburban” and “larger regional centres” - in the three geographic categories of “regional centres” (12.5%; 1,946 members), “outer regional/rural centres” (6.5%; 1,009), and remote areas” (1.1%; 173). If only “outer regional/rural centres” and “remote areas” are taken into account (ie. truly “rural and remote”) the statistic reduces to 7.6% (ie. 1,182 practitioners). (NB. Figures provided to the APS Board of Directors’ Professional Practice Advisory Group – 14 February 2008).

These figures represent a slight decline from 2004 when, of the total APS membership of 11,520 (inclusive of associate members), 22% (ie. 2,544) were located in regional, rural and remote areas (see Tables 4.2 & 4.3 below).

<table>
<thead>
<tr>
<th>Metropolitan No. No.</th>
<th>%</th>
<th>Rural No. No.</th>
<th>%</th>
<th>Total</th>
<th>Total Registered as at</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACT</td>
<td>a</td>
<td>227</td>
<td>100</td>
<td>-</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>b</td>
<td>279</td>
<td>100</td>
<td>-</td>
<td>0</td>
</tr>
<tr>
<td>NSW</td>
<td>a</td>
<td>2,571</td>
<td>83</td>
<td>523</td>
<td>17</td>
</tr>
<tr>
<td></td>
<td>b</td>
<td>3,240</td>
<td>82</td>
<td>694</td>
<td>18</td>
</tr>
<tr>
<td>NT</td>
<td>a</td>
<td>35</td>
<td>88</td>
<td>5</td>
<td>13</td>
</tr>
<tr>
<td></td>
<td>b</td>
<td>36</td>
<td>86</td>
<td>6</td>
<td>14</td>
</tr>
<tr>
<td>QLD</td>
<td>a</td>
<td>389</td>
<td>31</td>
<td>870</td>
<td>69</td>
</tr>
<tr>
<td></td>
<td>b</td>
<td>520</td>
<td>30</td>
<td>1,205</td>
<td>70</td>
</tr>
<tr>
<td>SA</td>
<td>a</td>
<td>447</td>
<td>94</td>
<td>28</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>b</td>
<td>528</td>
<td>94</td>
<td>35</td>
<td>6</td>
</tr>
<tr>
<td>TAS</td>
<td>a</td>
<td>40</td>
<td>21</td>
<td>148</td>
<td>79</td>
</tr>
<tr>
<td></td>
<td>b</td>
<td>43</td>
<td>21</td>
<td>164</td>
<td>79</td>
</tr>
<tr>
<td>VIC</td>
<td>a</td>
<td>2,996</td>
<td>91</td>
<td>280</td>
<td>9</td>
</tr>
<tr>
<td></td>
<td>b</td>
<td>3,608</td>
<td>91</td>
<td>354</td>
<td>9</td>
</tr>
<tr>
<td>WA</td>
<td>a</td>
<td>612</td>
<td>89</td>
<td>74</td>
<td>11</td>
</tr>
<tr>
<td></td>
<td>b</td>
<td>722</td>
<td>89</td>
<td>86</td>
<td>11</td>
</tr>
<tr>
<td>TOTAL</td>
<td>a</td>
<td>7,317</td>
<td>79</td>
<td>1,928</td>
<td>21</td>
</tr>
<tr>
<td></td>
<td>b</td>
<td>8,976</td>
<td>78</td>
<td>2,544</td>
<td>22</td>
</tr>
</tbody>
</table>

In 2004, of the nine specialist APS Colleges, 18.67% (ie. 685) of the total college membership of 3,670 were in rural areas. However, this was largely due to skews in both Queensland and Tasmania where many more college members reside and work outside the capital cities than in other states (see Table 4.3).
### Table 4.3: Metropolitan vs rural split of APS College memberships

| College Type          | Sydney | Non-Sydney | Melbourne | Non-Melbourne | Brisbane | Non-Brisbane | Perth | Non-Perth | Hobart | Non-Hobart | Darwin | Non-Darwin | Canberra | Non-Darwin | Adelaide | Non-Adelaide | TOTAL |
|-----------------------|--------|------------|-----------|---------------|----------|--------------|-------|-----------|--------|------------|--------|------------|---------|------------|---------|--------------|--------|---------------|-------|
| Clinical Neuro        | 72     | 4          | 95        | 3             | 6        | 27           | 9     | 7         | 10     | 7          | 1      | 1          | 1       | 1           | 16     | 7             | 241   |
| Clinical              | 384    | 60         | 378       | 10            | 53       | 109          | 71    | 1         | 10     | 35         | 1      | 1          | 29      | 1           | 71     | 16            | 1,233 |
| Community             | 15     | 3          | 37        | 2             | 8        | 5            | 21    | 1         | 1      | 3          | 1      | 1          | 29      | 2           | 71     | 2             | 93    |
| Counselling &         | 137    | 36         | 402       | 15            | 12       | 47           | 22    | 3         | 2      | 3          | 2      | 1          | 9       | 4           | 702    | 2             | 324   |
| Educational &         | 46     | 10         | 160       | 15            | 12       | 31           | 27    | 3         | 1      | 3          | 3      | 1          | 9       | 4           | 274    | 2             | 274   |
| Developmental         | 93     | 17         | 66        | 5             | 15       | 31           | 14    | 3         | 3      | 10         | 10     | 1          | 22      | 5           | 435    | 94            | 435   |
| Forensic              | 49     | 8          | 111       | 5             | 5        | 36           | 6     | 2         | 3      | 10         | 23     | 1          | 9       | 5           | 274    | 2             | 274   |
| Health                | 164    | 9          | 118       | 5             | 5        | 39           | 32    | 4         | 3      | 1          | 23     | 1          | 22      | 11          | 435    | 94            | 435   |
| Organisational        | 18     | 1          | 25        | 2             | 3        | 17           | 7     | 1         | 1      | 1          | 1      | 1          | 4       | 1           | 10     | 1             | 94    |
| Sports                |        |            |           |               |          |              |       |           |         |            |        |            |         |             |        |               | 7     |
| TOTAL                 | 978    | 148        | 1,392     | 93            | 125      | 342          | 209   | 16        | 76     | 76         | 5      | 3          | 65      | 11          | 191    | 7             | 3,670 |

Of the Colleges most relevant to mental health service provision (Clinical, Clinical Neuro, Health, Counselling and Forensic), 18.98% of the total 2,724 members were found to be in non-metropolitan areas, again reflecting the skew mentioned above. 19.14% (ie. 236 members) of clinical college membership (total: 1,233) were found to be “non-metropolitan”. (NB. it is not clear whether these figures are a “true reflection” of the situation, given that at the time of analysis the “metro vs rural” split was decidedly “arbitrary” - ie. postcode allocation was not ARIA-based).*

Interestingly, (as alluded to above) neither the APS nor the Psychologists’ Registration Boards consistently keep figures relevant to geographic distribution of psychologists and specialist psychologists across the metropolitan vs. regional/rural/remote (“RRR”) divide. Recent communication (late January 2008) with all eight Psychologists Registration Boards across Australia has revealed that

---

* Data and information provided by the APS Manager of APS Units – personal communication: July 2004 and March 2008. 2007/2008 college figures/analyses were not available at time of writing. Since overall APS membership has increased to over 16,000 members (ie. by 28%) since the earlier analysis, the real college member distribution may now vary from that described. However, these are “best estimates” available.
none keep accurate statistics on geographic distribution and only the Victorian Registration Board suggested that approximately 16% of their registrants live and work in “rural areas”. The other Boards can provide no estimates/figures at all. This is surprising, given the increasing health policy emphasis on service provision in “RRR” areas over the past decade, and the recent allocation of Medicare rebates to psychological services which need to be tracked geographically to ensure that rural policy objectives are met.

As is manifest above, estimates vary according to study and source of the data. State-based (2003) figures from an Australian Institute of Health and Welfare study (AIHW, 2006a) indicate geographic spread of registered psychologists differs across state jurisdictions with the estimated proportion working primarily in a “metropolitan” (major city and inner regional) area varying from 86.9% in Queensland to 98.3% in Victoria (NSW: 97.4%; SA: 96.1%; ACT: 100%)

Latest figures from an APS Medicare provider survey (circulated 27 March 2008; responses: N=2,381) showed a distribution of Medicare practitioners in the following geographic categories as follows: 72% in “major metropolitan” areas; 7% in “outer suburban – major city”; 13% in “major regional centre”; 7% in “outer regional/rural centre” and 1% in the “remote” category (figures provided by the APS, May 2, 2008). This indicates that 21% of total respondents to the survey were practicing outside the capital/major cities. However, the survey sample may have been skewed due to response being voluntary and the questions included (eg. about geographic location and fee gaps charged) may have discouraged some urban-based practitioners from responding.

More accurate data are those derived from Commonwealth Government HIC data which indicate geographic distribution of “psychological therapy services” (ie. clinical psychology) Medicare items as follows: 80% located in “capital city”; 7% “outer metro”; 4% “large rural”; 3% small rural; 5% “other rural”; 0.2% “remote centre”; 0.2% “other remote” (ie. 87% city vs. 13% rural distribution). “Focused psychological therapy” (ie. general psychology) Medicare items were found to have a 79.6% city vs. 20.4% rural distribution as follows: 69% “capital city”; 10% “outer
Amongst psychologists who do locate to rural areas, it is often the youngest and least experienced health practitioners who do so, probably as a consequence of high levels of competition for metropolitan positions. Rural psychologists are frequently under pressure to be generalists due to both high demand for their services and lack of alternative, broad-ranging services. In addition, professional development, supervision and networking opportunities are difficult to access, whilst far more readily available in metropolitan contexts. This creates a frequent “double-effect” of lack of expertise combined with lack of support (Roufeil & Lipzker, 2007). The “small town” phenomenon also means that if they too have personal or emotional issues to deal with (including work stress), there is very little way of obtaining confidential help and support.

As is well known (and has been discussed previously) psychological services, both in metropolitan and rural locations, were not publicly funded under Medicare until very recently (from November 2006). Access was therefore limited and inequitably available. This was particularly the case in rural areas where few positions for practising psychologists were provided by either the State or Commonwealth Health Departments. The majority of professional positions in rural areas were to be found in academic/university departments, other institutions/environments (eg. Community Health Centres where staff numbers have shrunk consistently over the past decade) and in fee-paying private practice. Access to psychological services was therefore skewed towards those who could afford to pay and, given that people in rural areas are both more prone to mental health risk factors and more likely to be in the lower socioeconomic levels, the effect of this lack of publicly-funded services was starkly apparent. Over the past decade, Federal initiatives such as MAHS (the “More Access to Allied Health Services” program) and BOMHC (“Better Outcomes in Mental Health Care”) – outlined in Chapter 1 – have had a positive effect in at least some rural communities during the past six-eight years. However, prior to this time, however, there was very little available. (This was one of the key factors in 1998 which precipitated the research project outlined in this dissertation - designed as a
way of obtaining scarce Commonwealth funding via research for “pro-bono” service delivery in at least a few under-serviced regional, rural and remote areas.)

4.7.3 General Practice

In real terms, GPs are the first point of contact many Australians have with our health care system (AMWAC, 2005) and they most frequently receive the brunt of formal mental health presentations in rural areas. However, waiting lists in rural General Practice are long and costs for patients can be prohibitive as many local GPs do not bulk bill. Despite this, recent estimates indicate that 20 years ago there was a relatively small differential of 20% in earnings between a rural GP and city specialist; with the gap now having widened to 200-250%, making one in five rural practices not economically viable (RDA, 2008a)

It is difficult to obtain accurate estimates of percentages of practising doctors outside metropolitan areas. AMWAC (2005) indicates that 70.4% of the General Practice workforce are located in major cities, with 29.6% residing and working in regional, rural and remote areas. November 2003 figures, however, indicated that only approximately 19-20% of the nation’s approximate 22,000 registered GPs are to be found practising in rural and remote locations of Australia (ie. a total of 4,074 registered GPs; 70.3% of whom were males, 29.7% female). As outlined in Chapter 3, latest figures from the Annual Survey of Divisions of General Practice: 2005-2006 (Hordacre et al., 2007) indicate that 18% of the nation’s 22,564 GPs (ie. approximately 4,062 doctors) are located in “rural”, “rural/remote” and “remote” RRMA classifications (PHC RIS 2007), with 82% found to be working in urban areas (ie. “metropolitan” or “metropolitan-rural”). This is relatively high when compared to other less well represented medical specialties - but when one considers that, in rural NSW for example, there are 1.9 persons per square kilometre (compared to the NSW urban average of 96.1 persons per square kilometre) service delivery issues and equity of access remain clearly unaddressed.

Shortages in the rural health and specifically medical workforce are well known to have reached crisis point nationwide with, many rural practitioners indicating they are overworked, stressed and tired (Aoun, 1997; Aoun, Underwood & Rouse, 1997). The Rural Doctors’ Association (2008a) reports that, on average, rural GPs work 56 hours
per week, with 40% working over 60 hours – compared to 26% amongst their metropolitan counterparts. The AMWAC Report on the General Practice Workforce (2005) reports slightly different figures (on the basis of 2002/2003 figures), but indicates that average hours worked increases progressively with rurality and remoteness, with a GP in very remote areas averaging the longest hours per week. In addition, the Rural Doctors Association reports that the average age of rural doctors in Australia is nearly 55 years (RDA, 2008a), whilst that of rural GP proceduralists (in anaesthetics, obstetrics and surgery) is approaching 60 years. These figures are challenged by the AMWAC Report (2005) which indicates that the largest age concentration for rural GPs is in the 35-44 and 45-54 years age groups. However, both estimates suggest an ageing and potentially retiring population which will further diminish numbers in the next decade (RDA, 2008a). Recruitment rates are low with, for example, only two of the 280 Queensland medical graduates from 2005 locating and working in the bush (as at March 2007) – and less than 5% of Queensland and NSW medical graduates choosing rural and remote locations over the past 15 years (RDA, 2008a). Some practitioners argue that developing a situation that allows doctors to realise a “proper work-life balance” is critical to improving recruitment and retention rates in the rural health workforce (Eckermann & Howard, 2008).

In addition to the above, approximately 50% of Australia’s rural maternity units have been closed in the past 10 years, a further indication of the decline of medical services in rural areas. It is estimated that at least 1000 doctors are needed immediately in rural and remote Australia to provide even basic medical coverage (RDA, 2008a) with rural GP vacancies on the rise. In NSW alone, vacancies have risen from 257 to 270 from December 2007 to February 2008 (NSW Rural Doctors Network meeting, March 2008).

### 4.7.3.1 Overseas Trained Doctors (OTDs)

As outlined by the Australian Medical Workforce Advisory Committee General Practice Workforce Report (2005), overseas–trained doctors (OTDs), who now account for about 25% of the medical workforce in Australia, are internationally trained medical graduates (IMGs) who are allowed to enter Australia on either a temporary or permanent basis, with a range of limitations on their medical
registration. Many have been attracted from overseas to fill gaps in the GP workforce, particularly in rural, remote and outer metropolitan areas, with a variety of government programs (including the five year overseas trained doctor recruitment scheme) implementing Medicare provider number restrictions which confine work to districts of workforce shortage. AMWAC reports that in 2005 there were more than 1,500 OTDs with restricted approvals to work in general practice. A variety of concerns have been expressed about resolving Australia’s workforce shortages by recruiting OTDs: for example, ethical issues in recruiting from countries, less well able to pay, that also are experiencing workforce shortages; the need for standardised approaches to assessment of OTDs and locations of workforce shortage; and the frequent lack of quality supervision and support for OTDs to reach fellowship status. However, their recruitment has been one of a raft of initiatives to fill gaps in service provision in rural and remote areas.

Another recent Australian Government objective, for general practices to amalgamate as a way of increasing quality of practices and access to services for patients, has resulted in a decline of solo practices nation wide from 15.9% (AMWAC, 2005) to only 12.3% of all practices (PHC RIS, 2007b). However, it is unclear whether this has impacted equally on rural practices where GPs are sometimes on their own in isolated locations, on-call “24/7”, with a large and dispersed population base and sometimes, additionally, a local hospital to service (eg. in Kandos, NSW – one of the practices in which we piloted rural primary care psychology services and in which an overseas trained doctor has been working for many years). As outlined in Chapter 3, interestingly, the highest proportion of solo practices exists in “Rural/Remote” and “Remote” RRMA categories (with 49.7% and 55.5% of practices being solo in these two geographic categories respectively); the proportion reducing to 37% of “Metro” practices and 31% in “Metro/Rural” practices. Practice size in the “other” practices not included in these percentages varies from 2-5 GPs to 6+ GPs in each practice (Hordacre et al., 2007).

With regard to mental health issues in rural communities, high incidence presentations combined with scarcity of GPs and low numbers of mental health practitioners make appropriate referral difficult, particularly beyond the better serviced regional centres. Lower levels of uptake by rural GPs of Level 1 and Level 2 training under Better
Outcomes in Mental Health Care (Continuing Professional Development (CPD) relative to their urban and metropolitan counterparts (Level 1: 17.4% compared to 31.4% in regional centres) is concerning, given higher prevalence of mental health morbidity in rural and remote areas. Lower participation rates may reflect difficulties in accessing CPD, in affording time away (both practically and financially) on the part of rural GPs who are often working alone, and/or in accessing appropriate locum support. Or they may reflect a continuing sense that mental health is not “core business”, particularly since there is little available support for these often complex presentations. In an attempt to further upskill rural GPs in mental health issues, the RACGP has recently recommended extension of the Federal Government’s Training for Rural and Remote Procedural GPs Program (TRRPGPP – which provides grants of $1,500 a day for up to 12 days a year to access CPD) to include non-procedural areas such as mental health, and Aboriginal and Torres Strait Islander health (Lawrance, 2008). Despite these attempts to upskill GPs in high incidence common mental disorders, referral criteria for mental health interventions often remain focused on the more acute and extreme mental health conditions. This leaves people with high prevalence disorders of depression, anxiety, stress and substance-use frequently slipping through the net, with their needs remaining unmet (this issue, of course, is not unique to rural areas alone). It is in these areas of intervention that the current research project/dissertation has relevance.

4.7.3 Mental health nursing

Figures in relation to nursing and specifically mental health nursing are out of date (most recently published information - AIHW, 2008a - is based on 2005 data) and incomplete (overall response rates were estimated at 55%; a substantial decline from the 2001 survey of 77.2%. Response rates in the Northern Territory and Western Australia were particularly low, 13.7% and 26.9% respectively, with Victoria providing no data at all – Victorian estimates were based on responses to a follow-up survey in 2006 and weighted to enable comparison with other 2005 data. It is also indicated that “estimates provided in the report may vary from workforce estimates produced by individual jurisdictions”).
Overall, however, it is clear that there has been a long-term shortage in the mental health nursing workforce (AMWAC, 2003). One of the key aims of MHWAC (the Commonwealth Mental Health Workforce Advisory Committee) was to establish and monitor the progress of the mental health nursing education, supply, recruitment and retention across Australia with the Mental Health Nurse Education Taskforce (MHNET) assigned the task of taking “the mental health nurse education agenda forward and building on the “Mental Health Nurse Supply, Recruitment and Retention Report” (AHWAC, 2003). Similarly, the objective of the Australian College of Mental Health Nurses (ACMHN - the “peak and only body that has represented mental health nurses in Australia for the past 31 years”) is to advocate for and ensure that “mental health nursing remains a focal point on all agendas in relation to mental health at local, state and national levels”. The profession was one of the four included under the new COAG initiatives (DoHA, 2006).

As is the case with a number of other health professions, there is little indication that data collection indicating distribution in regional, rural and remote areas occurs consistently.

Key findings/trends from the 2005 AIHW study of the nursing labour force indicate that “nursing supply appears to be evenly distributed across regions, ranging from 1,177 FTE nurses per 100,000 in very remote areas to 1,074 in major cities”. (These figures provide numbers relative to size of population, but do not take into account the geographic spread of population). However (somewhat confusingly), detailed figures in the appendix to the report indicate that of the total 244,360 nurses in Australia in 2005; 62.6% (ie. 152,889) were located in major cities; 21.1% (ie. 51,610) in inner regional; 10.1% (24,657) in outer regional; and only 1.45% (3,543) and 0.79% (1,936) were in remote and very remote locations respectively (9,725 of the total – ie. approximately 3.9% - did not state their location). Nurses in remote and very remote areas were found to work longer hours than other nurses: an average of 34.7 hours per week in remote areas, 38.2 in very remote areas - compared with the national average of 33 hours per week. Like GPs, the average age of employed nurses is increasing (from 42.2 years in 2001 to 45.1 years in 2005; whilst the proportion of those over 50 years increased from 24.4% to 35.8%). Employed nurses working in inner regional areas were, on average, older (46.1 years) than colleagues in other regions, while
those in major cities were younger (44.6 years). The proportion of male nurses was found to be lower in outer regional and remote areas (6.1% and 4.9% respectively) compared with the national figure (7.9% of all nurses were male). Between 2001 and 2005, the largest increase in figures occurred in outer regional areas and very remote areas (up by 131 nurses, from 1,059 to 1,190 per 100,000 of population and 121, from 957 to 1,078 respectively).

In relation to mental health nursing, figures were as follows:

- **NSW**: 4,315 out of a total of 73,174 – ie. 5.9% were in mental health nursing, with one third (33.4%) of these male (compared to 9.7% for the state); 25.6% of mental health nurses were working part-time compared with 43% for the state. Whilst approximately 50% had post-registration qualifications, only approximately 23.5% held qualifications in the field of mental health (with an overall average of 17.6% of nurses holding a qualification in the field corresponding with the clinical area of their job).

- **Victoria**: 3,869 (ie. 5.6% of the total 69,036) nurses were found to be in mental health nursing: 29.1% were male; average hours: 36.4 hours per week (longest of all nursing specialities); 34.5% part-time (lowest); 50.7% with some post-enrolment qualifications, approximately 22% of total with qualifications in mental health.

- **Queensland**: 2,317 (ie. 5.6% of a total of 41,373 nurses) were in mental health: 31.8% male (considerably higher than other clinical specialities); average age: 48.2 years; average of 37 hours per week worked (higher than other areas); 50.1% with post-registration qualifications but only approximately 18% with qualifications in the mental health area.

- **Western Australia**: 1,037 of 22,904 nurses (ie. only 4.5%) work in mental health; 41.9% have post-registration qualifications with only approximately 17% of the total having mental health training; 29.9% were male (compared with 5.2% for the state); much less likely to work part-time (only 31.1% compared to average 52.6% of all WA nurses).
- **South Australia**: 1,153 (i.e. 4.9% of the 23,651 nurses) were in mental health; 46.6% with post-registration qualifications; with a surprising 40% holding qualifications in the mental health field; 32.2% were male (compared to 9.1% of all nurses); only 28.2% were part-time compared with 54.9% of total.

- **Tasmania**: 343 nurses (i.e. 5.2% of the total 6,645) were working in mental health. Whilst 49.1% had post-registration qualifications only, approximately 18% had mental health qualifications; 34.8% male (compared to average of 10.5%); only 28.1% were part-time (compared to 51.4% of total nurses).

- **Australian Capital Territory**: 221 nurses (out of 4,108 – i.e. 5.4%) were in mental health; 59% had post-registration qualifications, only 25% specifically in mental health. Just over one-quarter (i.e. 28.5%) were male, compared with 7.2% for the Territory; only 32.2% worked part-time compared with 44.4% of the total.

In summary, mental health nurses are more likely to be male; more likely to work full-time longer hours; and only a small proportion across all states have specialist post-registration qualifications in mental health nursing. They are also, on average, likely to be older than other nursing cohorts (AIHW, 2008a).

Later summaries from the Mental Health Workforce Advisory Committee (MHWAC, 2008d – unpublished paper) suggested that for the majority of Mental Health Nurses (MHNs), inner regional areas are the main place of work (with 74 FTE’s per 100,000 population), 69 FTE’s per 100,000 working in major cities, 38 per 100,000 in outer regional areas, and 20 FTE’s per 100,000 in remote and very remote locations. Whilst they are still maldistributed (with distribution varying between states and territories), they are relatively more evenly distributed and form a higher proportion of the rural and remote workforce than other mental health professionals (MHWAC, 2008 – unpublished paper).
4.8 Conclusion

It is clear that people in regional, rural and remote Australia are disadvantaged in a number of different ways. They have, on average, poorer health and a higher mortality rate than their metropolitan counterparts and a greater incidence of a number of key health issues such as chronic disease and mental illness. In addition, they are disadvantaged in relation to service delivery. There are significantly fewer required health professionals (and particularly mental health professionals) per head of population, and, additionally, these are dispersed over vast geographic areas. One of the key objectives of the research described in this study was to redress, albeit in a small way, some of these shortages in regional, rural and remote Australia.
Chapter 5
INTERNATIONAL COMPARISONS

5.1 Overview
This chapter provides a brief comparative overview of the situation in Britain and Canada in relation to provision of mental health services and specifically clinical psychology services. Whilst these are only two representatives of a number of models in similar western countries, they provide contextual examples of service delivery. In Britain clinical psychology is available under the public health system; whilst in Canada services are difficult to access due to lack of government inclusion under public health arrangements. Canadian practitioners are currently dealing with the ongoing obstacles that operated in Australia for many years and are continuing the struggle towards gains already achieved in the Australian context.

5.2 The situation in Britain
In contrast to the situation in Australia, mental health service delivery involving the collaboration between GPs and clinical psychologists in primary care has been operative and working effectively in the United Kingdom for nearly 30 years. As a consequence of the Trethowan Report (Department of Health, 1977), which advocated that clinical psychology be funded as a profession under the public health system in parallel to psychiatry, clinical psychologists have worked with GPs in providing an early intervention and prevention approach to mental disorders in the community - most recently funded under Primary Health Care Trusts. Indeed “psychological care and psychological aspects of health and social care (have been) at the heart of national priorities for health services” for a number of years (Paxton, 2001).

Figures from 2003 indicate that there were approximately 7,800 clinical psychologists employed at the time by the NHS in England alone. This comprised 6,401 full-time equivalents - ie. one fully-qualified clinical psychologist under the NHS per 10,000 population. Similar workforce statistics exist in Scotland, Ireland and Wales. These
statistics are additional to/separate from those representing other psychologists (chartered, etc) of whom there are significantly more - similar to the situation in Australia where there are many more registered psychologists without clinical psychology qualifications than those with specialist skills.

In the UK therefore, clinical psychology has been a publicly funded profession for more than 30 years, with coherent workforce development resulting from government implementation of the recommendations of the Trethowan Report (1977) which included the profession under the National Health System.

5.2.1 Clinical psychology workforce data: England

5.2.1.1 Current estimates

There has been consistent growth in the profession since the recommendations of Trethowan (1977). As mentioned above, in the late 1970’s/early 1980’s there were approximately 780 fully qualified, specialist clinical psychologists working under the NHS. Growth trends since that time are illustrated in Table 5.1:

<table>
<thead>
<tr>
<th>Year</th>
<th>Headcount</th>
<th>Whole-time equivalent</th>
</tr>
</thead>
<tbody>
<tr>
<td>1984</td>
<td>1,548</td>
<td>1,379</td>
</tr>
<tr>
<td>1985</td>
<td>1,753</td>
<td>1,534</td>
</tr>
<tr>
<td>1986</td>
<td>1,873</td>
<td>1,637</td>
</tr>
<tr>
<td>1987</td>
<td>2,004</td>
<td>1,709</td>
</tr>
<tr>
<td>1988</td>
<td>2,141</td>
<td>1,974</td>
</tr>
<tr>
<td>1989</td>
<td>2,283</td>
<td>2,084</td>
</tr>
<tr>
<td>1990</td>
<td>2,500</td>
<td>2,333</td>
</tr>
<tr>
<td>1991</td>
<td>2,820</td>
<td>2,622</td>
</tr>
<tr>
<td>1992</td>
<td>3,076</td>
<td>2,802</td>
</tr>
</tbody>
</table>

Table 5.1 Clinical psychology staff in England (at 30 September each specified year): NHS hospital and community health services

<table>
<thead>
<tr>
<th>Year</th>
<th>Headcount</th>
<th>Whole-time equivalent</th>
</tr>
</thead>
<tbody>
<tr>
<td>1994</td>
<td>3,311</td>
<td>3,012</td>
</tr>
<tr>
<td>1995</td>
<td>3,635</td>
<td>3,162</td>
</tr>
<tr>
<td>1996</td>
<td>3,895</td>
<td>3,336</td>
</tr>
<tr>
<td>1997</td>
<td>4,464</td>
<td>3,799</td>
</tr>
<tr>
<td>1998</td>
<td>4,918</td>
<td>4,162</td>
</tr>
<tr>
<td>1999</td>
<td>5,131</td>
<td>4,313</td>
</tr>
<tr>
<td>2000</td>
<td>5,674</td>
<td>4,681</td>
</tr>
<tr>
<td>2001</td>
<td>6,224</td>
<td>5,097</td>
</tr>
<tr>
<td>2002</td>
<td>7,160</td>
<td>5,904</td>
</tr>
<tr>
<td>2003</td>
<td>7,839</td>
<td>6,401</td>
</tr>
</tbody>
</table>

Notes: Figures are rounded to the nearest whole-number. A new classification of the non-medical workforce was introduced in 1995. Information based on this classification is not directly comparable with earlier years.

(Source: Department of Health Non-medical Workforce Census (Department of Health, 2004b.).)

Varied work locations of the profession (as shown in Table 5.2) again highlight steady growth, particularly of those employed in primary care, mental health & community, and multi-service trusts – ie. those relevant to this project.
## Table 5.2: NHS hospital and community health services:
Qualified clinical psychology staff in England by organisation type
as at 30 September 2003

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute Trusts</td>
<td>243</td>
<td>207</td>
<td>215</td>
<td>226</td>
<td>295</td>
<td>407</td>
<td>577</td>
</tr>
<tr>
<td>Health Authorities</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mental Health &amp; Community trust</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>3,596</td>
<td>3,656</td>
</tr>
<tr>
<td>Multi-service Trusts</td>
<td>605</td>
<td>507</td>
<td>516</td>
<td>541</td>
<td>349</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary Care Trusts</td>
<td></td>
<td></td>
<td>1</td>
<td>1</td>
<td>271</td>
<td>697</td>
<td>1,098</td>
</tr>
<tr>
<td>Priority Trusts</td>
<td>2,313</td>
<td>2,700</td>
<td>2,806</td>
<td>3,059</td>
<td>3,303</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Special health authorities</td>
<td>45</td>
<td>47</td>
<td>50</td>
<td>62</td>
<td>21</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Teaching Trusts</td>
<td>168</td>
<td>197</td>
<td>175</td>
<td>163</td>
<td>160</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>3,376</td>
<td>3,660</td>
<td>3,763</td>
<td>4,052</td>
<td>4,399</td>
<td>4,846</td>
<td>5,331</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute Trusts</td>
<td>299</td>
<td>259</td>
<td>276</td>
<td>284</td>
<td>366</td>
<td>495</td>
<td>702</td>
</tr>
<tr>
<td>Health Authorities</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mental Health &amp; Community trust</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>4,511</td>
<td>4,632</td>
</tr>
<tr>
<td>Multi-service Trusts</td>
<td>721</td>
<td>627</td>
<td>628</td>
<td>672</td>
<td>418</td>
<td>173</td>
<td></td>
</tr>
<tr>
<td>Primary Care Trusts</td>
<td></td>
<td></td>
<td>1</td>
<td>3</td>
<td>350</td>
<td>913</td>
<td>1,423</td>
</tr>
<tr>
<td>Priority Trusts</td>
<td>2,775</td>
<td>3,243</td>
<td>3,399</td>
<td>3,807</td>
<td>4,168</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Special health authorities</td>
<td>48</td>
<td>51</td>
<td>57</td>
<td>66</td>
<td>23</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Teaching Trusts</td>
<td>194</td>
<td>226</td>
<td>209</td>
<td>200</td>
<td>189</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>4,038</td>
<td>4,408</td>
<td>4,572</td>
<td>5,032</td>
<td>5,514</td>
<td>6,092</td>
<td>6,757</td>
</tr>
</tbody>
</table>

Notes: Figures are rounded to the nearest whole-number.

(Source: Department of Health Non-medical Workforce Census (Department of Health, 2004b).)

### 5.2.1.2 Estimated need

Paxton claims that the “services that clinical psychologists can provide are of huge and growing national importance” (2001), particularly in light of increasing emphases on mental health and services for the elderly as priority areas in the National Service Framework for Mental Health and the NHS Plan (Department of Health, 2000). Despite the growth in numbers outlined above, Paxton argues that “the clinical psychology workforce remains inadequate, as it has been for decades” (2001). Detailed estimates have been provided for staff needed to deliver the services required by the National Service Framework for Mental Health (Department of Health, 1999) which set standards for Britain in relation to mental health promotion, service delivery at primary care level and for people with severe mental health problems – taking account of the needs of carers and suicide prevention. On the basis of local population estimates of 250,000 it is estimated that approximately 7,300 (FTE) clinical psychologists and 1,200 counselling psychologists are required to deliver adult mental health services in England (Lavender & Paxton, 2004). This is well ahead of the 5,331
FTE total outlined above. Equivalent estimates based on population are provided for Scotland, Ireland, and Wales.

Recommendations have been made in relation to involvement of clinical psychologists in primary mental health care teams with 11 clinical psychologists recommended per 250,000 population - an additional approximate 2,640 FTEs - in parallel with counseling psychologists (3), counselors (5), primary care mental health workers (4), “gateway workers” (2.5), a voluntary services coordinator and administrator - using the stepped care approach to presenting difficulties. It is estimated by Lavender and Paxton (2004) that even with these optimal staffing levels, caseloads would high with other workers needing to focus on providing access to community based self-help groups and voluntary services (see also Tomson, 2001).

5.2.2 Clinical psychology service provision

The National Health Service collected information about patient contacts with NHS Clinical Psychology Services in England on an annual basis until April 2003. A comprehensive overview of these services was therefore provided up until the September 2003 publication – the latest of the series (Department of Health, NHS Clinical Psychology Summary Information, 2003). It was indicated at the time that continuing information about NHS clinical psychology services would be available through the Mental Health Minimum Dataset (MHMD) of the Department of Health annual returns (see below). However, the 2002-2003 complete data set provides a coherent picture as follows:

- The number of contacts (ie. different people receiving care) with NHS-funded clinical psychology staff increased steadily by 7% from 1990-1991 to 1997-1998 but levelled off until 2001-2002 when it fell by almost 2%, then increased again by almost 2% in 2002-2003. The number of people receiving care increased overall by 46% from 1988-1989 to 2002-2003.
- The number of new episodes of care commenced in a year increased by approximately 6% from 1990-1991 to 1996-1997; then fell until 2001-2002
when there was a 3% increase again in 2002-2003 from 181,000 to 186,000 – an overall 24% increase from 1988-1989 to 2002-2003.

- Of these new episodes of care over 77,000 (41%) arose from GP referrals, 17% were via hospital psychiatric departments.
- The large majority (63%) fell in the 16-54 year age group; 13% were school-aged children.
- Most referrals (55%) were female - new episodes of care being higher for females than males in all age groups between 16 to 84 years. The highest incidence was for females aged 16 to 54 at 5.2 per 1,000 population; with the 55 to 64 year age group also being high at 3.6 referrals per 1,000 population).
- New episodes of care were highest for males in the 5 to 15 year age group (4.0 per 1,000 people) and for males aged 16 to 54 (3.7 per 1,000). In all other groups for both males and females the incidence was less (3 or fewer episodes per 1000 population).
- The number of new people seen (“first contacts”) rose by nearly 2% from 252,000 in 2001-2002 to 256,000 in 2002-2003.
- The average duration of an episode of care (ratio of contacts to initial contacts) during 2003-2003 was over 4.5 months; having risen from the average duration between 1988-1989 and 1995-1996 of just over 2 months with 1996-1997 at 3 months and over 4 months in 1998-1999 – possibly reflecting increasing complexity in cases.

The “National Service Framework for Mental Health” (Department of Health, 2004a) highlighted that mental health services in the UK represent a continuum of care from primary care/general practice to highly specialised services. Any local health and community mental health services are provided by two or more organisations (National Health Service Trusts) with no configuration unifying all service provision. The interfaces and boundaries require careful and effective management to provide integrated care – as is the case in Australia (Department of Health, 2004a). The National Service Framework spells out national standards for mental health, what they aim to achieve, how they should be developed and delivered and how to measure performance across the United Kingdom. Derived from the policies announced in the
government White Paper “Modernising Mental Health Services” (Government White Paper, 1998), the framework focused on the need for mental health to be given a higher policy priority indicating that, despite its high prevalence and importance, mental illness had been given insufficient attention. The objective of the new framework was to give mental health the same priority as coronary heart disease and to lay down models of treatment and care which people could be entitled to expect in every part of the country.

5.2.3 Patient access to services

As mentioned above, the mental health minimum data set (MHMDS) was introduced in April 2003, superseding the NHS Clinical Psychology Summary Information. It was designed to show the detailed patterns of care received by individuals who had been looked after by all specialist mental health care providers in England (each mental health provider trust makes quarterly and annual returns documenting the care they have provided to individual patients). The first “occasional paper” in the series focused on year end returns for 2004-2005 and aimed to identify the challenges involved in developing this new data source for full national use. The paper provided an introduction to the key issues in assessing MHMDS data quality and the challenges involved in improving it.

The summary findings from the paper indicated that 84 mental health providers composed of 59 NHS trusts, 5 care trusts, and 20 primary care trusts, had produced data for 2004/2005 indicating that just under 2% of the working age population and just over 3% of older adults had received care from specialist mental health services during the year. A total of 1,357,693 records of service were returned for the year, 26.7% for people aged over 65 or over, 70.9% for working age adults. These services included inpatient care (8.5% of records), outpatient (39.6%), day hospital/NHS day-care facilities, community psychiatric nursing (28.7%), clinical psychology (14.9% reporting contact) and occupational therapy (8.9%). It was found that 83.3% of all trusts provided data in each IDS (immediate data set) table – indicating relatively widespread access to these services. The data were unable to answer questions from an epidemiological perspective (ie. rates of treatment), as no delineation of catchment populations for each trust were available. Indeed the paper itself was largely focused
on ironing out methodological flaws in data collection rather than providing a cohesive picture of service delivery. Nonetheless, it highlights widespread access to the profession of clinical psychology across health care trusts and through the public health system.

5.2.4 Professional registration

The British Psychological Society (BPS) is the representative body for psychologists and psychology in the United Kingdom. The society is registered as a charity which imposes some constraints on its activities - for example, “it is not empowered to campaign on political issues” (The British Psychological Society, 2008a).

Founded in 1901 at University College, London it was originally called The Psychological Society, changing to its current name - The British Psychological Society - in 1906 to avoid confusion with another group. It initially admitted only recognised teachers in the field of psychology. However, membership was opened up to members of the medical profession in 1919. The society was incorporated in 1941 and, following receipt of a royal charter in 1965, became the keeper of the national Register of Chartered Psychologists. Only via recognised chartered status within the BPS can a person register as a chartered psychologist and write "C. Psychol." after their name (British Psychological Society, 2008a)

The aim of the BPS is to raise standards of training and practice in psychology in Britain, increase public awareness of the discipline and the influence of psychological practice in society.

The society currently has 10 divisions and 13 sections. These differ in that the former are open to practitioners in a certain field of psychology (ie. only professional and qualified psychologists will be entitled to full membership of a division) whereas the latter are interest groups comprising members who are interested in a particular aspect of psychology – very similar to the Australian Psychological Society. The Divisions include the Divisions of Clinical, Health, Forensic, Counselling and Neuropsychology - as well as the Divisions of Teachers and Researchers in Psychology; Child and Educational Psychology, Occupational Psychology and the Scottish Division of
Educational Psychology (the structure is again similar to the APS which has nine specialist colleges).

Overall, British Psychological Society membership in all fields of psychology is approximately 45,000, whilst the Division of Clinical Psychology (DCP) represents over 6,000 Clinical Psychologists in the UK. This is the Society's largest division and is run by elected national and local committees. The majority of clinical psychologists in Britain are members of the Division - the objectives of which are to “further the development of clinical psychology both as a body of knowledge and skills and as a profession” (The British Psychological Society, 2008b). Entry requirements are based on formal qualifications in clinical psychology, with entry to clinical training courses highly competitive - less than 30% of applicants are successful each year with a good undergraduate degree classification, (normally a 2:1 or above), relevant work experience and demonstrable research skills being necessary prerequisites.

Recent developments in Australia (from November 2006) now mirror many of the well-established precedents in Britain, with membership of the Australian Psychological Society College of Clinical Psychologists being the formal accreditation requirement for registration as a clinical psychologist/mental health specialist provider under the MBS/Medicare scheme. Interestingly, the Australian Psychological Society has recently signed an “historic Memorandum of Understanding with the British Psychological Society” to further these links and complementarities (Gordon, 2008).

5.3 The situation in Canada*

5.3.1 Overview

In Canada, mental health services are delivered in a conventional manner with identification of patient diagnoses and core problems being via primary care physicians (the Canadian equivalent of GPs) who then refer, if needed, to psychiatrists. Waiting lists for psychiatrists are frequently so long (6-12 months) that

* Much of the information about Canada in this chapter has been gleaned from Professors Jean Grenier and Marie-Helene Chomienne at the University of Ottawa – email communications: 20.6.06; 6.10.06; 7.10.06; 20.5.08; 30.5.08. Thanks are due for our ongoing communication/conversations about the comparative state primary mental health care and of the profession of clinical psychology in Canada and Australia.)
many family physicians initiate treatment themselves. Access to psychologists for evidence-based treatment of high prevalence disorders remains limited with the vast majority of consultations occurring in the private sector – beyond the reach of many people due to cost (Moulding, Grenier, Blashki, Ritchie, Pirkis & Chomienne, in press). Patients either need insurance cover or to be able to afford to pay for services themselves (fees for a psychologist in private practice in Ontario, for example, vary from $140 to $190 per hour). In certain provinces family physicians can refer free of charge to a psychologist within a community centre but these psychologists are not clinical psychologists and typically have received less training (Grenier & Chomienne, email communication, June 20, 2008)

Under recent primary care reforms, different provinces have implemented various ways of accessing mental health services. In Ontario the College of Family Physicians have supported liaison services between family physicians and psychiatrists to facilitate more efficient access to psychiatrists (Kates, Craven, Crustolo, Nikolau & Allen, 1997a; Kates, Craven, Bishop, Clinton, Kraftcheck, LeClair, Leverette, Nash & Turner, 1997b; Kates & Craven, 1998; Kates & Ackerman; 2002). However this approach does not address the most prevalent psychological problems found in family practice – such as the common mental disorders of depression, anxiety, adjustment difficulties, etc. A number of provinces have also implemented family health teams: the composition of which varies from province to province but the concept remains the same - to gather various professionals under the same roof and have them collaborate in providing comprehensive health care services. The professionals involved include: nurses, nurse practitioners, dieticians, social workers, occupational therapists, mental health workers and psychologists (McElheran, Eaton, Rupcich, Basinger & Johnston, 2004). However, psychologists (and particularly clinical psychologists) are rarely included because of financial issues and frequently lack of understanding of their role. In summary, Medicare in Canada provides funding and support for mental health services primarily through family physicians (GPs) and psychiatrists.

There are about 15,000 psychologists in Canada - with approximately 8,000 in Quebec and 4,000 in Ontario. With Canada’s population being at approximately 33 million people - with approximately 8 million in Quebec and 13 million in Ontario -
this equates to a varying ratio of psychologist-to-population of 1:2,200 nationally; 1:1,000 in Quebec and 1:3,250 in Ontario. The greater ratio of psychologists-to-population in Quebec is due to the fact that traditionally, although changing, entry into the profession has been less rigorous and training less lengthy in this province.

There is therefore a total workforce of 15,000 psychologists in Canada who are not covered under Medicare - almost all are in the private and university sectors, with a very small minority in hospitals. In essence, the situation in Canada currently replicates that which applied in Australia in relation to psychological services for many years, prior to the COAG induced changes applying from November 2006. In Canada, it is difficult for people to access these evidence-based services due to lack of government support and consequent costliness to consumers.

In the province of Ontario, a new “College” of psychotherapists in Ontario (a regulating body governing a profession) has been established to create and endorse a new registered profession of “Psychotherapist”. The details of qualifying requirements have not yet been established. However, it is likely that those now known as “mental health workers”, will become registered “psychotherapists”. Registration is seen as a positive move by some as it will at least ensure some standard of accreditation.

5.3.2 Organisation, accreditation and training of psychologists

In Canada, psychologists are regulated health professionals with an average of eight years of education in addition to a 4 years undergraduate degree. This includes academic and applied training and independent research.

The Canadian Psychological Association is the national professional body for psychologists across Canada. It represents a significant proportion of Canadian psychologists across a broad spectrum of psychology with a membership of over 6,000 – of whom 4,375 are full members (with masters and doctoral degrees), 1,643 are student affiliate members (senior undergraduate and graduate students) and 170 are Retired members. Approximately 5,500 are Anglophone and 500 Francophone (Canadian Psychological Association, 2008a).
Chapter 5: International Comparisons

The mission statement of the association is “to advance and promote psychology for the benefit of all” with four key objectives:

- to improve the health and welfare of all Canadians;
- to promote excellence and innovation in psychological research, education, and practice;
- to promote the advancement, development, dissemination, and application of psychological knowledge; and
- to provide high quality services to members (Canadian Psychological Association, 2008a).

The Association was organized in 1939 and incorporated under the Canada Corporations Act in May 1950 “to meet the needs of Canadian psychologists and to advocate for the science and practice of psychology in Canada” (Canadian Psychological Association, 2008b). Each province and territory also has a psychological association of its own with similar mandates, aims and objectives in each jurisdiction. In addition, they frequently maintain referral directories and help members of the public to access psychological services (as does the Australian Psychological Society).

Psychological services in Canada are provided in schools, private practices, businesses, health clinics, hospitals, jails, courts, social welfare agencies, rehabilitation centres, etc. (Canadian Psychological Association, 2008b). Services are provided by provincial and territorial governments or in the private sector - with governments being responsible for both public psychological services and the regulation of the profession (unlike Australia where movement towards a national accreditation/registration body are well advanced). To practice psychology in Canada, one must be licensed, with being “registered” or “chartered”. Registration/licensing requirements vary from jurisdiction to jurisdiction with some requiring a doctoral qualification, others a master’s degree (psychologists with a doctoral degree use the title “Dr” – as in Australia). Accreditation/licensing requirements vary between the provinces/territories of Alberta, British Columbia, Manitoba, New Brunswick, Newfoundland, Nova Scotia, Ontario, Prince Edward Island, Quebec, Saskatchewan,
Northwest and Nunavut Territories, with all having their own accrediting/registration body labelled respectively: Board of Examiners in Psychology, Psychologists Registration Board, College of Psychologists, Professional Licensing Board, etc.

Psychologists are one of only five regulated health professions authorized to use the title “doctor” (contingent on a doctoral qualification – see below). Beyond the licensure outlined above, the Canadian Register of Health Service Providers in Psychology (CRHSPP) provides additional voluntary certification of psychologists who provide health services – of whom there are 800 in Ontario

In Canada, whilst individual practitioners of psychology are “licensed”, doctoral programmes and internships in professional areas of psychology are “accredited” by the Canadian Psychological Association (as is the case in Australia). Accreditation is voluntary but since it allows doctoral and internship programmes to demonstrate appropriate credentialing/recognition of standard of training, graduation from an accredited doctoral/masters programme is advantageous. Whilst neither a requirement for registration as a psychologist or of potential employers, it does provide an advantage for those who have graduated from them as they often receive ‘fast-track’ credential reviews by regulatory bodies. Similarly, accredited programmes usually hire faculty and staff who themselves have graduated from accredited programmes (Canadian Psychological Association, 2008c).

The CPA has recently developed a strategic plan for the next five years (2008/2013) - key recommendations of which are to:

- develop programmes to enhance membership;
- explore the feasibility of a Canadian College of Psychology that develops and promotes high national standards of professional training and practice;
- continue to identify opportunities for collaboration with other professional associations through joint policy development, research projects and other initiatives;
- continue to develop a leadership role in the development of national health policy which broadens its focus from medical and acute care (physicians,
nurses and hospitals) to a more comprehensive and realistic focus on the biopsychosocial dimensions of health and wellness;

- continue to promote collaborative care across a continuum of care from community to hospital, across human service domains and between privately and publicly funded services;
- continue to advocate with government and third party players for access to psychological services for Canadians and reimbursement to psychologists at competitive rates.

As such, many of the recent changes affected by the psychology profession and specifically clinical psychology in Australia, have still to be realised in Canada.

### 5.3.3 Clinical psychology

The Canadian Council of Professional Psychology Programs (CCPPP) formerly known as the Canadian Council of Clinical Psychology Programme Directors (CCCPPD) was founded in 1977 at the University of British Columbia. The Council was developed “to serve as the interface between academic programs and internship training sites and to create an arena for program directors to exchange ideas about professional training” (Alden, Mothersill, Steffy, McIlwrath, Steinberg, McMullen & Tasca, 1996, p. 223). In the early '80s, a major focus for the Council was development of accreditation criteria for graduate clinical programmes across Canada. Accreditation criteria for clinical psychology programmes and internships were endorsed and adopted in 1983 by the CPA Board (Craig, 1993). Throughout this process, which occurred between 1982 and 1985, the CCCPPD became more organized and changed its name from the Canadian Council of Clinical Psychology Program Directors (CCCPPD) to the Canadian Council of Clinical Psychology Programs (CCCPP) to permit representatives other than the program directors to attend meetings. The name was then further changed from CCCPP to the Canadian Council of Professional Psychology Programs (CCPPP) to include counselling psychology, neuropsychology, and other branches of professional psychology. It is possible to speculate therefore that, since clinical psychology in Canada does not have its own specialist College under the jurisdiction of the national psychological association (as is the case in Australia), it has become in some ways indistinguishable
from other related specialties. In so doing it may have diluted its own unique characteristics and bargaining position.

5.3.4 Recent primary care initiatives

As in Australia, psychosocial problems form a large proportion (30-70%) of family medicine/general practice consultations in Canada (Grenier & Chomienne, 2006; Shiber, Maoz, Atonovsky & Antonovsky, 1990; Craven & Allen, 1995; Craven, Cohen, Campbell & Williams, 1997). As first-line health care professionals, family physicians play a key role in the identification, diagnosis, and treatment of psychosocial problems. As outlined above, current shared mental health care models in Canada revolve primarily around collaboration between psychiatrists, mental health workers and family physicians (Nickels, 1996; Kates, Crustolo, Farrar & Niolaou, 2002). It is asserted, however, that many psychosocial problems seen in family practice do not necessarily require psychiatric intervention, are beyond the competency levels of generic mental health workers and that clinical psychologists are better placed to effectively assess, diagnose and treat these presentations (Grenier & Chomienne, 2006). Psychologists with these competencies are largely underutilized by the current Canadian primary health care system.

Recent trials of on-site integration of full-time psychologists in each of two family medicine clinics in Eastern Ontario (one rural and one urban) have been undertaken for a period of 12 months (Grenier & Chomienne, 2006) – similar to those established in Australia (eg. Winefield & Chur-Hansen, 2003, 2004; Winefield, Marley, Tablin, Beilby, Turnbull, Wilson & Williams, 2003). The objectives of the research were to:

- study the collaborative process that develops between family physicians and a psychologist in a family practice setting;
- identify the barriers and factors that assist the collaboration between psychologists and family physicians;
- study the referral patterns of the primary care doctors;
- study the impact of the integration of a psychologist in a family practice:
  - on patient satisfaction, patient quality of life, patient treatment outcome,
○ on provider satisfaction,
○ on physician billing profile;
• gather qualitative data from patients, physicians and psychologists on the integration of a psychologist in a family practice (Grenier & Chomienne, 2006).

Results from the total of 376 participants/patients seen - 68% of whom were female, the majority in the 25-44 year age group, 95% referred by the family physician, 5% self-referred - indicated that the majority of referring problems were high prevalence/common mental disorders as follows: anxiety disorders (44%), depression (34%), family problems (20.7%), marital problems (12.5%), interpersonal difficulties (12.5%), stress (11.4%), work-related problems (10.4%), grief (7.7%), health problems (6.6%), anger problems (5.8%) and “other” (2.6%). Outcomes were successful after a mean number of 4.9 sessions, with measures showing clinically significant improvement, and 78% of patients reporting feeling more confident in handling day-to-day problems on their own. Conclusions indicated overall satisfaction with the project from both providers and patients alike, and that key amongst the priorities in primary care must be the alleviation of the burden on family physicians – ie. increasing their quality of life through reduced work-related stress and provision of support in their everyday practice, etc. (Grenier & Chomienne, 2006). In light of the burden of psychosocial problems in everyday practice, the inclusion of psychologists was felt to be essential. The family physicians involved in the study generally felt that they had been given insufficient training to treat psychological problems. The physicians also indicated that the “psychological care” they provide generally falls within the realm of counselling (empathetic listening, giving advice, offering emotional support, etc.) rather than formal psychological treatment – and that they considered the psychologist to be expert in the field of psychology - much like any other specialist in the field of medicine. They also indicated that they felt comfortable referring patients and that a clinical psychologist was the most appropriate provider of complete psychological care (from diagnosis to treatment) for their patients. It was seen as advantageous as there was no duplication in services, as in the case of referral to another medical specialist (Grenier & Chomienne, 2006).
Proposals are underway for further primary care trials to explore and promote at all levels (from practice to policy) the efficacy of the early intervention, family medicine based model. However, there remains the key issue that public health funding remains unavailable across Canada to enable the model to thrive.

5.3.5 Health policy developments

Data from 2003 and 2004 provided by the Canadian Institute for Health Information (Jacobs, Yim, Ohinmaa, Eng, Dewa, Bland, Block & Slomp, 2008) indicates that total spending across Canada on mental health was approximately $6.6 billion, of which $5.5 billion was government/public funding during these years. Largest expenditures were on hospitals, community mental health and pharmaceuticals – varying by province. Public mental health spending was 6% of total public spending on health whilst total mental health spending was found to be 5% of total health expenditure. This is lower than most developed countries and a little below the minimum acceptable amount stated by the European Mental Health Economics Network (Jacobs et al., 2008).

Publication of data by the Canadian Institute of Health Information (November 2006) also indicated that more than one in three patients discharged from general hospital after admission for a primary diagnosis of mental illness are readmitted within one year of discharge (higher than all other categories of illness). Risk of readmission was found to increase with age (from 26% of those from 0 to 14 years of age to 38.7% of those 65 and over) and was related to diagnostic category with primary diagnosis of personality disorder being linked to a 45% readmission rate, followed by schizophrenia (41%). Men and women were found to have similar rates of readmission (38.3% and 35.5% respectively). The length of initial stay also correlated with likelihood of readmission within one year. Readmission was linked to poor outpatient treatment, rehabilitation and follow-up in the community, and signalled recurrence of severe symptoms if effective treatment is unavailable. Given that hospital care is significantly more expensive than outpatient or community care, this elicited considerable concern at government level, indicating awareness that alternative paths of care were required. Whilst representing an overall decline in both
general and psychiatric hospital admissions in the last ten years, the findings were relevant to primary care service provision for several reasons:

a) competently administered, readily accessible, evidence-based therapy was clearly required in the community to provide appropriate follow-up care on discharge and prevent the “revolving door” back into hospital;

b) psychiatric care needs to be freed up from treatment of common mental disorders in the community to enable treatment of these more severe/recalcitrant disorders – which are within the psychiatric spectrum of care and not being given sufficient attention.

These findings echoed key outcomes from the first-ever national study of the Canadian Standing Senate Committee on Social Affairs, Science and Technology into mental health, mental illness and addiction. This was undertaken from February 2003 and included 130 hours of hearings, 300 witnesses and written testimony of more than 2,000 pages. The final report of the Committee, “Out of the Shadows at Last – Transforming Mental Health, Mental Illness and Addiction Services in Canada” (2006) affirmed, amongst other things, the need for a Mental Health Commission to provide an ongoing national focus on national mental health issues. As Lurie indicates “the development of an excellent mental health system at the national level or even at the state or provincial jurisdiction (in Canada) resembles the search for the Holy Grail” (Lurie, 2005), with the last 20 years seeing an explosion of progressive mental health policy statements but no clear follow through to effective outcomes in the community.

The recently launched Mental Health Commission of Canada (2008) is the most recent phase of this quest. The key aims of the Commission are to reform mental health policies and implement service delivery improvements; to facilitate a national approach to mental health issues; diminish the stigma associated with living with mental illness and to disseminate evidence based information on all aspects of mental health and mental illness to governments, stakeholders and the public. The launch of the Commission provides a timely opportunity to reflect on options for enhanced service delivery in the community and particularly family practice – the context of most mental health care across the country. It is argued by Moulding, Grenier,
Chapter 5: International Comparisons

Blashki, Ritchie, Pirkis 7 Chomienne (in press 2008) that integrating psychologists into publicly-funded primary care in Canada would be “feasible, beneficial for consumers and cost effective” and that the current Commission opens up this possibility.

5.4 Conclusions

Over many years, evidence from Britain has provided strong support and precedence for likely efficacy of collaborative primary mental health care in the Australian context. As a consequence, it was believed that serious consideration should be given to the funding of clinical psychology as a mental health speciality within the public health sector and as part of a new collaborative workforce providing treatment and management of mental disorders in general practice. The aim was to augment the psychiatric workforce, with many GPs also indicating that evidence-based, best practice clinical psychology provided a better complement to their own mental health work.

It was suggested that public funding of clinical psychology could be either via salaried positions as in the UK under the NHS - located either in Divisions of General Practice providing outreach services to a number of general practices - or directly within the practices themselves. In parallel with the situation in Britain, it was recommended that a full career structure be established in parallel to psychiatry, ranging from “basic grade” through “senior” to “principal” and finally “consultant”. In addition, it was also indicated that time-limited, accountable Medicare funding for evidence-based, short-term interventions (six, plus six if needed, sessions) be made available to enable enlistment of those in the private sector into the public health domain. It was argued that this could be provided without cost blowouts, if similar requirements and accountabilities for time-limited, effective treatment were implemented for and by other mental health specialists already funded under Medicare.

In light of models overseas and particularly in Britain, advocacy occurred over many years for the systematic roll-out of a generic, collaborative model of primary care in Australia - with clear, best practice guidelines and quality control mechanisms in
place. The aim was to ensure that an early intervention and prevention approach to mental health care was established to provide intervention for high prevalence/common mental disorders that previously went untreated (except by medication). Financial incentives/salaried and supported positions were also proposed to facilitate equitable service delivery in outlying metropolitan, regional and rural areas.

The presence of these arrangements in a number of other countries provided inspiration and encouragement for trial of the model. In addition, the parallel struggle of nations such as Canada to enable better access to evidence-based psychological services for people in need, helped to drive the process.
Chapter 6

METHOD

6.1 Overview

The current study implemented and evaluated a new model of mental health service delivery involving collaboration between the two professions of medical general practice and clinical psychology in servicing patients with mental health needs. The objectives of the “Clinical Psychology in General Practice Project”, which began in 1998, were to assess the efficacy of introducing clinical psychology services into the primary care setting in regional and rural areas, and to develop a model of early intervention by psychologists for general practice patients with common mental illnesses. The aim therefore was to assess whether early intervention collaborative care results in: better patient health outcomes, better outcomes for GPs, and practical training and professional development experiences for clinical psychology registrars*. 

The project was funded by the Australian Government Department of Health and Ageing over four years (2001-2005: total of $771,000) and approval was given by the Department to use all data as part of a doctoral dissertation. The model, involving collaborative care and early intervention by psychologists for primary care patients with common mental disorders was evaluated over a formal two year trial period (2001 and 2002) and continued until 2004, during which time pre- and post-data were collected from patients and GPs. Clinical psychology registrar responses to their placement experiences were also collected post-placement and additionally towards the end of the project.

The scientific merit of the study lay in establishing empirical data in relation to specialist psychological interventions in primary care. The aim was to assess whether

* The term “clinical psychology registrar” refers to a Masters or Doctorate of Psychology student on clinical placement in general practice. The label established parity with “general practice registrars” who also obtain much of their professional training through internships in the primary care setting. The title was widely accepted by GPs involved in the project and gave the clinical psychology interns a clearer sense of their own professional role and identity whilst on clinical placement. The terms registrar, student and intern are used interchangeably in the text, referring to postgraduate clinical psychology students (preferably in later years of their postgraduate professional training) on a professional internship in primary care. On placement, “Registrar” was used at all times.
involvement of clinical psychologists and clinical psychology registrars provided “value added” to supplement “treatment as usual” by GPs of common mental disorders in the general practice setting. In addition, it was hoped to establish whether collaborative care could enhance outcomes for GPs and additionally, provide good primary care training for clinical psychologists. Given current projections of the increasing burden of disease due to common mental disorders outlined in Chapter 2, evidence about the effectiveness of new models of care is crucial in developing better services for improved patient outcomes. When the project began, randomised trials in primary care providing rigorous evidence of the effectiveness of such mental health care interventions were lacking - and are still rare. As Winefield and Chur-Hansen (2004) indicate in their review of the empirical literature, “controlled evaluation studies are required to show the costs and benefits of integrated primary health care to all participants” including both the distressed clients themselves and the professional caregivers.

As discussed in Chapter 3, primary health care is the frontline of Australia’s health care system (Australian Government Department of Health and Ageing (DoHA), 2008) with a range of primary health care providers now involved in addition to GPs - nurses, midwives, allied health professionals including psychologists, pharmacists, and dentists (DoHA, 2008). In the face of the growing burden of disease, ageing population and health workforce pressures (DoHA, 2008), evaluation of the effectiveness of collaborative care involving integration of multiple professions has become even more imperative. Since the advent of the Better Outcomes in Mental Health Care (BOiMHC) program in 2001, its Access to Allied Psychological Services (ATAPS) component has been comprehensively evaluated by The University of Melbourne’s Centre for Health Policy, Programs and Economics (PHC RIS, 2008). Twelve Interim Evaluation Reports (see Fletcher, Bassilios, Pirkis, Kohn, Blashki and Burgess, 2008) have been written, demonstrating that the ATAPS projects have gained considerable momentum, with 108 projects now being conducted by 114 Divisions of General Practice. Whilst highlighting the progressive achievements of the projects in terms of increased participation by GPs, allied health professionals and uptake and changing profile of consumers, the studies do not provide the “controlled evaluation ... required to show the costs and benefits of integrated primary health care to ... participants”. The aim of the research outlined in this dissertation was
therefore to provide empirical data enabling such rigorous evaluation within the Australian context.

The project also aimed to address the question of limited and variable access that both GPs and patients have to mental health specialist support in regional and rural areas. Before it began, GPs in the Central West of New South Wales managed most mental health issues on their own, with only sporadic access to limited mental health services within the region. This was also the case for GPs working in other non-metropolitan regions of Australia. The original idea of collaborative care provision in Central West NSW emerged in 1998 in response to the dearth of such services, and was created as a way of harnessing the psychological expertise at Charles Sturt University to assist local GPs in treating common mental illness in the local region. From 2001 Charles Sturt University was the primary location of the (by then funded) evaluation trial (Vines, Hurley & Thomson, 2002), which subsequently articulated in 2002 to the Universities of Ballarat and New England, both of which are similarly located in rural areas (Vines, Richards et al., 2004). Trainee/intern clinical psychologists (known as clinical psychology registrars) and some fully qualified clinical psychologists were involved in service delivery and data collection in all three locations.

6.2 Preliminary Pilot Study

A pilot phase of the project was run by the author in one Bathurst general practice for one session a week over a period of more than two years (1998-2001). Initial discussions were held with the Mental Health Advisory Committee of the NSW Central West Division of GPs (CWDGP), in which the potential contribution of the psychology discipline at Charles Sturt University (CSU) to local general practices was canvassed. The concept began with observation by the author of two random sessions with volunteer GPs to detect the incidence of psychological impairment amongst patients presenting in the primary care setting. One session entailed seeing 15 patients in a morning; the other 14 patients over a similar time interval. There was clear agreement between the two GPs and clinical psychologist that 60% of patients in the first session had some degree of psychological disturbance amenable to psychological intervention; a 40% prevalence was found in the second group of patients.
It was decided to pilot the provision of clinical psychology services in the General Practice setting in an attempt to both adequately treat the patients’ conditions and to relieve some of the pressure on the general practitioners to deal with such issues. Service delivery was established one morning a week by the author, and an initial pilot placement was carried out by a senior academic at CSU under the supervision of the author/senior clinical psychologist in fulfilment of Master of Psychology placement requirements at the University of NSW†. One hundred patients were seen by the author, referred by nine medical general practitioners. During this phase, design features of the main project were finalised.

6.2.1 Patient survey

A brief survey of the first 56 patients seen was carried out to assess their attitudes to and experience of the collaborative service delivery model. Response rates were low (32% - ie. 18 patients returned questionnaires: see Appendix 6.1). However, it was still useful preliminary feedback as it gave some appreciation of how the model was working. Responses were as follows:

- 83% (15) found seeing a clinical psychologist a helpful experience (2 were not sure - all patients being seen at the time, even those at the beginning of their treatment, were sent a questionnaire. Hence, some were not in a position to fully answer some of the questions);
- 78% (14) found their problem improved after seeing the psychologist (again, some were not in a position to fully answer this question for the reasons above);
- 89% (16) said they liked being able to be seen by a psychologist in the general practice setting;
- 72% (13) indicated that they felt more comfortable seeing a psychologist in the doctor’s practice rather than being referred to another practice;
- 89% (16) felt their doctor explained the psychologist’s role to them;

† Clinical placement requirements are set by the Australian Psychological Society College of Clinical Psychologists and entail four full-time placements of 250 contact hours including 50 hours of clinical supervision for the MPsych and the equivalent number of placements with 500 contact hours for DPsych requirements.
100% of respondents (6) found the doctor attending the first session with the psychologist helpful (not all patients had experienced this – only 6 patients had the doctor briefly attending the first session);

89% (16) found the clinical psychologist easy to talk to;

83% (15) indicated that they were given an explanation/understanding of their condition;

89% (16) felt involved in their assessment and/or treatment;

72% felt they received the right treatment for their presenting problems (some had received only assessment, not treatment, when surveyed);

47% (8 out of 17 invoiced) indicated that the fees ($100 per session during the pilot phase of the project) were a problem. Comments on the question: “Did you find fees a problem?” were as follows:

- Need to register clinical psychologists fees with Medicare – this would be of assistance.
- No - but I had to stop because I could not afford it - though I needed help.
- My financial situation did not allow me to pay full fees - adjustments were made for which I am extremely grateful.
- People who are on a pension or financially challenged have a major problem with the cost.
- The fee was tailored to help me (which it did) but I still found it difficult to pay. I would have gone more if I could have afforded it.
- Yes, they were a problem but (the psychologist) was very good to me about my fees. I could not to keep up with the full fee each time.
- I had them paid as a workers compensation matter.

6.2.2 GP survey

The nine referring doctors involved in the preliminary phase of the project were similarly surveyed to assess their perception of working with a clinical psychologist over this period of time (for questionnaire see Appendix 6.2). Only six (66%) of the doctors responded – however, these were those most closely involved in establishing
the trial in the first place and hence had most experience of it. Their responses were as follows.

6.2.2.1 “Value to patients”

- 100% (6) of doctors believed their patients had benefited from the extra professional support and counselling;
- 100% (6) indicated that management of patients with both acute and non-acute emotional/psychological disturbance had improved;
- 83% (5) agreed their patients exhibited an improvement in/healthier behaviour patterns (as with the patient survey, some patients had not completed treatment at the time of survey);
- 100% (6) indicated that their patients had received cost effective psychological services.

6.2.2.2 “Value to GPs”

The doctors indicated the following:

- 100% (6) said that they:
  i) benefited from the personal support/sharing care with a clinical psychologist;
  ii) found the opportunity to introduce their patient to the psychologist valuable;
  iii) found that the clinical psychologist provided a valuable option for more accessible psychological services;
  iv) would like to see the “Clinical Psychologist in General Practice Project” continue in their practice.

- 83% (5) indicated that:
  i) they benefited from the collaboration in developing a “case management model of care”;
  ii) their skills and confidence in working with patients with emotional/psychological disturbances had increased;
• 83% (5) said that the clinical psychologist reduced the amount of time they needed to spend with particular patients.

(All responses in this section were either in the “strongly agree/agree” range – as outlined above – or in the “not sure” category.)

6.3 Design
6.3.1 The Project
6.3.1.1 Project stages
There were two stages in the implementation of the project:

- Stage 1 (2001): involved placements of clinical psychology registrars in Bathurst alone (via supervision at CSU);
- Stage 2 (2002-2004): involved registrar placements supervised in all three regional locations (Bathurst, Ballarat and Armidale).

See Figure 6.1 for a summary of the placement design.
6.3.1.2 Participating surgeries and clinical psychology registrars

Following completion of the pilot stage of the project, data on the collaborative model of mental health service delivery were collected over a 4 year period (2001-2004) from nine general practices in three regional cities (Bathurst and Armidale in NSW, and Ballarat in Victoria†), and in two solo practices in two rural and remote NSW townships (Rylstone and Kandos).

† The three research locations of Bathurst, Armidale and Ballarat are fairly typical Australian regional cities. Bathurst, Australia’s first inland settlement (established in 1815), is located on the central tablelands of New South Wales, about 207km west of Sydney beyond the Blue Mountains (2½ hours by car). Current population is approximately 37,500 people. Armidale has a population of approximately 25,000 people, and is located on the New England Highway, approximately 567 km north-west of Sydney, 467 km south-west of Brisbane and approximately 170 km from the east coast of Australia. Ballarat is one of Australia’s largest inland cities with a population
The general practice doctors in the surgeries identified patients whom they believed might benefit from psychological intervention via the normal process of GP consultation. They then referred these patients to a clinical psychology registrar located in their practice (a total of 22 psychological registrars across all settings) who administered mental health indices (outlined below) and provided treatment to patients in the intervention group (see below). The following tables show the gender and age of registrars and the locations of their clinical placements:

**Table 6.1: Number of psychological registrars in participating surgeries**

<table>
<thead>
<tr>
<th>Location/General Practices</th>
<th>No. of Registrars</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Armidale, Inverell, Glen Innes</td>
<td>1</td>
<td>4.5</td>
</tr>
<tr>
<td>Kandos/Rylstone</td>
<td>1</td>
<td>4.5</td>
</tr>
<tr>
<td>Ballarat Group, Ballarat</td>
<td>1</td>
<td>4.5</td>
</tr>
<tr>
<td>Gillies Street, Ballarat</td>
<td>1</td>
<td>4.5</td>
</tr>
<tr>
<td>Rusden Street, Armidale</td>
<td>2</td>
<td>9.1</td>
</tr>
<tr>
<td>Drummond Street, Ballarat</td>
<td>2</td>
<td>9.1</td>
</tr>
<tr>
<td>George Street, Bathurst</td>
<td>7</td>
<td>31.9</td>
</tr>
<tr>
<td>Russell Street, Bathurst</td>
<td>7</td>
<td>31.9</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>22</strong></td>
<td><strong>100.0</strong></td>
</tr>
</tbody>
</table>

Fourteen of the 22 registrars were placed in Bathurst, with seven at the George Street and seven at the Russell Street Practices. Two registrars each were placed at Rusden Street in Armidale and at Drummond Street in Ballarat. One registrar was at the Ballarat Group Practice, one more at Gillies Street, Ballarat and one at clinics in Kandos and Rylstone in rural NSW (which were serviced by a single GP and provided one placement across the two practice settings). Finally, one registrar divided her time among practices in Armidale, Inverell and Glen Innes. Since the registrar in Kandos and Rylstone was supervised in Bathurst, a total of 15 registrars had Bathurst supervisors, four had Ballarat supervisors, and three had supervisors in Armidale.

The majority of registrars were female (approximately 82%), reflecting the predominance of women in the profession of psychology as a whole; with ages ranging from 23 to “50+”. The majority were in their 20s or 30s, the largest age group of over 88,000. Located in the Central Highlands Region of Victoria, Ballarat is approximately 110 km north-west of Melbourne (75 minutes by car). All three towns contain regional universities: Charles Sturt University and the Universities of New England and Ballarat respectively. All have education, tourism and agriculture as their local industries.
representation being in the 30-39 year range as follows: 7 registrars: 20-29 age group, 10: 30-39; 4: 40-49; and 1: 50+, reflecting a predominance of mature age students amongst them. Several of the universities they were enrolled at provide distance mode education enabling mature age students to combine postgraduate studies with other work. The largest number of students (nine) were studying at Charles Sturt University, whilst four were studying at Ballarat, three each at the Universities of New England and Newcastle, and one each at La Trobe and Macquarie Universities and one at the University of South Australia. Fourteen of the registrars were in a Master’s program in Psychology, and seven were in a Doctoral program in Psychology, nearly two-thirds (13 of the 22) of whom were full-time students. At time of placement they were fairly evenly spread across their first, second and third years of study, with two in a fourth year of postgraduate study as follows: eight registrars (36%) in the 1st year of their PG studies, five (23%) in second year, seven (32%) in third year and two (9%) in fourth year – total: 22. This was despite clear preference for only later year students to undertake this placement in preparation for readiness for the primary care workforce and due to the complex nature of the work. All had done at least one other clinical placement previously.

6.3.2 Design issues

6.3.2.1 Control group
Despite methodological issues associated with appropriate matching of patient groups, the use of a control group was deemed essential in testing the efficacy of the collaborative model of treatment. Random allocation of patients requiring treatment for a mental illness to intervention and control groups was considered. However, for both logistical and ethical reasons (ie. duty of care to patients who clearly required psychological intervention), this was not done. A normative control/comparison group was created from patients surveyed in the general practice waiting area (using the same indices as the patient intervention group), who were not referred for psychological treatment by their GP, but were attending the same general practice. This, of course, skewed the initial scores of the comparison group on the mental health measures towards the normal range. The comparison “control” group was therefore a normative sample drawn from a similar demographic population attending the GPs’ surgeries. Given the “action research” nature of the project, pragmatic
considerations (ie. the wish to be of help rather than hindrance to already hard pressed GPs) and ethical constraints (the need to find immediate intervention options for patients clearly requiring treatment) an RCT approach was not appropriate. It was believed that a normative sample (and inherent changes over time with GP consultation alone) provided an adequate reference comparison enabling evaluation of the collaborative intervention/treatment outcomes.

In retrospect after the main study had been done, it was thought that differences between the intervention and control groups may have been confounded by demographic variables such as age, sex, and socioeconomic status. The intervention and control groups from the Bathurst practice were therefore compared on these parameters to determine whether they differed significantly (retrospective data was available only for the Bathurst patients – see further sections in Method and Results below).

6.3.3 Ethics approval

The study was approved by the Charles Sturt University, University of Ballarat, University of New England and University of Sydney ethics committees in 2001.

6.3.4 Patients in the intervention group

Any patient with a common mental illness (primarily depression and/or anxiety), whom participating GPs felt might benefit from psychological intervention, was eligible. Once patient consent was obtained (see Appendix 6.3 for patient/intervention group consent form), the patient was referred by the GP to the “in-house” clinical psychologist or clinical psychology registrar (co-located in the general practice) for psychological treatment in collaboration with the GP. If feasible, an initial short joint consultation between the patient, GP and clinical psychologist/registrar was held before a full psychological assessment (including the indices discussed below) took place.
A total of 309 general practice patients with mental health problems received collaborative treatment. Of these, only 203 completed both pre- and post-measures (see below).

6.3.5 Normative comparison group

Random allocation of patients referring to their GP with mental health conditions to treatment and control groups was considered. As this was not possible, both for pragmatic and ethical reasons (outlined above), a waiting-room-survey control group was established as the comparison group: ie. patients who had not been referred for psychological treatment by their GP, but were attending the same general practice. If any of the comparison patients scored within the severe-to-extremely-severe ranges on the indices: the Depression, Anxiety and Stress Scales (DASS; Lovibond & Lovibond, 1995b) or General Health Questionnaire (GHQ; Goldberg & Williams, 1991), they were referred for psychological intervention following consultation with their GP and were included as part of the intervention group (thereby diminishing the average scores of the control group). A total of 198 patients attending the same general practice surgeries as the intervention group comprised the final normative sample group (see Appendix 6.4 for control/comparison group consent form). Of these, only 98 completed both pre- and post-measures (see below).

6.3.6 Patients in the intervention and control groups

A total of 507 patients were recruited to either the Intervention or the Control group in the surgeries listed above. The following table shows the number of patients initially participating within each town/research centre (NB. a town represents several GP surgeries).
### Table 6.2: Numbers of control and treatment patients from each town/research centre

<table>
<thead>
<tr>
<th>Research Centre</th>
<th>Count</th>
<th>% within Condition</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Control</td>
<td>Treatment</td>
<td></td>
</tr>
<tr>
<td>Armidale</td>
<td>80</td>
<td>61</td>
<td>141</td>
</tr>
<tr>
<td></td>
<td>40.4%</td>
<td>19.7%</td>
<td>27.8%</td>
</tr>
<tr>
<td>Ballarat</td>
<td>14</td>
<td>87</td>
<td>101</td>
</tr>
<tr>
<td></td>
<td>7.1%</td>
<td>28.2%</td>
<td>19.9%</td>
</tr>
<tr>
<td>Bathurst</td>
<td>104</td>
<td>161</td>
<td>265</td>
</tr>
<tr>
<td></td>
<td>52.5%</td>
<td>52.1%</td>
<td>52.3%</td>
</tr>
<tr>
<td>Total</td>
<td>198</td>
<td>309</td>
<td>507</td>
</tr>
<tr>
<td></td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

#### 6.3.6.1 Attrition

As outlined above, whilst a total of 507 patients were scored on the initial measures, there was attrition in both the Treatment and Control Groups by the time the follow-up measures were administered (some eight weeks after the initial measures for the Control Group, or at the completion of treatment for the Treatment Group). The following diagram shows the numbers of participants from each town/research centre initially, and at follow-up/completion of treatment.
In the control group there were 100 (out of 198) fewer participants who took the post-intervention measures than who undertook the pre-intervention measures; and in the treatment group there were 106 (out of 309) fewer participants at the end of the study than at the beginning. Therefore, the control group diminished by about half, whilst the treatment group lost about one-third of its original participants. The 66% return rate of repeat questionnaires (ie. 34% lost to follow-up) in the treatment group was the result of a number of factors, including a clear emphasis on healthcare provision, rather than insistence on questionnaire completion and return. Some dependence on postal returns after the final treatment session also contributed to further attrition. In the control group, return of measures (both pre- and post-) was especially reliant upon the good will of participants, since they were not involved in any intervention and repeat measures/questionnaire responses were fully reliant upon mail return.

Given high attrition rates in both groups, a key concern was whether the subjects who completed the study were substantially different from those who started the study but did not complete post-testing; and in particular if those that began the study in the treatment group were measurably more severely affected than were those who completed the study. Comparisons were therefore made for both the treatment and control groups between mean pre-test scores with the pre-test means of those who
completed both pre-test and post-test measures. Findings are discussed in the results chapter (see section 7.2.2).

6.3.6.2 Comparison of demographic data

Another key concern was whether differences found between treatment and control groups may be attributable to or confounded by demographic differences (gender, age, socioeconomic) between the groups. Gender was the only background variable systematically collected/available for treatment and control patients across treatment centres, and a few cases lacked even this piece of information. However, in the following figure it is apparent that in the control group, the percentage of the group who took both measures who were female was roughly comparable to the percent female in the initial Control Group; similarly in the treatment group, where more than 70% of the treated patients were female, the percent of the initial 309 patients who were female is approximately parallel to the group who provided both pre- and post-measures (see Figure 6.2).

![Figure 6.3: Numbers of control and treatment patients by gender at beginning and completion of study](image-url)
(See sections 7.2.2.1 and 7.2.3.4 for results on gender as a factor ie. comparison of pre-test scores and analysis of treatment effects comparing male and female patients.)

Other demographic data, apart from gender, were not systematically collected at time of initial contact with patients/subjects. However, since slightly more than half of both the original treatment (309) and the control (198) group patients came from GP surgeries in Bathurst, it was possible to collect further demographic information on age and socioeconomic status retrospectively for Bathurst patients (the main research centre) after the other data collection had occurred - in an effort to determine whether the people in the treatment group were roughly comparable to those in the control group. (Due to constraints of time and distance, it was not possible to gather it for patients in the other research centres of Ballarat and Armidale).

Patient age was found to range from 15 to 81 years and was categorised into five groups, as shown in Table 6.3. A measure of socioeconomic status (income quintile) was constructed from the patient’s address as shown on surgery records. The Australian Bureau of Statistics maps of Statistical Local Areas (eg. for Bathurst) - created in its Socio-Economic Indexes for Areas (SEIFA) series at the time of the latest census - were used to establish the “Index of Economic Resources” (a measure of family income, expenditure, assets and dwelling size). This index was grouped into quintiles, with Bathurst’s population covering and mapping across all five levels/quintiles. Control and treatment group patients were allocated to socioeconomic quintiles on the basis of their address and location on the local map (which was divided geographically into these five quintiles).

Findings are presented in Table 6.3
### Table 6.3: Comparison of intervention and control groups from Bathurst on the basis of demographic data

<table>
<thead>
<tr>
<th>Attribute</th>
<th>Control Group</th>
<th>Intervention Group</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Sex</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>30 (28.8%)</td>
<td>39 (24.3%)</td>
<td>69</td>
</tr>
<tr>
<td>Female</td>
<td>74 (71.2%)</td>
<td>122 (75.7%)</td>
<td>196</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>104</strong></td>
<td><strong>161</strong></td>
<td><strong>265</strong></td>
</tr>
<tr>
<td>x² = 0.70; P = 0.40</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| Age                |               |                    |       |
| 15-29              | 14 (15.7%)    | 27 (23.3%)         | 41    |
| 30-39              | 20 (22.5%)    | 29 (25.0%)         | 49    |
| 40-49              | 23 (25.8%)    | 26 (22.4%)         | 49    |
| 50-59              | 14 (15.7%)    | 22 (19.0%)         | 36    |
| 60-81              | 18 (20.2%)    | 12 (10.3%)         | 30    |
| **Total**          | **89**        | **116**            | **205**|
| x² = 5.47; P = 0.24|               |                    |       |

| Income quintile (based on address)* |               |                    |       |
| Lowest                          | 10 (10.2%)    | 24 (19.5%)         | 34    |
| Second                          | 41 (41.8%)    | 43 (35.0%)         | 84    |
| Third                           | 23 (23.5%)    | 36 (29.3%)         | 59    |
| Forth                           | 8 (8.2%)      | 12 (9.8%)          | 20    |
| Highest                         | 5 (5.1%)      | 6 (4.9%)           | 11    |
| Unknown address                 | 11 (11.2%)    | 2 (1.6%)           | 13    |
| **Total**                       | **98**        | **123**            | **221**|
| x² = 13.13; P = 0.02            |               |                    |       |

* For the income quintile, we used Australian Bureau of Statistics index of economic resources (family income and expenditure, family assets and dwelling size) Socio-Economic Indexes for Areas (SEIFA). This index is grouped into quintiles, with Bathurst's population covering all five. We allocated control- and intervention group patients to quintiles on the basis of their address as shown on surgery records.
While nearly three-quarters of the Bathurst patients, both in the treatment and the control group, were female, both patient groups showed diversity in terms of age and socioeconomic background. On all demographic indices, the two groups were found to be comparable to/indistinguishable from each other, hence laying the concern of demographic confounders to rest. Patients in the Bathurst control group were not significantly different from patients in the Bathurst treatment group on the basis of gender, age or income level, as shown by the Pearson chi-squares at the end of each cross-tabulation in Table 6.3. There were slightly higher percentages of young patients and patients in the lowest income quintile in the treatment group, but overall the cross-tabulation percentages were roughly comparable.

6.3.6.3 Medication

Whilst retrospectively obtaining background information on Bathurst patients of the Russell and George Street clinics as outlined above, information was also retrieved from patient files in relation to any current prescriptions for drugs used in the treatment of depression, anxiety or stress. It was felt that prescription of medication was an important variable to attempt to control for (and certainly monitor) since it could have some impact on any treatment effect if found to be more frequently ingested by the treatment group – ie. be a potential confounder. Such information was obtained for all patients for whom names were available – for confidentiality reasons, two clinical psychology registrars had entered patient results by number rather than name. This resulted in it being possible to retrieve information on a higher percentage of Control than Treatment patients. (All results in relation to medication are shown in sections 7.2.2.2 and 7.2.3.5.)

6.3.6.4 Varied numbers across measures

Another issue that became apparent as data were collected was that the number of cases across measures varied by measure (not just in retrospective collection of demographic data, but in the main study itself). This was because for some patients there were some missing data on either the pre-test or the post-test measures, but because participants still had complete data on other measures, they were not excluded from the study. For example, with one measure (DASS Anxiety – see
below), there were two participants who were missing post-test scores and three who were missing pre-test scores, resulting in a total of five for whom a pre-test/post-test difference could not be generated. Therefore the number of cases for the difference variable was 198 (203 minus 5). These cases did, however, have pre-test and post-test scores for other measures and so were not discarded. Number fluctuations in the results chapter need to be read accordingly.

6.3.7 Intervention

The intervention for the treatment group comprised six sessions (with four-to-six more if needed, for more complex conditions) involving full assessment, case formulation and choice of relevant “focused psychological interventions” for the patient’s condition – usually individually targeted and tailored cognitive behaviour therapy (Andrews, Hunt & Jarry, 1997; Andrews, Creamer, Crino, Hunt, Lampe & Page, 2003; Barlow & Hoffman, 1997; Clark & Fairburn, 1997; Diekstra & Jansen, 1990). These were then provided by clinical psychology registrars under close supervision with a senior clinical psychologist (including the author). Ongoing face-to-face discussion and consultation between GPs and clinical psychologists occurred during the course of the patients’ treatment.

Patients were seen by the psychologists *pro bono*. As mentioned previously, there was at the time very little funding available for clinical psychological/psychotherapeutic treatment in regional (and metropolitan) areas, usually necessitating payment of fees to access services. The project was an attempt to redress this, particularly in the regional, rural and remote areas in which it operated where people frequently are not in a position to pay. Support from the Commonwealth enabled funded service provision during the project trial - provision of services otherwise unavailable in these regions had been a key rationale for establishing the project in the first place.

6.3.7.1 Model of collaborative service delivery entailed

- Co-location and provision of clinical psychology services in the medical general practice setting, preventing the need for articulation of assessment and
treatment to another specialist setting as is often required. Patient attrition, often occurring at this point, was therefore minimised;

- “In-house” referral of patients whom the general practitioner assessed could benefit from psychological intervention for either: psychological issues (most referrals within the project were cases of high prevalence depression and anxiety), or physiological issues with a psychological dimension (a small percentage of patients required careful management of physiological and other co-morbid conditions; mental health sequellae/parallels to chronic illnesses such as cardiovascular disease, arthritis, Parkinson’s disease, diabetes etc. were addressed using techniques including behavioural self-management strategies);

- where practically possible, an initial joint session between the patient, general practitioner and clinical psychologist occurred at the commencement of the psychological assessment enabling:
  
  a) establishment of rapport between the psychologist and patient through endorsement by the GP;
  
  b) patient communication to both professionals of their own perception of the presenting problem/condition and its background;
  
  c) both professions to provide a formulation of the patient’s condition and explaining treatment options;
  
  d) communication between the GP and psychologist about the patient’s condition (ie. presenting issues/problems and background);
  
  e) a request for patient consent for cross-professional communication during the course of treatment and access to medical notes by the psychologist (see Appendix 6.3 for formal consent form given to all patients);
  
  f) appreciation by both professions of their alternative and complementary ways of formulating patient difficulties and presenting conditions.

Early intervention objectives also included autonomy/resilience building and importantly, prevention/diminution of continued dependency on the health system.
6.3.8 Data Collection

6.3.8.1 Pre- and post-measures/indices

Questionnaires measuring level of psychological dysfunction were completed by intervention group patients pre- and post-treatment and by the comparison group over a similar time interval. Both intervention and control group patients were asked to fill out three self-report mental health measures: the DASS (Depression, Anxiety and Stress Scale – Lovibond & Lovibond, 1995), the GHQ (General Health Questionnaire Goldberg & Williams, 1991) and the GWBI (General Well Being Index - Dupey, 1978). These were chosen on the advice of a small National Primary Care Research Group (see Appendix 6.3), created by the author as director of the project, to establish which indices were being used in similar research projects around the country. The aim was to ensure that data collected in different locations would be compatible, enabling a patient data bank to be created within the primary care sector. Discussions were held between members of the group during two audio conferences (6.3.01 and 14.5.01). The chosen indices provided baseline and post-treatment measures for the collaborative treatment group and the comparison/“GP treatment as usual” group, and covered the high prevalence conditions of depression, anxiety and stress as well as general health and well being.

The intervention group completed all three mental health measures at their first session and again after their final treatment session with the psychologist. In addition, a number of qualitative indices were used to monitor progress, as well as a patient satisfaction questionnaire at the conclusion of treatment. The control group completed initial mental health measures at the time of recruitment and were sent the same measures to complete 8 weeks later, which was about the same time interval as those receiving the intervention. See Figure 6.4 for a summary presentation of data collection.
Figure 6.4: Diagrammatic model of patient parameters and data collection

**PATIENT PARAMETERS**

<table>
<thead>
<tr>
<th>Demographic Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age:</td>
</tr>
<tr>
<td>Sex:</td>
</tr>
<tr>
<td>Presenting Problem:</td>
</tr>
<tr>
<td>Has help been received before?</td>
</tr>
<tr>
<td>Medication:</td>
</tr>
<tr>
<td>Duration of medication use?</td>
</tr>
</tbody>
</table>

**PRE-MEASURES**

- a) DASS
  - Depression
  - Anxiety
  - Stress
  - Composite

- b) GHQ (health) Composite

- c) GWBI Composite

- d) Subjective list of PROBLEMS

**INTERVENTION**

(6-10 sessions of treatment)

**POST-MEASURES**

- a) DASS
  - Depression
  - Anxiety
  - Stress
  - Composite

- b) GHQ
  - Composite

- c) GWBI
  - Composite

- d) Subjective list of "Things that Have Changed"

**No. of sessions:**

**e) Patient Satisfaction Questionnaire**
Lovibond and Lovibond (1995a) was chosen as it provides clear and visually representable measures of symptomatology of these three common mental conditions in the primary care setting. It is also an Australian measure with Australian norms available. It is the main measure used in the study due to its relevance to the Australian population. (Originally, the DASS 42 was chosen, although subsequently some treatment patients completed the DASS 21, due to working in conjunction with another project which required a briefer questionnaire. A syntax file was created to convert these scores into a format compatible with the original data.)

Of the 42 items on the questionnaire, 14 relate to the person’s experiences of depression, 14 to their experiences of anxiety and 14 to their experiences of stress. Items are presented in a random order, with a four-point scale for each question labelled from:

- “0” (“did not apply to me at all”) to
- 1 (“applied to me some of the time”)
- 2 (“applied to me to a considerable degree, or a good part of the time”) and
- 3 (“applied to me very much, or most of the time”).

Instructions at the top of the page highlight that each statement needs to be evaluated on how much it has applied to the patient “over the past week” using the 0-3 point scale. Global sub-scores are produced for all three symptom scales (see below) and an overall DASS score is calculated by summing all three global scores. DASS scores fall within one of five ranges: ‘Normal’, ‘Mild’, ‘Moderate’, ‘Severe’, and ‘Extremely Severe’. Each of the three global scores has different thresholds for each range (see the DASS and DASS profile sheet in Appendices 6.5 & 6.6). Ranges for the subscales are as follows:

- **Depression**: mild-to-moderate severity: 12-20; severe-to-extremely severe: 20-42. As outlined in Lovibond and Lovibond (1995a), characteristics of high scorers on the Depression scale are: “self-disparaging; dispirited, gloom and blue; convinced that life has no meaning or value; pessimistic about the
future; unable to experience enjoyment or satisfaction; unable to become interested or involved; slow, lacking in initiative”. Item examples are: “I felt downhearted and blue” (reflecting on of the seven components: dysphoria), “I felt that life was meaningless” (devaluation of life), “I felt that I had lost interest in just about everything” (lack of interest/involvement).

- **Anxiety:** mild-to-moderate: 9-14; severe to extremely severe: 14-42. Characteristics of those scoring highly on the Anxiety scale are: “apprehensive, panicky; trembly, shaky; aware of dryness of the mouth, breathing difficulties, pounding of the heart, sweatiness of the palms; worried about performance and possible loss of control” (Lovibond & Lovibond, 1995b). Item samples are: “I was aware of the action of my heart in the absence of physical exertion” (autonomic arousal), “I had a feeling of shakiness - eg. legs going to give way” (skeletal musculature effects), “I was worried about situations in which I might panic and make a fool of myself” (situational anxiety).

- **Stress:** mild-to-moderate: 16-26; severe-to-extremely-severe: 26-42. Characteristics of high scorers on the Stress scale are: “over-aroused, tense; unable to relax; touchy, easily upset; irritable; easily startled; nervy, jumpy, fidgety; intolerant of interruption or delay” (Lovibond & Lovibond, 1995). Sample items are: “I found it hard to wind down” (difficulty relaxing), “I found myself getting upset rather easily” (agitated), “I was intolerant of anything that kept me from getting on with what I was doing” (impatient).

The DASS profile sheet provided an easy visual representation of patient standardised scores (ie. relative to national norms) and was hence a useful device for the practitioners involved (see Appendix 6.6). The psychometric properties of the DASS have been intensively evaluated, indicating that the three scales have excellent internal consistency and temporal stability (Brown, Chorpita, Korotitsch & Barlow, 1997). Comparison of and correlations between the DASS sub-scales and other questionnaire measures (eg. the Beck Depression Inventory and the Beck Anxiety Inventory) demonstrate both convergent (to a greater degree than is typically observed
in self-report scales) and discriminant validity of the scales (Brown et al., 1997; Lovibond & Lovibond, 1995a and 1995b).

6.3.8.1b) **GHQ 28: General Health Questionnaire 28**

Goldberg and Williams (1991) was chosen as it has been used extensively in both international and Australian research to measure psychological health in a variety of communities, and provides easily accessible and visually presentable results (Van Schoubroeck (1896) for a review of use of the GHQ in Australia). It is a 28 item self-report questionnaire designed to measure changes in experience (rather than current actual experience as measured by the DASS). It requires patients/participants to respond to the 28 statements about a range of physical and psychological/psychiatric symptoms by stating how often they experienced these “over the past few weeks” using a 4-point scale ranging from 0 (“not at all”) to 3 (“much more than usual”). Sample items include: “been feeling run down and out of sorts?”, “been getting scared or panicky for no good reason?”, “felt capable of making decisions about things?”, “found yourself wishing you were dead and away from it all?” The GHQ has four seven-item sub-scales (derived by factor analysis) measuring: Somatic Symptoms, Anxiety, Social Functioning and Depression. The four sub-scale scores are summed to produce an overall patient GHQ score (taking into account that some items load positively, some negatively, on pathology measures). The global GHQ score is used throughout this study. A clinical threshold score lies between 16 and 20, patients’ summed scores being assessed relative to this reference range (see Appendix 6.7).

Goldberg and Williams (1991) provide an overview of twelve validity studies on the GHQ-28, concluding that the measure has adequate validity across a variety of settings. Various forms of the measure have been demonstrated to possess good split-half reliability (ranging between 0.77 to 0.95) and internal consistency, but test-retest reliability studies vary considerably - and are extraordinarily difficult to undertake in a clinical population whose degree of disturbance may vary between pre-test and follow-up - or indeed in any population where subjects’ states may change. Findings have indicated test-retest reliabilities of +.85 in a small sample of neurological patients over a five day period (DePaulo & Folstein, 1978); +.90 in 103 stroke...
patients tested approx. 8 months apart (Robinson & Price, 1982); but only +.58 amongst 186 school leavers and +.51 amongst 101 men facing redundancy tested 11-12 months apart (Layton, 1986). Further, a rate of only +.36 was found amongst 195 medical housemen, tested as fourth year medical students two years previously (Goldberg & Williams, 1991). As indicated in the “User’s Guide to the General Health Questionnaire” it appears that the “definitive test-retest reliability study remains to be done” (Goldberg & Williams, 1991).

6.3.8.1c) **GWBI: General Well Being Index**

Dupey (1978) was chosen through a process of exclusion after several other wellbeing indices: the SF16, the SF36 and a new WHO “quality of life” measure had been considered. The SF (used in other Australian studies) provided an index of functioning at too low a level for the Primary Care group of patients within the current study; whilst the more recent Quality of Life measure used in WHO research was deemed inappropriately long (at 100 items) for the treatment and control group/survery patients. It was decided, however, despite these difficulties that a “quality of life”/”wellbeing” measure was important as the treatment model being used was not a medical one and any change/remission in “pathology”/“illness” measures should be reflected in an inverse increase in perceived wellbeing and functioning. The General Well Being Index was therefore chosen: a 22 item measure of general wellbeing (see Appendix 6.8) and a multi-dimensional indicator of subjective feelings of wellbeing as well as distress. The 22 items form six sub-scales: anxiety, depression and positive wellbeing, general health perceptions, vitality and perceptions of self-control. The questions ask the patient to evaluate their experience “during the past two weeks” (as with the GHQ). There are six response categories for each item ranging from very positive to very negative, with allowance made in the six categories for possibilities of change in either direction (eg. “I’ve been up and down a lot”). Sample items include: “How have you been feeling in general?”, “Have you felt in firm control of your actions?”, “How happy, pleased or satisfied have you been?”, “Have you been waking up feeling fresh and rested?”. All 22 questions are asked and scored in the same way (on a Likert scale from 1-5). Half of the questions/scoring ranges are inverted (ie. 11 items score straightforwardly onto wellbeing: eg. “During the past two weeks, have you felt stable and sure of
Chapter 6: Method

6.3.8.1d) Qualitative measures

In addition to the above three quantitative measures, several qualitative indices were used pre- and post-intervention, in an attempt to capture the unique “presenting problems” and the “changes made” in treatment by each patient. These included the Problems to Goals Sheet (see Appendix 6.10) and a “List of Things That Have Changed” compiled during the final session between the patient and clinician. Case study examples of these, as they apply to different patients, are provided in Appendix 6.11.

6.3.8.1e) Patient Satisfaction Questionnaire

Treatment patients were asked to complete a Patient Satisfaction Survey at the end of their treatment. Compliance rates were low as they relied on postal returns (see results). The aim of the questionnaire was to obtain an understanding of whether the intervention was viewed positively by participants and met their needs.

6.3.9 Statistical methods/analyses

SPSS was used for all statistical analyses (SPSS, Version 10 - Coakes & Steed, 2000).

... yourself?”; the other half are inverted: eg. “During the past two weeks, have you felt tired, worn out or exhausted?”). To obtain the total GWBI score, half of the questions/scoring ranges were inverted and summed with the 50% non-inverted scores. (A syntax file was created to calculate the total score from raw data, all of which was entered into the data file in the same way/without inversion.) No clinical threshold score exists for the GWBI.

The psychometric qualities of the GWBI have not been widely demonstrated but tests of reliability are good (Dupey, 1978). Its choice as an index was based on its “face value” and its reliability as a measure of global wellbeing deemed to be assessable within the study by an inverse correlation with the DASS and GHQ – both valid and reliable clinical measures of psychological dysfunction (see Results section).
6.3.9.1 Comparison of Intervention and Control Groups

6.3.9.1a) Pre- and post-measures

There were two major issues of interest:

- Whether, within the intervention group, the initial scores on the mental health measures differed significantly from the follow-up scores; and
- Whether the scores on the initial and follow-up mental health measures differed significantly between the control and intervention groups.

The total scores and subscores of DASS and GHQ, and GWBI were assumed to be normally distributed for each group on each testing occasion. To answer the first question (ie. to test the significance of differences between pre- and post-intervention scores) a paired samples t-test was used which yielded a difference in means, a \( t \) value and a significance \((p)\) value (Coakes & Steed, 2000; Field, 2000). An independent samples t-test was used to answer the second question, which once again yielded a difference in means, a 95\% confidence interval of this difference, and a two-tailed test of significance of the t-test. Equal variances were assumed (see section 7.2.3 for results).

Two analyses of variance were also done to test statistically and assess more efficiently whether there was any difference in scores between geographic locations and by gender - including any interactive effects of these variables with condition: ie. treatment vs. control. The aim was to clarify whether main statistical effects were from the “condition” (ie. treatment vs. control) or whether location (ie. Bathurst, Armidale and Ballarat) also had some impact on scores. Additionally, it was important to assess whether males had different scores from females and whether there were any interactions between the three factors/variables (see section 7.2.3.8 for results).

6.3.9.1b) Pairing data across intervention and control groups

It was felt that comparison between an intervention and control group that differed on initial/pre-test scores may not provide conclusive indication of intervention effect, even if significant results were found. A small sample of matched pairs across both
groups was therefore found, enabling comparison between intervention and control participants who started out at the same level of functioning/disturbance. Initial DASS profiles for participants were used to match control participants to treatment group patients on their pre-test scores. Matching was based on the pattern on the DASS profile – ie. if a control participant scored ‘medium’ on depression, ‘severe’ on anxiety and ‘medium’ on stress, a treatment participant with the same profile was located. If there proved to be more than one option for the matching (as was sometimes the case) then participants having the closest actual scores were paired. If there remained any doubt about which participant to include (either from the control or intervention group), the remaining measures (ie. GWBI and GHQ) were consulted to inform the decision.

Forty-eight suitable matched pairs were created from the intervention and control groups, drawn from the relatively small overlap between the two groups of patients (the control group, being a “normative comparison”, had significantly lower average scores on all indices than the treatment group). Comparison of the average pre-test mean for the DASS, GWBI and GHQ, using a paired samples t-test, gave an indication of how closely these participants were matched (a non-significant t value indicating that the matching was adequate, the participants in each pair not differing significantly on their scores). The 48 pairs were then compared on all post-intervention measures to assess the significance of the impact of the collaborative model of treatment on the intervention group, compared to their matched controls who received “GP treatment alone”. (Comparison of the post-test scores, again using a paired sample t-test, would give an indication of whether the intervention had an impact, a significant t value indicating a marked difference between the control and treatment participants. It was assumed that there would probably be at least a trend towards treatment participants’ scores improving, whilst control participants’ scores may not change markedly - if there were a marked treatment effect.)

6.3.10 General practitioners

Baseline measures of GP attitudes to the use of a collaborative care framework were measured in early 2001 by an audit/survey of the local Division of General Practice.
A “Clinical Psychologists in Primary Care Questionnaire” (formulated in collaboration with Adelaide, Ballarat, Bond, and James Cook Universities and the Central West Division of GP’s), was mailed out to 176 in the NSW Central West Division of NSW (see Appendix 6.12). 111 GPs responded (ie. a 63% response rate). A follow-up questionnaire providing post-measures (including satisfaction with the model of collaborative service delivery) was mailed to the small group of participating GPs in mid 2004, to enable qualitative comparisons with the baseline indices provided by the initial questionnaire and some indication of whether participating GPs found “value added” in the collaborative model of care compared to “GP treatment” alone (see Appendix 6.13 for the follow-up questionnaire). Fourteen of the participating GPs responded.

6.3.11 Clinical Psychology Registrars

Student Primary Care internships consisted of 250 hours of practicum (ie. 8 weeks full-time; 12-18 weeks part-time), inclusive of 50 hours of supervision by senior clinical psychology supervisors (as specified by Australian Psychological Society clinical placement requirements).

6.3.11.1 Clinical psychology registrar placement protocols

Two random, pre-arranged GP observation sessions were provided at the beginning of each placement for all registrars (ie. the psychology intern sitting in with volunteer GPs on a morning or afternoon session). The aim of these was to provide an introduction and orientation to the General Practice setting and an opportunity for collaborative discussion about the prevalence of psychological issues in primary care.

6.3.11.2 Allocation of patients

Registrars were required to see 20 patients on placement, referred by the general practice GPs (as outlined in Figure 6.1). Referrals were primarily for high prevalence depression and anxiety, although a number of co-morbid conditions were also included. GPs were encouraged to use the service to a maximum, as it enabled full treatment (using a 6-10 session treatment framework) of patients on a pro-bono basis. Since, due to lack of public health funding at the time, most patients were not in a
position to afford fees, this was a service that they (both GPs and patients) were exceedingly pleased to access. Referrals were therefore not a problem as need was high.

6.3.11.3 Patient parameters and procedures

As outlined in the patient section above, a number of quantitative and qualitative measures were used prior to and post-treatment (refer to Figure 6.2). GPs and clinical psychology registrars requested patients to fill out the DASS, GHQ and GWBI prior to the initial assessment session, although on occasion, when this was not possible, they filled them out between the first and second session. In addition, patients were also required to complete a subjective/qualitative list of their presenting problems, complementing the quantitative assessment devices already mentioned. All indices provided pre-measures of the patient’s condition and situation prior to the intervention. Post-measures were taken on the same indices, including a subjective list of “Things that have Changed”, usually completed in the final session. A patient satisfaction questionnaire was completed post-treatment, although completion and return rates from this were not high due to being reliant on postal return.

Formal written feedback/letters to the referring doctor were provided after the initial assessment session and at conclusion of treatment, summarising gains made both on objective indices and the patient-generated problem list. Brief summary statements were placed in patient medical notes at the conclusion of each session indicating to the GP that the patient had seen the clinical psychologist since their previous medical consultation (patient consent for the psychologist’s access to their medical notes was obtained in the first session – see Consent Form in Appendix 6.3). In addition, a clinical psychology form including treatment plan and discharge summary was filed at the back of the notes to provide the GP with an overview of the psychological treatment undertaken (see Appendix 6.14).

6.3.11.4 Intervention

See Intervention under Patient Section above.
6.3.11.5 Internship evaluation

Clinical psychology registrar attitudes to the placement were assessed post-placement using an evaluation of placement form (see Appendix 6.15). In addition, qualitative reports from each registrar on their experience of primary care placement and the collaborative model were required. In 2004, a follow-up questionnaire was sent to all 22 registrars who had undertaken placements/internships across all locations between 2001-2004 (see Appendix 6.16). With 100% response rate, this survey provided valuable feedback/data on registrars’ clinical placement experience evaluations. None of them had participated in primary care service delivery prior to this experience.

6.3.11.6 Clinical placement documentation

See Figures 6.1 and 6.4 for overview of clinical placements and data collection protocols; and Appendices 6.3–6.18 for placement documentation.

6.5 Summary and hypotheses

The Project described in the current dissertation involves the implementation and evaluation of a new model of collaborative of mental health service delivery in a number of regional and rural settings across Australia where limited mental health resources were available.

6.5.1 General objectives of the collaborative model of care were to:

- facilitate/enable early clinical psychology intervention with mental health conditions (and some physical conditions with either a psychological cause or psychological sequellae) thereby preventing the development of more severe conditions and consequent greater frequency of use of medical services;
- locate services in the General Practice setting, thereby decreasing the stigma for patients in seeking help for psychological problems and increasing the frequency of access to specialist mental health services for those in need;
- develop and strengthen positive partnerships between medical general practitioners and clinical psychologists in primary mental health care;
• provide an effective way of supporting regional and rural GPs to more adequately meet their patients’ mental health needs, particularly in the context of lack of adequate, accessible and affordable specialist mental health services in rural areas.

In addition, it was aimed that the project would:

• support ongoing continuing medical education for GP’s ‘in situ’ by providing learning outcomes for general practitioners whilst working collaboratively with the profession of clinical psychology;

• offer optimal placement opportunities for postgraduate interns/registrars in clinical psychology at Charles Sturt, Ballarat, New England and several other Universities, and develop a generic training model for clinical psychology registrars in primary care (similar to general medical practice registrarships);

• provide opportunities to increase consumer awareness and improve the mental health of people living in regional/rural areas of Australia;

• develop appropriate and sustainable funding models for collaborative care between GPs and psychologists, enabling patients access to services where fee paying was not viable - ie. in most regional/rural areas. (When the project began, there was scarce funding for psychological services meaning that service delivery was essentially skewed towards those who could afford to pay);

• provide an innovative generic model of mental health service delivery which could be articulated nationally and funded under the public health system.

6.5.2 Hypotheses

Three key predictions underpinned the Clinical Psychology in General Practice Project.

1) Firstly, it was predicted that patients undertaking treatment for common mental disorders in primary care would do significantly better under a shared
care, collaborative model involving both GPs and clinical psychologists, than under GP treatment alone.

2) It was also predicted that GPs involved in collaborative care would find the model useful and of more value to their patients than straightforward medical care provided by themselves alone (ie. that significant “value added” was created through involvement of clinical psychologists in collaborative care).

3) Finally, it was predicted that students undertaking the primary care internships (ie. the clinical psychology registrars) would find their placement experiences of significant value in preparing for work in the general practice setting, and that more of them would opt for work in primary care as a consequence.
Chapter 7

RESULTS

7.1 Overview

The results are divided into three sections: patients, general practitioners and clinical psychology registrars. Methodologies differ: the latter two sections outline survey responses from doctors and clinical psychology registrars, the first section describes both quantitative and qualitative findings from the treatment group of patients, and quantitative comparisons with the control group. Findings from screening analyses undertaken to confirm equivalence of the treatment and control groups on demographic variables (gender, age and socioeconomic status) were presented in the method chapter. Results presented here focus on the core questions surrounding pre- and post-intervention within-and-between-group differences on the mental health indices, and highlight findings in relation to efficacy of the collaborative care model. As outlined in the method, the Depression, Anxiety and Stress Scale (DASS) is the main measure used in the study, with scores on the three key dimensions (depression, anxiety and stress) falling within one of five ranges: ‘normal’, ‘mild’, ‘moderate’, ‘severe’, and ‘extremely severe’. The General Health Questionnaire (GHQ) and General Wellbeing Index (GWBI) were also used, the former designed to measure changes in experiences (rather than actual experience as measured by the DASS) with four key sub-measures: somatic symptoms, anxiety, social functioning and depression; the latter to highlight hypothesised inverse growth in wellbeing with improvement. All statistical analyses for the present study were undertaken using SPSS Version 10.0 for Windows (Coakes & Steed, 2001).

7.2 Patients

7.2.1 Summary

As outlined in Chapter 6, the Clinical Psychology in General Practice Project was aimed at testing the efficacy of introducing clinical psychology services into the medical general practice setting in rural and regional areas of Australia, and
developing a model of early intervention by psychologists for primary care patients with common mental illnesses. By mid-2004, 309 patients had received treatment through the project in the three research centres of Bathurst, Armidale and Ballarat. It was estimated that the consent/participation rate of patients was high (about 95%). As outlined in Chapter 6, of the 66% of these patients (n=203) who completed initial and follow-up measures 71.9% were female and 28.1% were male. Treatment and control groups were found to be comparable in terms of demographic variables including sex ratio, age and socioeconomic status.

7.2.1.1 Varied numbers across measures

As mentioned in section 6.3.6.3, as data were collected and analysed, it became apparent that the total number of cases/patients varied by measure. There were missing data for some patients on either the pre-test or the post-test measures, but because participants still had complete data on other measures, they were not excluded from the study. When reading the following tables, this needs to be taken into account - and explains varying totals (“N’s”).

7.2.2 Between group comparison of pre-test scores

To establish whether pre-test differences on scores between the groups were determined or confounded by geographically-determined differences and gender, an analysis of variance (ANOVA) was done comparing pre-test scores of both groups on three factors: condition (1,2: ie. treatment vs. control), location (1,2,3: ie. Bathurst, Armidale and Ballarat) and gender (1,2: male vs. female) – see Appendix 7.3a for ANOVA table. Results indicated that the factor of statistical significance was “condition” – ie. treatment vs. control (F values less than 0.001), whilst location and gender had little bearing on the results (ie. an insignificant impact). Two way interactions between condition and location were apparent; however, none of the F values reached significance. These findings enabled confidence that between-group differences were not confounded by gender or geographic location.

Given high attrition rates in both groups a key concern was whether subjects who completed the study were substantially different from those who started the study but
did not complete post-testing; and in particular if those that began the study in the
treatment group were measurably more severely affected than were those who
completed the study. Comparisons were therefore made for both the treatment and
control groups between mean pre-test scores of those who completed pre-measures
only (309 and 198) with the pre-test means of those who completed both pre-test and
post-test measures (203 and 98). Patients completing both initial and follow-up
measures in both the treatment (309 reducing to 203 patients) and control (198
reducing to 98) groups were found to be approximately representative of the total
group. In terms of initial scores on sub-scale measures, treatment group patients
completing initial scores only on the three measures (the DASS, GWBI and GHQ)
were found to be equivalent to those who completed both initial and post-testing (see
Tables 7.1 below). This indicates that the sub-sample of patients (203) who provided
full data were representative on all measures of the referred/treated patients as a
whole (309) - the majority of these being referred by their GPs for, and presenting
with, the common mental disorders of depression and anxiety.

Table 7.1 Pre-test data

<table>
<thead>
<tr>
<th>Pre-Test Measure</th>
<th>Original Group</th>
<th>Group with post-test scores</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>Mean</td>
</tr>
<tr>
<td>DASS Depression</td>
<td>306</td>
<td>21.58</td>
</tr>
<tr>
<td>DASS Anxiety</td>
<td>306</td>
<td>15.78</td>
</tr>
<tr>
<td>DASS Stress</td>
<td>302</td>
<td>23.26</td>
</tr>
<tr>
<td>DASS Composite</td>
<td>302</td>
<td>60.49</td>
</tr>
<tr>
<td>General Well Being</td>
<td>299</td>
<td>35.81</td>
</tr>
<tr>
<td>GHQ somatic symptoms</td>
<td>304</td>
<td>9.76</td>
</tr>
<tr>
<td>GHQ anxiety</td>
<td>304</td>
<td>11.70</td>
</tr>
<tr>
<td>GHQ social functioning</td>
<td>303</td>
<td>11.21</td>
</tr>
<tr>
<td>GHQ depression</td>
<td>304</td>
<td>7.00</td>
</tr>
<tr>
<td>GHQ total</td>
<td>302</td>
<td>39.65</td>
</tr>
</tbody>
</table>
Both groups of treatment patients (ie. the original group with pre-test scores only and those with both pre- and post-test scores) have almost identical means and standard deviations (see Table 7.1a). In contrast, slight differences were found in mean scores between the original group of control patients who took the pre-test compared to those who completed both pre- and post-tests (see Table 7.1b). In general, the scores for the remaining control group of 98 participants tended to be slightly lower (ie. more towards the normal range) than those in the original/larger control group (198), but in most cases this was by less than one score point. This trend added confirmation that the group was a normative control rather than a treatment group comparison.

Table 7.1b: Comparison of pre-test scores of control patients with only pre-test data to those with both pre- and post-test data

<table>
<thead>
<tr>
<th>Pre-Test Measure</th>
<th>Original Group</th>
<th></th>
<th>Group with post-test scores</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>Mean</td>
<td>Std Dev</td>
<td>N</td>
</tr>
<tr>
<td>DASS Depression</td>
<td>193</td>
<td>8.86</td>
<td>10.38</td>
<td>98</td>
</tr>
<tr>
<td>DASS Anxiety</td>
<td>193</td>
<td>7.26</td>
<td>9.12</td>
<td>98</td>
</tr>
<tr>
<td>DASS Stress</td>
<td>193</td>
<td>11.90</td>
<td>9.86</td>
<td>98</td>
</tr>
<tr>
<td>DASS Composite</td>
<td>193</td>
<td>27.96</td>
<td>27.52</td>
<td>98</td>
</tr>
<tr>
<td>General Well Being</td>
<td>192</td>
<td>55.15</td>
<td>18.15</td>
<td>96</td>
</tr>
<tr>
<td>GHQ somatic symptoms</td>
<td>196</td>
<td>6.87</td>
<td>5.07</td>
<td>96</td>
</tr>
<tr>
<td>GHQ anxiety</td>
<td>196</td>
<td>6.42</td>
<td>5.22</td>
<td>96</td>
</tr>
<tr>
<td>GHQ social functioning</td>
<td>194</td>
<td>7.96</td>
<td>3.46</td>
<td>96</td>
</tr>
<tr>
<td>GHQ depression</td>
<td>194</td>
<td>2.35</td>
<td>4.08</td>
<td>96</td>
</tr>
<tr>
<td>GHQ total</td>
<td>194</td>
<td>23.46</td>
<td>14.71</td>
<td>96</td>
</tr>
</tbody>
</table>

Not surprisingly, the intervention group and the control group were found to differ markedly on their initial measures (see Tables 7.2a and 7.2b for statistical significance of these differences) - in part because any members of the control group who scored within the severe or extremely severe range on the DASS or the GHQ were referred to the intervention group for treatment. As a consequence, the initial scores for the control group were strongly skewed toward the normal range. Table 7.2a highlights the differences between all participants in the two groups who undertook the pre-test including all treatment and control participants, whilst Table 7.2b limits the analysis to those participants who completed both the pre-test and post-test measures. Table
7.2b provides a clear point of reference for Table 7.8 (pre- and post-test comparisons) since it contains the same patients (at pre-test) as those in the post-test group in Table 7.8.

Table 7.2: Between group pre-test comparison

Table 7.2a: Pre-test comparisons between all control and treatment participants who took initial pre-test

<table>
<thead>
<tr>
<th></th>
<th>Control</th>
<th></th>
<th>Treatment</th>
<th></th>
<th>Diff*</th>
<th>t</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>(SD)</td>
<td>n</td>
<td>(SD)</td>
<td>t</td>
<td></td>
<td>p</td>
</tr>
<tr>
<td>Depression</td>
<td>193</td>
<td>8.86 (10.38)</td>
<td>306</td>
<td>21.59 (12.08)</td>
<td>-12.73</td>
<td>-12.507</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>Anxiety</td>
<td>193</td>
<td>7.26 (9.12)</td>
<td>306</td>
<td>15.79 (10.74)</td>
<td>-8.53</td>
<td>-9.483</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>Stress</td>
<td>193</td>
<td>11.90 (9.86)</td>
<td>302</td>
<td>23.27 (10.71)</td>
<td>-11.37</td>
<td>-12.092</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>GWBI</td>
<td>192</td>
<td>55.16 (18.15)</td>
<td>299</td>
<td>35.82 (15.82)</td>
<td>19.34</td>
<td>12.107</td>
<td>&lt;.001</td>
</tr>
</tbody>
</table>

* The Difference Score is the difference between the control group and treatment group means.

Table 7.2b: Pre-test comparisons between control and treatment participants who completed both pre- and post-intervention measures

<table>
<thead>
<tr>
<th></th>
<th>Control</th>
<th></th>
<th>Treatment</th>
<th></th>
<th>Diff*</th>
<th>t</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>(SD)</td>
<td>n</td>
<td>(SD)</td>
<td>t</td>
<td></td>
<td>p</td>
</tr>
<tr>
<td>Depression</td>
<td>98</td>
<td>7.80 (9.59)</td>
<td>200</td>
<td>21.00 (11.87)</td>
<td>-13.21</td>
<td>-10.303</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>Anxiety</td>
<td>98</td>
<td>6.68 (9.16)</td>
<td>200</td>
<td>15.36 (10.71)</td>
<td>-8.67</td>
<td>-7.255</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>Stress</td>
<td>98</td>
<td>10.52 (9.54)</td>
<td>198</td>
<td>23.15 (10.66)</td>
<td>-12.64</td>
<td>-10.308</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>GWBI</td>
<td>96</td>
<td>56.27 (18.81)</td>
<td>200</td>
<td>35.97 (15.61)</td>
<td>20.30</td>
<td>9.168</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>GHQ</td>
<td>96</td>
<td>22.47 (14.32)</td>
<td>200</td>
<td>39.42 (16.72)</td>
<td>-16.95</td>
<td>-9.015</td>
<td>&lt;.001</td>
</tr>
</tbody>
</table>

*The Difference Score is the difference between the control group and treatment group means.

7.2.2.1 Gender differences

Whilst the ANOVA outlined above indicated no confounding differences between the groups at pre-test from gender and geographic location (see Appendix 7.3a), separate analyses of the impact of gender alone were done as early analyses of Bathurst
patients (with incomplete N’s) on pre-test scores showed some tendency to gender differences in pre-test measures - with females showing higher average depression, anxiety and stress levels and lower general wellbeing scores when compared to male patients (see Appendix 7.1). However, entire-group comparisons of male and female pre-test scores for treatment and control groups showed both variation in direction and insignificance of difference between mean scores, suggesting no gender differences on pre-test measures – ie. when t-tests were run, nothing was found to be significant (see Tables 7.5a and 7.5b).

Table 7.3: Gender: Pre-test comparisons between male and female patients

### 7.3a: Treatment group patients

<table>
<thead>
<tr>
<th></th>
<th>n</th>
<th>Female mean (SD)</th>
<th>Male mean (SD)</th>
<th>Diff*</th>
<th>t</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>DASS Depression</td>
<td>224</td>
<td>21.80 (12.07)</td>
<td>21.14 (12.19)</td>
<td>0.662</td>
<td>0.420</td>
<td>0.675</td>
</tr>
<tr>
<td>DASS Anxiety</td>
<td>224</td>
<td>15.79 (10.54)</td>
<td>15.89 (11.34)</td>
<td>-0.10</td>
<td>-0.071</td>
<td>0.943</td>
</tr>
<tr>
<td>DASS Stress</td>
<td>220</td>
<td>23.52 (10.75)</td>
<td>22.80 (10.51)</td>
<td>0.72</td>
<td>0.520</td>
<td>0.604</td>
</tr>
<tr>
<td>GWBI</td>
<td>220</td>
<td>35.37 (15.50)</td>
<td>36.95 (16.78)</td>
<td>-1.58</td>
<td>-0.728</td>
<td>0.468</td>
</tr>
<tr>
<td>GHQ</td>
<td>221</td>
<td>40.32 (16.75)</td>
<td>38.03 (16.55)</td>
<td>2.29</td>
<td>1.058</td>
<td>0.292</td>
</tr>
</tbody>
</table>

* The Difference Score is the difference between the female and male means.

** Incomplete numbers (as compared to N=309) were due to gender not being available on all patients, and complete scores similarly not being available for all patients.

### 7.3b: Control group patients

<table>
<thead>
<tr>
<th></th>
<th>n</th>
<th>Female mean (SD)</th>
<th>Male mean (SD)</th>
<th>Diff*</th>
<th>t</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>DASS Depression</td>
<td>127</td>
<td>7.83 (9.78)</td>
<td>10.53 (10.85)</td>
<td>-2.70</td>
<td>-1.608</td>
<td>0.202</td>
</tr>
<tr>
<td>DASS Anxiety</td>
<td>127</td>
<td>6.54 (8.83)</td>
<td>8.42 (9.31)</td>
<td>-1.87</td>
<td>-1.283</td>
<td>0.111</td>
</tr>
<tr>
<td>DASS Stress</td>
<td>127</td>
<td>10.70 (9.02)</td>
<td>13.75 (10.64)</td>
<td>-3.05</td>
<td>-1.882</td>
<td>0.063</td>
</tr>
<tr>
<td>GWBI</td>
<td>125</td>
<td>55.33 (18.15)</td>
<td>55.77 (16.62)</td>
<td>-0.44</td>
<td>-0.161</td>
<td>0.872</td>
</tr>
<tr>
<td>GHQ</td>
<td>128</td>
<td>23.37 (14.07)</td>
<td>22.80 (14.35)</td>
<td>0.560</td>
<td>0.247</td>
<td>0.806</td>
</tr>
</tbody>
</table>

* The Difference Score is the difference between the female and male means.

** Incomplete numbers (as compared to N=198) were due to gender not being available on all patients, and complete scores not being available for all patients.
Chapter 7: Results

Despite no indication of gender differences on pre-test scores, it was felt that difference between pre-test and post-test scores would be the most useful variable by which to gauge any treatment effects by gender. These were analysed and are reported on below (see section 7.2.3.4).

7.2.2.2 Medication

As outlined in section 6.3.6.3 of the method chapter, information was obtained from the notes of the Bathurst patients (the only group on whom data was available retrospectively) on how many had been prescribed medication relevant to psychological disorders (antidepressants, anti-anxiety drugs etc). For reasons outlined in the method chapter (see section 6.3.6.3) information on medication status was available on fewer treatment than control patients. This resulted in data being available on a higher percentage of control than treatment patients as follows:

| Table 7.4: Use of medication in members of treatment and control groups - Bathurst patients only |
|-----------------------------------|---------|---------|----------|
|                                  | Group   |         |          |
|                                  | Control | Treatment | Total    |
| Any medication for psych treatment? | Not known, because patient name not provided | Count | 2 | 20 | 22|
|                                  | % within Group | % within Group | 2.2% | 11.9% | 8.4% |
| Took medication                 | Count | 24 | 78 | 102 | |
|                                  | % within Group | 25.8% | 46.4% | 39.1% | |
| Did not take medication          | Count | 67 | 70 | 137 | |
|                                  | % within Group | 72.0% | 41.7% | 52.8% | |
| Total                            | Count | 93 | 168 | 261 | |
|                                  | % within Group | 100.0% | 100.0% | 100.0% | |

It appeared that close to half of the treatment group patients and more than one-quarter of the control group patients were taking some prescription medication for the treatment of psychological issues/mental disorders during the study. Only two medications were written down for each patient although in some cases patients were taking more than two types of psychotropic medication at the same time. The table below shows the combined frequency distributions of ‘Medication 1’ and ‘Medication
2’ - it is clear that there are more prescriptions than there are patients taking them (137 vs. 102) since some patients were taking two or more prescriptions at the same time.

**Table 7.5: Frequency of prescriptions for Bathurst patients**

<table>
<thead>
<tr>
<th>Medication</th>
<th>Number</th>
<th>Medication</th>
<th>Number</th>
<th>Medication</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alepam (oxazepam)</td>
<td>1</td>
<td>Lithium No. of trade names</td>
<td>1</td>
<td>Temazapam (Restoril)</td>
<td>3</td>
</tr>
<tr>
<td>Aropax (paroxetine)</td>
<td>11</td>
<td>Lovan (fluoxetine)</td>
<td>3</td>
<td>Toframil (imipramine)</td>
<td>1</td>
</tr>
<tr>
<td>Ativan (lorazepam)</td>
<td>1</td>
<td>Luvox (fluvoxamine)</td>
<td>7</td>
<td>Tryptanol (amitriptyline)</td>
<td>1</td>
</tr>
<tr>
<td>Avanza (mirtazapine)</td>
<td>12</td>
<td>Murilex (Trade name not available)</td>
<td>2</td>
<td>Valium (diazepam)</td>
<td>10</td>
</tr>
<tr>
<td>Avapro (irbesartan)</td>
<td>1</td>
<td>Olanzapene (Zyprexa, Zydis)</td>
<td>3</td>
<td>Xanax (alprazolam)</td>
<td>6</td>
</tr>
<tr>
<td>Cipramil (citalopram)</td>
<td>19</td>
<td>Prozac (fluoxetine)</td>
<td>3</td>
<td>Zantac (ranitidine HCL)</td>
<td>1</td>
</tr>
<tr>
<td>Clozaril (clozapine)</td>
<td>1</td>
<td>Resperdal (risperidone)</td>
<td>1</td>
<td>Zoloft (sertraline)</td>
<td>21</td>
</tr>
<tr>
<td>Effexor (oxycodone)</td>
<td>14</td>
<td>Serepax (oxazepam)</td>
<td>10</td>
<td>Zyban (bupropion HCL)</td>
<td>1</td>
</tr>
<tr>
<td>Endone (oxycodone)</td>
<td>1</td>
<td>Talohexal (citalopram)</td>
<td>2</td>
<td><strong>TOTAL</strong></td>
<td><strong>137</strong></td>
</tr>
</tbody>
</table>

* Generic and Trade names of medications are included: Trade names are capitalised.

It was important to determine whether the taking of medication prescribed specifically for mental disorders had any impact on patients’ scores on the measures used in the research study and particularly on post-treatment results. It was therefore assessed whether patients who took medication were substantially different on their pre-test measures from those who did not. Results indicated that that there were no substantial differences in pre-test means, although not surprisingly, there was a slight tendency for those taking medication to have higher mean scores, especially in the control group (see Appendix 7.2 for “Mean scores on pre-test measures for control and treatment group members by whether or not they were taking medication”).

Of greater importance, however, was whether the taking of medication impacted on post-test scores, confounding any treatment effect provided by the psychological intervention. This is addressed in section 7.2.3.5.
7.2.3 Pre- and post-intervention comparisons between treatment and control groups

An analysis of variance was done comparing difference scores (ie. difference between pre-test and post-test scores) for treatment and control groups by the three factors: “condition”, “gender” and “location” (see Appendix 7.3b). Results again indicated that the factor of statistical significance was “condition” – ie. treatment vs control (F values at less than 0.001), with geographic location and gender having little bearing on the results (ie. an insignificant impact). Whilst research location and gender were independently found to be insignificant, some two way interactions (condition by research centre/location) were found to be significant for some of the measures (see Appendix 7.3 for F values). This suggested that research site/supervision may have had some slight differential impact on results. However, it could be concluded overall that gender and geographic location were not determining factors in the results found between the groups.

7.2.3.1 Simple “Sign Test” pre- to post-intervention for treatment and control groups

Prior to analysing group averages to establish whether there had been a significant impact from treatment on the intervention group, it was felt that the simplest way of viewing treatment gains was via a simple sign test: ie. establishing in each group how many patients had got worse from pre- to post-test, how many had remained the same and, most importantly, how many had improved. Results were as follows in Table 7.6 (with cell indicating improvement highlighted).

<table>
<thead>
<tr>
<th>Table 7.6: Simple “Sign Test” of improvement or worsening of scores pre- to post-test for patients in the treatment and control groups</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>DASS Depression sign test</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Control</th>
<th>Treatment</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Worsened from pre- to post-test</td>
<td>29</td>
<td>21</td>
<td>50</td>
</tr>
<tr>
<td>% within Condition</td>
<td>29.6%</td>
<td>10.3%</td>
<td>16.6%</td>
</tr>
<tr>
<td>Remained the same from pre- to post-test</td>
<td>20</td>
<td>18</td>
<td>38</td>
</tr>
<tr>
<td>% within Condition</td>
<td>20.4%</td>
<td>8.9%</td>
<td>12.6%</td>
</tr>
<tr>
<td>Improved from pre- to post-test</td>
<td>49</td>
<td>164</td>
<td>213</td>
</tr>
<tr>
<td>% within Condition</td>
<td>50.0%</td>
<td>80.8%</td>
<td>70.8%</td>
</tr>
<tr>
<td>Total</td>
<td>98</td>
<td>203</td>
<td>301</td>
</tr>
<tr>
<td>% within Condition</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
</tr>
</tbody>
</table>
These figures indicate that, whilst there is not a lot going on for the control group (ie. only about half “improved” and half - or more than half on some measures - did not), about 80% of the treatment group improved from pre- to post-test and consistently smaller percentages of this group “remained the same” or “worsened”.

Further, patients in the “clinical range” were examined (ie. those whose scores on the DASS measures were in the “moderate”, “severe” or “extremely severe” ranges), with the sign test indicating that nearly 90% of them improved after treatment with small percentages (ie. less than 10%) remaining the same or getting worse (see Figure 7.6).
Table 7.7: Percentage of treatment patients in the “Clinical Range” whose scores improved, remained the same or worsened

*Sign Test for DASS Anxiety, Depression and Stress Measures*

<table>
<thead>
<tr>
<th></th>
<th>DASS Anxiety</th>
<th></th>
<th>DASS Depression</th>
<th></th>
<th>DASS Stress</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Frequency</td>
<td>Percent</td>
<td>Frequency</td>
<td>Percent</td>
<td>Frequency</td>
<td>Percent</td>
</tr>
<tr>
<td>Worsened from pre-</td>
<td>9</td>
<td>7.2</td>
<td>12</td>
<td>8.6</td>
<td>10</td>
<td>7.4</td>
</tr>
<tr>
<td>to post-test</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Remained the same</td>
<td>4</td>
<td>3.2</td>
<td>5</td>
<td>3.6</td>
<td>5</td>
<td>3.7</td>
</tr>
<tr>
<td>from pre- to post-test</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Improved from pre-</td>
<td>112</td>
<td>89.6</td>
<td>123</td>
<td>87.9</td>
<td>120</td>
<td>88.9</td>
</tr>
<tr>
<td>to post-test</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>125</td>
<td>100.0</td>
<td>140</td>
<td>100.0</td>
<td>135</td>
<td>100.0</td>
</tr>
</tbody>
</table>

7.2.3.2 Differences between pre- and post-intervention scores of control and intervention groups on mental health measures

Table 7.8 below highlights differences (significant at the 0.001 level) between the treatment and control groups prior to intervention, with control group participants having scores on average within the normal range, whilst treatment group means were significantly higher (or lower on the GWBI) as predicted. This was to be expected as the GP referral process was not random, but targeted those suffering higher levels of depression, anxiety and/or stress. Follow-up scores indicated that those undergoing treatment had improved to the point where there were no longer significant differences between them and the control group on all measures.
Table 7.8: Comparison of initial and follow-up scores of control and intervention groups on mental health measures

<table>
<thead>
<tr>
<th>Measure</th>
<th>Control Group</th>
<th>Intervention group</th>
<th>Difference in means</th>
<th>95% CI of difference</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>Mean score (SD)</td>
<td>n</td>
<td>Mean score (SD)</td>
<td></td>
</tr>
<tr>
<td>A: Initial</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>DASS Depression</td>
<td>193</td>
<td>8.86 (10.38)</td>
<td>306</td>
<td>21.59 (12.08)</td>
<td>-12.73</td>
</tr>
<tr>
<td>DASS Anxiety</td>
<td>193</td>
<td>7.26 (9.12)</td>
<td>306</td>
<td>15.79 (10.74)</td>
<td>-8.53</td>
</tr>
<tr>
<td>DASS Stress</td>
<td>193</td>
<td>11.90 (9.86)</td>
<td>302</td>
<td>23.27 (10.71)</td>
<td>-11.37</td>
</tr>
<tr>
<td>General Health Questionnaire (total)</td>
<td>194</td>
<td>23.47 (14.71)</td>
<td>302</td>
<td>39.66 (16.70)</td>
<td>-16.19</td>
</tr>
<tr>
<td>General Wellbeing Index</td>
<td>192</td>
<td>55.17 (18.45)</td>
<td>299</td>
<td>35.82 (15.82)</td>
<td>19.34</td>
</tr>
<tr>
<td>B: Follow-up scores</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>DASS Depression</td>
<td>98</td>
<td>6.37 (8.41)</td>
<td>200</td>
<td>8.03 (9.73)</td>
<td>-1.66</td>
</tr>
<tr>
<td>DASS Anxiety</td>
<td>98</td>
<td>5.14 (7.41)</td>
<td>201</td>
<td>6.82 (8.03)</td>
<td>-1.69</td>
</tr>
<tr>
<td>DASS Stress</td>
<td>98</td>
<td>9.40 (8.57)</td>
<td>201</td>
<td>11.23 (10.23)</td>
<td>-1.83</td>
</tr>
<tr>
<td>General Health Questionnaire (total)</td>
<td>98</td>
<td>20.03 (14.69)</td>
<td>196</td>
<td>18.07 (13.90)</td>
<td>1.96</td>
</tr>
<tr>
<td>General Wellbeing Index</td>
<td>96</td>
<td>59.27 (16.07)</td>
<td>197</td>
<td>58.53 (16.34)</td>
<td>0.74</td>
</tr>
</tbody>
</table>

* difference in means = mean initial or follow-up score for the control group minus mean initial or follow-up score for the intervention group. SD = standard deviation. DASS = Depression, Anxiety, and Stress Scale. Positive General Well Being Index scores indicate improved levels of wellbeing.

The statistical significance of differences between pre- and post-intervention scores across the two groups was determined by running a paired samples t-test (see Coakes and Steed, 2000 who indicate that it is to optimal test for situations in which one wishes “to determine whether the difference between means for two sets of scores is the same or different”: p. 71). Results were as follows.
Table 7.9: Pre- and post-test comparisons for all participants
(including treatment and control groups)

<table>
<thead>
<tr>
<th></th>
<th>N</th>
<th>Pre (SD)</th>
<th>Post (SD)</th>
<th>Diff*</th>
<th>t</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>DASS Depression</td>
<td>295</td>
<td>16.78 (12.79)</td>
<td>7.50 (9.38)</td>
<td>9.28</td>
<td>13.335</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>DASS Anxiety</td>
<td>296</td>
<td>12.51 (11.03)</td>
<td>6.25 (7.89)</td>
<td>6.26</td>
<td>11.780</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>DASS Stress</td>
<td>294</td>
<td>18.89 (11.88)</td>
<td>10.64 (9.76)</td>
<td>8.25</td>
<td>13.155</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>GWBI</td>
<td>289</td>
<td>42.59 (19.32)</td>
<td>58.65 (16.30)</td>
<td>-16.07</td>
<td>-14.310</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>GHQ</td>
<td>289</td>
<td>33.89 (17.93)</td>
<td>18.67 (14.13)</td>
<td>15.22</td>
<td>14.219</td>
<td>&lt;.001</td>
</tr>
</tbody>
</table>

* The Difference Score is the difference between the pre- and the post-test means.
** Tables above and below again manifest variations in totals because a number of patients were missing individual scores on either the pre-test or post-test.

The table above obviously compounds any differences between treatment and control groups (as both groups are included), but it does provide reference averages across both groups against which to compare results from each group separately. Separate analyses of pre- and post-test differences for the treatment and control groups is provided below (see Tables 7.11 and 7.12).

Table 7.10: Pre- and post-test comparisons for treatment participants

<table>
<thead>
<tr>
<th></th>
<th>n</th>
<th>Pre (SD)</th>
<th>Post (SD)</th>
<th>Diff*</th>
<th>t</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>DASS Depression</td>
<td>197</td>
<td>20.95 (11.92)</td>
<td>8.06 (9.80)</td>
<td>12.89</td>
<td>15.333</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>DASS Anxiety</td>
<td>198</td>
<td>15.40 (10.75)</td>
<td>6.80 (8.08)</td>
<td>8.60</td>
<td>12.418</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>DASS Stress</td>
<td>196</td>
<td>23.08 (10.68)</td>
<td>11.27 (10.27)</td>
<td>11.81</td>
<td>15.191</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>GWBI</td>
<td>195</td>
<td>35.89 (15.62)</td>
<td>58.42 (16.38)</td>
<td>-22.53</td>
<td>-17.282</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>GHQ</td>
<td>193</td>
<td>39.58 (16.83)</td>
<td>18.13 (13.98)</td>
<td>21.44</td>
<td>17.454</td>
<td>&lt;.001</td>
</tr>
</tbody>
</table>

*The Difference Score is the difference between the pre- and the post-test means.

After treatment, average scores in the intervention group had improved significantly at the 0.001 level on all measures (ie. declined on the DASS, GHQ and increased on the GWBI), suggesting that the intervention had had an impact. Comparison of pre- and post-severity levels on the three DASS sub-scale scores (depression, anxiety and stress) also indicated a significant movement of patients’ scores on all measures.
towards the “normal” range, and a significant decrease in those scoring within the severe-to-extremely severe ranges (see Tables 7.3, 7.4 and 7.5).

Table 7.11: Pre- and post-test comparisons for control participants

<table>
<thead>
<tr>
<th></th>
<th>Pre (SD)</th>
<th>Post (SD)</th>
<th>Diff*</th>
<th>t</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>DASS Depression</strong></td>
<td>7.80 (9.59)</td>
<td>6.37 (8.41)</td>
<td>1.43</td>
<td>2.113</td>
<td>.037</td>
</tr>
<tr>
<td><strong>DASS Anxiety</strong></td>
<td>6.68 (9.16)</td>
<td>5.14 (7.41)</td>
<td>1.55</td>
<td>2.887</td>
<td>.005</td>
</tr>
<tr>
<td><strong>DASS Stress</strong></td>
<td>10.52 (9.54)</td>
<td>9.40 (8.57)</td>
<td>1.12</td>
<td>1.904</td>
<td>.06</td>
</tr>
<tr>
<td><strong>GWBI</strong></td>
<td>56.47 (18.94)</td>
<td>59.14 (16.21)</td>
<td>-2.67</td>
<td>-1.993</td>
<td>.049</td>
</tr>
<tr>
<td><strong>GHQ</strong></td>
<td>22.47 (14.32)</td>
<td>19.76 (14.44)</td>
<td>2.71</td>
<td>1.988</td>
<td>.05</td>
</tr>
</tbody>
</table>

*The Difference Score is the difference between the pre- and the post-test means.

In the control group pre- and post-test comparisons and t tests also showed improvements with three of the differences being significant, one at the 0.005 level, two at the 0.05 level, and two marginally significant (see Table 7.11). There are several possible explanations for this marginal improvement, as outlined in Chapter 8. Whatever the reasons, if the project did effect some modest improvement in mood for control group patients, this was a fortuitous by-product.

7.2.3.3 Levels of severity on the DASS scales

7.2.3.3a) Between-group comparisons on DASS sub-scale scores: pre- and post-intervention

Using the DASS scoring profile, each patient’s levels on the depression, anxiety and stress scales of the DASS were ascertained. These were then used to demonstrate the severity of mental disorders experienced by both the treatment and control groups, both pre- and post-intervention. The following tables (7.3, 7.4 and 7.5) provide:

a) a comparison between control and treatment groups in terms of initial levels of severity;

b) an overview of the impact of treatment on patients participating in treatment compared with control patients at pre- and post-intervals.
Table 7.12: Levels of severity on DASS scores in treatment and control groups: pre- and post

### 7.12a: Depression

<table>
<thead>
<tr>
<th>DASS Depression</th>
<th>Pre-Intervention</th>
<th>Post-Intervention</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Control</td>
<td>Treatment</td>
</tr>
<tr>
<td>Extremely Severe</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(6)</td>
<td>6.1%</td>
<td>34.5%</td>
</tr>
<tr>
<td>Severe</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(7)</td>
<td>7.1%</td>
<td>16.0%</td>
</tr>
<tr>
<td>Moderate</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(8)</td>
<td>8.2%</td>
<td>19.5%</td>
</tr>
<tr>
<td>Mild</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(10)</td>
<td>10.2%</td>
<td>10.5%</td>
</tr>
<tr>
<td>Normal</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(67)</td>
<td>68.4%</td>
<td>19.5%</td>
</tr>
<tr>
<td>Total</td>
<td>98</td>
<td>200</td>
</tr>
</tbody>
</table>

### 7.12b: Anxiety

<table>
<thead>
<tr>
<th>DASS Anxiety</th>
<th>Pre-Intervention</th>
<th>Post-Intervention</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Control</td>
<td>Treatment</td>
</tr>
<tr>
<td>Extremely Severe</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(14)</td>
<td>14.3%</td>
<td>34.5%</td>
</tr>
<tr>
<td>Severe</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(1)</td>
<td>1.0%</td>
<td>16.5%</td>
</tr>
<tr>
<td>Moderate</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(11)</td>
<td>11.2%</td>
<td>11.5%</td>
</tr>
<tr>
<td>Mild</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(8)</td>
<td>8.2%</td>
<td>11.0%</td>
</tr>
<tr>
<td>Normal</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(64)</td>
<td>65.3%</td>
<td>26.5%</td>
</tr>
<tr>
<td>Total</td>
<td>98</td>
<td>200</td>
</tr>
</tbody>
</table>
### 7.12c: Stress

<table>
<thead>
<tr>
<th>DASS Stress</th>
<th>Pre-Intervention</th>
<th>Post-Intervention</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Control</td>
<td>Treatment</td>
</tr>
<tr>
<td>Extremely Severe</td>
<td>(1) 1.0%</td>
<td>(39) 19.7%</td>
</tr>
<tr>
<td>Severe</td>
<td>(7) 7.1%</td>
<td>(43) 21.7%</td>
</tr>
<tr>
<td>Moderate</td>
<td>(16) 16.3%</td>
<td>(53) 26.8%</td>
</tr>
<tr>
<td>Mild</td>
<td>(7) 7.1%</td>
<td>(18) 9.1%</td>
</tr>
<tr>
<td>Normal</td>
<td>(67) 68.4%</td>
<td>(45) 22.7%</td>
</tr>
<tr>
<td>Total</td>
<td>98</td>
<td>198</td>
</tr>
</tbody>
</table>

For both the control and treatment condition participants, there was a trend towards improvement, with a greater proportion of participants scoring within the normal range on all scales post-test compared to pre-test scores. On all measures, particularly within the extremely severe, severe and moderate ranges of pathology, the treatment group showed considerably greater percentage improvements than their control group counterparts in the same ranges.

Additionally, there was a greater proportion of participants scoring within the normal range on the pre-test measures within the control group than within the treatment group, indicating that the referrals of patients by the GP to the psychologists were appropriate. However, between 20 and 28 per cent of treatment patients score within the normal range on the scales on their pre-intervention measures. Whilst it is possible that some 25% of patients are being referred unnecessarily, it is also possible that the GPs are referring them for symptoms not picked up by the DASS.

#### 7.2.3.3b) Comorbidity

There was a high degree of comorbidity amongst these conditions/disorders: eg. 67% of participants with an extremely high level of depression also had an extremely high level of anxiety at pre-test (see Table 7.15 for correlations between pre-test measures).
Table 7.13: Correlations among pre-test measures for treatment patients with full data

<table>
<thead>
<tr>
<th></th>
<th>DASS Measures</th>
<th>General</th>
<th>General Health Questionnaire</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Anxiety</td>
<td>Depression</td>
<td>Stress</td>
</tr>
<tr>
<td>DASS Anxiety</td>
<td>1</td>
<td>0.63</td>
<td>0.78</td>
</tr>
<tr>
<td>DASS Depression</td>
<td>1</td>
<td>0.69</td>
<td>0.66</td>
</tr>
<tr>
<td>DASS Stress</td>
<td></td>
<td></td>
<td>-0.57</td>
</tr>
<tr>
<td>General Well Being</td>
<td>1</td>
<td></td>
<td>-0.66</td>
</tr>
</tbody>
</table>

7.2.3.4 Gender: Analysis of treatment effects comparing male and female patients

As suggested in section 7.2.2.1 - where observed early/initial differences in pre-test scores between male and female patients were hinted at but not found to be significant - gender was a crucial variable to explore as a potential factor in treatment responsiveness. This was done, analysing pre- and post-test differences in male and female patients in both the treatment and control groups (see Tables 7.14 and 7.15).

Table 7.14a: Comparisons between male and female treatment group members on the difference between pre-test and post-test measures

<table>
<thead>
<tr>
<th></th>
<th>n</th>
<th>Female mean (SD)</th>
<th>Male mean (SD)</th>
<th>Diff*</th>
<th>t</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>DASS Depression</td>
<td>141</td>
<td>13.34 (12.22)</td>
<td>11.79 (10.79)</td>
<td>1.54</td>
<td>0.870</td>
<td>0.386</td>
</tr>
<tr>
<td>DASS Anxiety</td>
<td>140</td>
<td>8.76 (9.98)</td>
<td>8.25 (9.29)</td>
<td>0.50</td>
<td>0.337</td>
<td>0.737</td>
</tr>
<tr>
<td>DASS Stress</td>
<td>139</td>
<td>11.98 (11.15)</td>
<td>11.50 (10.35)</td>
<td>0.48</td>
<td>0.286</td>
<td>0.776</td>
</tr>
<tr>
<td>GWBI</td>
<td>141</td>
<td>-22.58 (18.43)</td>
<td>-22.38 (17.75)</td>
<td>-0.20</td>
<td>-0.070</td>
<td>0.944</td>
</tr>
<tr>
<td>GHQ</td>
<td>139</td>
<td>22.13 (17.18)</td>
<td>19.70 (16.95)</td>
<td>2.43</td>
<td>0.885</td>
<td>0.378</td>
</tr>
</tbody>
</table>

*The Difference Score is the difference between the female and male means.
Table 7.14b: Comparisons between male and female control group members on the difference between pre-test and post-test measures

<table>
<thead>
<tr>
<th></th>
<th>n</th>
<th>Female mean (SD)</th>
<th>Male mean (SD)</th>
<th>Diff*</th>
<th>t</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>DASS Depression</td>
<td>67</td>
<td>0.97 (7.10)</td>
<td>2.74 (6.05)</td>
<td>-1.77</td>
<td>-1.219</td>
<td>0.228</td>
</tr>
<tr>
<td>DASS Anxiety</td>
<td>67</td>
<td>1.28 (5.19)</td>
<td>2.07 (5.69)</td>
<td>-0.79</td>
<td>-0.627</td>
<td>0.534</td>
</tr>
<tr>
<td>DASS Stress</td>
<td>67</td>
<td>0.41 (6.09)</td>
<td>2.52 (5.08)</td>
<td>-2.10</td>
<td>-1.713</td>
<td>0.092</td>
</tr>
<tr>
<td>GWBI</td>
<td>64</td>
<td>-2.37 (13.68)</td>
<td>-2.92 (12.24)</td>
<td>0.55</td>
<td>0.189</td>
<td>0.851</td>
</tr>
<tr>
<td>GHQ</td>
<td>66</td>
<td>2.62 (12.43)</td>
<td>2.92 (16.40)</td>
<td>-0.30</td>
<td>-0.085</td>
<td>0.933</td>
</tr>
</tbody>
</table>

*The Difference Score is the difference between the female and male means.

Results - both from pre-test scores and the difference between pre- and post-test scores (the latter the most useful variable in gauging treatment effects by sex) suggest that gender is not a determinant of treatment responsiveness. The control group also manifest no gender-related differences either pre- or post-test.

7.2.3.5 Medication

As outlined above in section 7.2.2.2, it was important to determine whether medication prescribed specifically for mental disorders (predominantly depression and anxiety) had any impact on patients’ scores on the measures, and specifically whether the taking of medication impacted on post-test scores confounding any treatment effect caused by the psychological intervention. To examine this question, it was necessary to look at the group of people who had:

a) completed both pre-test and post-test measures, and
b) information available on whether or not they took medication.

NB. It is important to note that there was no information available on medication taken by patients at centres other than those in Bathurst; the group on whom the required data was available was therefore small. Despite this caveat, the group of patients on whom all relevant data were available was analysed as follows:
<table>
<thead>
<tr>
<th>Any medication for psych treatment?</th>
<th>Group</th>
<th>Control</th>
<th>Treatment</th>
<th>Total Control</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not known, because patient name not provided</td>
<td>Count</td>
<td>2</td>
<td>20</td>
<td>22</td>
</tr>
<tr>
<td>% within Group</td>
<td>5.1%</td>
<td>29.0%</td>
<td>20.4%</td>
<td></td>
</tr>
<tr>
<td>Took medication</td>
<td>Count</td>
<td>16</td>
<td>27</td>
<td>43</td>
</tr>
<tr>
<td>% within Group</td>
<td>41.0%</td>
<td>39.1%</td>
<td>39.8%</td>
<td></td>
</tr>
<tr>
<td>Did not take medication</td>
<td>Count</td>
<td>21</td>
<td>22</td>
<td>43</td>
</tr>
<tr>
<td>% within Group</td>
<td>53.8%</td>
<td>31.9%</td>
<td>39.8%</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>Count</td>
<td>39</td>
<td>69</td>
<td>108</td>
</tr>
<tr>
<td>% within Group</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td></td>
</tr>
</tbody>
</table>

As indicated in the table above, it was found that of those patients for whom medication status and pre- and post-test data were available, approximately 41% of the control group and 39% of the treatment group were definitely taking medication for depression or anxiety. (For two of the control group patients and 20 of the treatment group data was not available enabling surgery records to be searched.)

To assess whether taking medication had an effect on treatment results (or in the case of the control group the passage of time), differences between pre- and post-test scores were assessed (ie. pre-test minus post-test: a positive difference indicating an improvement, except with the General Well-Being Index where improvement would imply a negative difference) – see Appendix 7.2b: “Mean difference scores for treatment and control group patients by use of medication”.

Results indicated that on average those who took medication(s) were not markedly different from those who did not in terms of pre- and post-test score differences. If anything, those not taking medication seemed to achieve better results (ie. improve more). However, it was necessary to examine this with a t-test comparing the treatment and control groups – see Appendices 7.2c and 7.2d. (NB. the t-test involves comparison between two groups only, so those whose medication status was not known were excluded).

It was found that neither the control nor treatment groups showed any significant effects of medication on any of the difference scores between pre- and post-test measures. This further suggested that significant treatment effects found were due to
the psychological intervention rather than pharmacological treatment. Caution needs to be exercised in interpreting and generalising these results to all patients in the study as, due to missing information on either medication status or post-test scores, group numbers were small. However, the trends illustrated in these findings are interesting as no significant impact of medication was found.

7.2.3.6 Graphic representation of pre- and post-test results

As can be seen in the histograms below (Figures 7.3, 7.4 and 7.5), in which normal curves are superimposed over histograms representing patient scores on all three DASS measures, the intervention group and the control group were found to differ markedly on all initial measures. The migration of scores towards the normal range in both groups, shown numerically in the tables above, is depicted graphically in the following figures. What is shown for both control and treatment patients, is the trend towards improvement, with a greater proportion of participants scoring within the normal range on all scales post-test compared to pre-test scores. Additionally, what is clearly seen is the greater proportion of participants scoring within the normal range on the pre-test measures within the control group than within the treatment group.
Figure 7.3a: Histograms representing distribution of the DASS PRE-TEST depression measure for control and treatment groups

Figure 7.3b: Histograms representing distribution of the DASS POST-TEST depression measure for control and treatment group
Chapter 7: Results

Figure 7.4a: Histograms representing distribution of the DASS PRE-TEST anxiety measure for control and treatment groups

Figure 7.4b: Histograms representing distribution of the DASS POST-TEST anxiety measure for control and treatment groups
Chapter 7: Results

Figure 7.5a: Histograms representing distribution of the DASS PRE-TEST stress measure for control and treatment groups

Figure 7.5b: Histograms representing distribution of the DASS POST-TEST stress measure for control and treatment groups
It is obvious from the figures above that it was not possible to superimpose a curve on the control group pre-test scores because the vast majority of the scores tended to be at the low end of the spectrum (indeed some down to zero). Contrastingly, it was somewhat easier to impose a normal curve on treatment group pre-test scores. On the basis of post-test scores, it is apparent that the score distribution for patients in the control group did not change markedly in the eight week period between their tests (a similarly skewed distribution is displayed for both pre-test and post-test scores). The intervention group, however, came to resemble the control group in its post-test scores, with most falling in the normal range (i.e. skewed toward the lower end of the scale). These graphs starkly illustrate the contrasts between the treatment and control groups, both pre- and post-treatment.

7.2.3.7 Conclusions from pre- and post-test comparisons

Results outlined above indicate that reduction in post-test scores was significantly greater for the treatment group, supporting the hypothesis that the intervention had a positive impact, greater than that observed when patients received treatment from their GP alone. However, further analysis was necessary to confirm that this was as a result of the treatment provided through the study. It may be, for example, that those patients whose scores were elevated at pre-test would naturally score lower upon re-testing, as there may be a natural “tendency towards normalisation”. To determine whether this was the case, and to gain confidence in the validity of the results, a matched-pair analysis was done in which control and treatment participants were matched on their pre-scores, with any post-test score difference then being attributable to the intervention and not to other factors.

7.3.4 Pairing the Data

As outlined above and in the method chapter, pre-test DASS profiles for participants were used to match control to treatment patients on the basis of their pre-test levels, enabling a matched-pair comparison between the two groups. They were matched on the basis of their scoring pattern – for example, if a control participant scored ‘medium’ on depression, ‘severe’ on anxiety and ‘medium’ on stress, a treatment participant with the same profile was located. If there was more than one option for
matching (as was the case not infrequently) then the individual scores on the DASS were consulted, and the participants with closest actual scores were paired. If there was still any debate about which participant to include, the remaining measures (ie. GWBI and GHQ) were consulted to inform the decision. Forty-eight suitable pairs were drawn from the participants (the relatively small number reflecting the small overlap between the groups) in an attempt to provide a true comparative “control group” enabling inferences about the impact of the intervention, rather than a normative comparison group (as used in the previous analyses).

7.2.4.1 Pre-test comparisons

Comparison of the average pre-test means on the DASS, GWBI and GHQ, using a paired-samples t-test to provide an indication of how closely the participants were matched, was undertaken. A non-significant $t$ value indicated that the matching was adequate and that participants in each pair did not differ significantly on any of the indices. Given no significant differences between the groups on the pre-test measures, pairing was concluded to be adequate (see Table 7.16).

<table>
<thead>
<tr>
<th></th>
<th>n</th>
<th>Control (SD)</th>
<th>Treatment (SD)</th>
<th>Diff*</th>
<th>t</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>DASS Depression</td>
<td>48</td>
<td>11.56 (10.03)</td>
<td>11.89 (10.14)</td>
<td>-.32</td>
<td>-1.149</td>
<td>.256</td>
</tr>
<tr>
<td>DASS Anxiety</td>
<td>48</td>
<td>8.77 (10.16)</td>
<td>9.25 (9.73)</td>
<td>-.48</td>
<td>-1.784</td>
<td>.081</td>
</tr>
<tr>
<td>DASS Stress</td>
<td>48</td>
<td>15.37 (9.02)</td>
<td>15.29 (9.11)</td>
<td>.07</td>
<td>.237</td>
<td>.813</td>
</tr>
<tr>
<td>GWBI</td>
<td>48</td>
<td>48.87 (17.69)</td>
<td>48.07 (15.21)</td>
<td>.80</td>
<td>.380</td>
<td>.706</td>
</tr>
<tr>
<td>GHQ</td>
<td>46</td>
<td>27.28 (14.49)</td>
<td>28.96 (15.07)</td>
<td>-1.67</td>
<td>-.861</td>
<td>.394</td>
</tr>
</tbody>
</table>

*Difference Score (Average)

Detailed analysis of matched-pair score levels on each of the DASS sub-scales also indicated how closely the groups were matched, highlighting that the matched participants were primarily located within the normal range (see Table 7.17).
### Table 7.17: DASS levels for the paired participants

#### 7.17a: Depression

<table>
<thead>
<tr>
<th>DASS Depression</th>
<th>Pre Control</th>
<th>Treatment</th>
<th>Total</th>
<th>Post Control</th>
<th>Treatment</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Extremely Severe</td>
<td>(5) 10.4%</td>
<td>(5) 10.4%</td>
<td>(10) 10.4%</td>
<td>(3) 6.3%</td>
<td>(0)</td>
<td>(3) 3.1%</td>
</tr>
<tr>
<td>Severe</td>
<td>(6) 12.5%</td>
<td>(6) 12.5%</td>
<td>(12) 12.5%</td>
<td>(3) 6.3%</td>
<td>(0)</td>
<td>(3) 3.1%</td>
</tr>
<tr>
<td>Moderate</td>
<td>(5) 10.4%</td>
<td>(5) 10.4%</td>
<td>(10) 10.4%</td>
<td>(7) 14.6%</td>
<td>(2) 4.2%</td>
<td>(9) 9.4%</td>
</tr>
<tr>
<td>Mild</td>
<td>(7) 14.6%</td>
<td>(7) 14.6%</td>
<td>(14) 14.6%</td>
<td>(7) 14.6%</td>
<td>(1) 2.1%</td>
<td>(8) 8.3%</td>
</tr>
<tr>
<td>Normal</td>
<td>(25) 52.1%</td>
<td>(25) 52.1%</td>
<td>(50) 52.1%</td>
<td>(28) 58.3%</td>
<td>(45) 93.8%</td>
<td>(73) 76.0%</td>
</tr>
<tr>
<td>Total</td>
<td>48</td>
<td>48</td>
<td>96</td>
<td>48</td>
<td>48</td>
<td>96</td>
</tr>
</tbody>
</table>

#### 7.17b: Anxiety

<table>
<thead>
<tr>
<th>DASS Anxiety</th>
<th>Pre Control</th>
<th>Treatment</th>
<th>Total</th>
<th>Post Control</th>
<th>Treatment</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Extremely Severe</td>
<td>(8) 16.7%</td>
<td>(8) 16.7%</td>
<td>(16) 16.7%</td>
<td>(6) 12.5%</td>
<td>(0)</td>
<td>(6) 6.3%</td>
</tr>
<tr>
<td>Severe</td>
<td>(1) 2.1%</td>
<td>(1) 2.1%</td>
<td>(2) 2.1%</td>
<td>(4) 8.3%</td>
<td>(0)</td>
<td>(4) 4.2%</td>
</tr>
<tr>
<td>Moderate</td>
<td>(6) 12.5%</td>
<td>(6) 12.5%</td>
<td>(12) 12.5%</td>
<td>(3) 6.3%</td>
<td>(5) 10.4%</td>
<td>(8) 8.3%</td>
</tr>
<tr>
<td>Mild</td>
<td>(6) 12.5%</td>
<td>(6) 12.5%</td>
<td>(12) 12.5%</td>
<td>(1) 2.1%</td>
<td>(4) 8.3%</td>
<td>(5) 5.2%</td>
</tr>
<tr>
<td>Normal</td>
<td>(27) 56.3%</td>
<td>(27) 56.3%</td>
<td>(54) 56.3%</td>
<td>(34) 70.8%</td>
<td>(39) 81.3%</td>
<td>(73) 76.0%</td>
</tr>
<tr>
<td>Total</td>
<td>48</td>
<td>48</td>
<td>96</td>
<td>48</td>
<td>48</td>
<td>96</td>
</tr>
</tbody>
</table>

#### 7.17c: Stress

<table>
<thead>
<tr>
<th>DASS Stress</th>
<th>Pre Control</th>
<th>Treatment</th>
<th>Total</th>
<th>Post Control</th>
<th>Treatment</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Extremely Severe</td>
<td>(0)</td>
<td>(0)</td>
<td>(0)</td>
<td>(1) 2.1%</td>
<td>(0)</td>
<td>(1) 1.0%</td>
</tr>
<tr>
<td>Severe</td>
<td>(7) 14.6%</td>
<td>(7) 14.6%</td>
<td>(14) 14.6%</td>
<td>(5) 10.4%</td>
<td>(0)</td>
<td>(5) 5.2%</td>
</tr>
<tr>
<td>Moderate</td>
<td>(10) 20.8%</td>
<td>(10) 20.8%</td>
<td>(20) 20.8%</td>
<td>(4) 8.3%</td>
<td>(1) 2.1%</td>
<td>(5) 5.2%</td>
</tr>
<tr>
<td>Mild</td>
<td>(7) 14.6%</td>
<td>(7) 14.6%</td>
<td>(14) 14.6%</td>
<td>(6) 12.5%</td>
<td>(1) 2.1%</td>
<td>(7) 7.3%</td>
</tr>
<tr>
<td>Normal</td>
<td>(24) 50.0%</td>
<td>(24) 50.0%</td>
<td>(48) 50.0%</td>
<td>(32) 66.7%</td>
<td>(46) 95.8%</td>
<td>(78) 81.3%</td>
</tr>
<tr>
<td>Total</td>
<td>48</td>
<td>48</td>
<td>96</td>
<td>48</td>
<td>48</td>
<td>96</td>
</tr>
</tbody>
</table>
7.2.4.2 Post-test comparisons

Comparison of the post-test measures, again using a paired sample t-test, gave an indication of whether the intervention had had an impact and whether there was a true “treatment effect” on the intervention group, as compared with controls. (see Tables 7.18 and 7.19). It was found that indeed there was a significant difference between the control and treatment participants on all scales, with the treatment patients scoring significantly lower on the DASS depression, anxiety and stress scales, as well as on the GHQ. Additionally and inversely they scored significantly higher on the GWBI as expected.

| Table 7.18: Post-test comparisons between paired control and treatment participants |
|---------------------------------|----------------|----------------|-----------|-----------|---|
| n                              | Control (SD)  | Treatment (SD) | Diff*     | t         | p  |
| DASS Depression                 |               |                |           |           |   |
| 48                             | 9.15 (8.67)   | 3.06 (3.93)    | 6.09      | 4.616     | <.001 |
| DASS Anxiety                    |               |                |           |           |   |
| 48                             | 6.76 (8.23)   | 3.29 (3.67)    | 3.46      | 3.043     | .004 |
| DASS Stress                     |               |                |           |           |   |
| 48                             | 12.57 (8.96)  | 5.67 (4.74)    | 6.90      | 5.162     | <.001 |
| GHQ                            |               |                |           |           |   |
| 47                             | 22.04 (13.04) | 12.04 (8.85)   | 10.00     | 4.309     | <.001 |
| GWBI                           |               |                |           |           |   |
| 47                             | 52.80 (15.18) | 65.72 (13.45)  | -12.92    | -4.503    | <.001 |

*Difference Score (Average)
Table 7.19: Summary table comparing pre- and post-test scores for 48 treatment-control pairs

<table>
<thead>
<tr>
<th>Measure</th>
<th>Control</th>
<th>Treatment</th>
<th>Dif.*</th>
<th>t</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>M</td>
<td>SD</td>
<td>M</td>
<td>SD</td>
</tr>
<tr>
<td>DASS Depression</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pre</td>
<td>48</td>
<td>11.56</td>
<td>10.03</td>
<td>11.89</td>
<td>10.14</td>
</tr>
<tr>
<td>Post</td>
<td>48</td>
<td>9.15</td>
<td>8.67</td>
<td>3.06</td>
<td>3.93</td>
</tr>
<tr>
<td>DASS Anxiety</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pre</td>
<td>48</td>
<td>8.77</td>
<td>10.16</td>
<td>9.25</td>
<td>9.73</td>
</tr>
<tr>
<td>Post</td>
<td>48</td>
<td>6.76</td>
<td>8.23</td>
<td>3.29</td>
<td>3.67</td>
</tr>
<tr>
<td>DASS Stress</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pre</td>
<td>48</td>
<td>15.37</td>
<td>9.02</td>
<td>15.29</td>
<td>9.11</td>
</tr>
<tr>
<td>Post</td>
<td>48</td>
<td>12.57</td>
<td>8.96</td>
<td>5.67</td>
<td>4.74</td>
</tr>
<tr>
<td>GHQ</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pre</td>
<td>46</td>
<td>27.28</td>
<td>14.49</td>
<td>28.96</td>
<td>15.07</td>
</tr>
<tr>
<td>Post</td>
<td>46</td>
<td>22.04</td>
<td>13.04</td>
<td>12.04</td>
<td>8.85</td>
</tr>
<tr>
<td>GWBI</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pre</td>
<td>47</td>
<td>48.87</td>
<td>17.69</td>
<td>48.07</td>
<td>15.21</td>
</tr>
<tr>
<td>Post</td>
<td>46</td>
<td>52.80</td>
<td>15.18</td>
<td>65.72</td>
<td>13.45</td>
</tr>
</tbody>
</table>

*The Difference Score is the mean Control group score minus the mean Treatment group score.

Results indicate that the decrease on all scores of pathology and increase in wellbeing is significantly greater in the treatment group than in the control group, suggesting the intervention had a significant impact. Whilst again there was some improvement in the matched control group, there was a significant difference between all groups at post-test, indicating a prominent intervention effect – see Chapter 8 for discussion of the implications of this finding.

7.2.5 Patients whose scores worsened

A further analysis was carried out on the scores of those participants whose post-test scores were worse than their pre-test. This provided an indication of what proportion of the treatment group worsened, despite receiving treatment. (including all participants whose scores worsened at all - even by one point - on any of the DASS measures.)

7.2.5.1 Treatment

Of the 203 patients who received treatment and completed both the pre and post-intervention measures, 45 (22.2%) worsened on at least one of the DASS measures.
Of these, 31 (69%) were female and 14 (31%) were male. Thirty participants worsened on only one scale (60%), while 12 worsened on two scales (24%) and 8 worsened slightly on all three scales (16%). DASS depression worsened, on average, by only 1.00; DASS anxiety worsened by 1.26, and DASS stress worsened by 0.39.

7.2.5.2 Control

Of the 98 participants who completed both the pre and post-test measures, 53 (54.1%) worsened on at least one of the DASS measures. Of these, 39 (73.6%) were female, and 13 (24.5%) were male. Twenty-five participants worsened on only one of the scales (47.2%), 15 worsened on two of the scales (28.3%), and 13 worsened on all three scales (24.5%). DASS depression worsened, on average, by only 1.43; DASS anxiety worsened by 0.89, and DASS stress worsened by 1.91.

The results indicate that a greater proportion of control participants’ scores worsened between the testing periods. This may be because the control participants’ pre-test scores were generally low (about two-thirds were in the normal range) and therefore more subject to fluctuation, including what might appear to be a slight worsening of score. Comparison of these participants’ pre-test scores (see Table 7.20) produces the same pattern as seen in previous analyses (i.e., a significant difference between the control and treatment groups’ average scores, with the treatment groups’ scores being higher on the DASS and GHQ and lower on the GWBI, indicating a poorer level of mental health).

<table>
<thead>
<tr>
<th>Table 7.20: Pre-test comparisons between control and treatment participants whose scores worsened at post-test</th>
</tr>
</thead>
<tbody>
<tr>
<td>n</td>
</tr>
<tr>
<td>-----</td>
</tr>
<tr>
<td>DASS Depression</td>
</tr>
<tr>
<td>DASS Anxiety</td>
</tr>
<tr>
<td>DASS Stress</td>
</tr>
<tr>
<td>GWBI</td>
</tr>
<tr>
<td>GHQ</td>
</tr>
</tbody>
</table>

* Difference Score (Average)
The post-treatment comparisons still showed a significant difference between the control and treatment participants on all scales except for the GHQ – as follows:

<table>
<thead>
<tr>
<th>Table 7.21: Post-test comparisons between control and treatment participants whose scores worsened at post-test</th>
</tr>
</thead>
<tbody>
<tr>
<td>n</td>
</tr>
<tr>
<td>----</td>
</tr>
<tr>
<td>DASS Depression</td>
</tr>
<tr>
<td>DASS Anxiety</td>
</tr>
<tr>
<td>DASS Stress</td>
</tr>
<tr>
<td>GWBI</td>
</tr>
<tr>
<td>GHQ</td>
</tr>
</tbody>
</table>

* Difference Score (Average)

This may indicate that the degree to which the patients worsened was similar for both groups, as the scores, in general, became closer to each other. To consider this pattern, a paired samples t-test was carried out on both the control and treatment data.

<table>
<thead>
<tr>
<th>Table 7.22: Pre- and post-test comparisons for treatment participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>n</td>
</tr>
<tr>
<td>----</td>
</tr>
<tr>
<td>DASS Depression</td>
</tr>
<tr>
<td>DASS Anxiety</td>
</tr>
<tr>
<td>DASS Stress</td>
</tr>
<tr>
<td>GWBI</td>
</tr>
<tr>
<td>GHQ</td>
</tr>
</tbody>
</table>

*Difference Score (Average)
Table 7.23: Pre- and post-test comparisons for control participants

<table>
<thead>
<tr>
<th></th>
<th>n</th>
<th>Pre (SD)</th>
<th>Post (SD)</th>
<th>Diff*</th>
<th>T</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>DASS Depression</td>
<td>53</td>
<td>6.83 (9.96)</td>
<td>8.26 (9.78)</td>
<td>-1.43</td>
<td>-1.795</td>
<td>.078</td>
</tr>
<tr>
<td>DASS Anxiety</td>
<td>53</td>
<td>5.02 (7.37)</td>
<td>5.91 (7.57)</td>
<td>-.89</td>
<td>-1.601</td>
<td>.115</td>
</tr>
<tr>
<td>DASS Stress</td>
<td>53</td>
<td>9.35 (9.30)</td>
<td>11.26 (8.71)</td>
<td>-1.91</td>
<td>-2.816</td>
<td>.007</td>
</tr>
<tr>
<td>GWBI</td>
<td>50</td>
<td>56.26 (18.11)</td>
<td>56.40 (15.76)</td>
<td>-.14</td>
<td>-.091</td>
<td>.928</td>
</tr>
<tr>
<td>GHQ</td>
<td>51</td>
<td>21.45 (13.29)</td>
<td>22.59 (16.97)</td>
<td>-1.14</td>
<td>-.610</td>
<td>.545</td>
</tr>
</tbody>
</table>

* Difference Score (Average)

These results showed a general trend towards improving scores on the DASS depression and stress for the treatment patients, and a trend towards worsening scores on the DASS anxiety, although these were non-significant. However, there were significant improvements for these participants in their GWBI and GHQ scores. This pattern did not hold for the control participants, who manifest a significant decline in DASS stress scores, and a trend towards worsening on the remaining DASS measures and the GHQ. There was a slight, but non-significant improvement in their GWBI.

Due to the small size of this sample, and the insignificance in many of the scores, these findings only suggested a tendency for the treatment provided during the study to reduce the likelihood of a decline in mental well being. Even for those participants whose scores worsened, there seemed to be some benefit in receiving treatment, as their results showed a tendency towards overall improvement (on some scales a significant improvement), and only an insignificant trend towards worsening scores on one scale, a trend not seen in the control participants.

7.2.5.3 Paired Participants

Running a similar analysis on the paired participants’ data indicated that 39 of the total 96 (40.6%) worsened on at least one scale. Of these, 25 (64.1%) were control participants, whilst 14 (35.9%) were treatment participants. In nine pairs (20%) both the control and the treatment participants worsened on at least one DASS scale. Thus, in four pairs (8.9%) the treatment patient worsened when the control participant did
not, and in 16 pairs (35.6%) the control participant worsened when the treatment patient did not.

Table 7.24: Pre- and post-test comparisons for control paired participants whose scores worsened

<table>
<thead>
<tr>
<th></th>
<th>n</th>
<th>Pre (SD)</th>
<th>Post (SD)</th>
<th>Diff*</th>
<th>T</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>DASS Depression</td>
<td>25</td>
<td>10.84 (10.76)</td>
<td>12.12 (9.36)</td>
<td>-1.28</td>
<td>-.896</td>
<td>.379</td>
</tr>
<tr>
<td>DASS Anxiety</td>
<td>25</td>
<td>6.60 (8.31)</td>
<td>7.77 (8.27)</td>
<td>-1.17</td>
<td>-1.226</td>
<td>.232</td>
</tr>
<tr>
<td>DASS Stress</td>
<td>25</td>
<td>14.18 (8.79)</td>
<td>14.84 (8.83)</td>
<td>-.66</td>
<td>-.594</td>
<td>.558</td>
</tr>
<tr>
<td>GWBI</td>
<td>24</td>
<td>47.61 (18.57)</td>
<td>49.58 (14.69)</td>
<td>-1.97</td>
<td>-.885</td>
<td>.385</td>
</tr>
<tr>
<td>GHQ</td>
<td>24</td>
<td>26.79 (14.34)</td>
<td>23.67 (16.97)</td>
<td>3.13</td>
<td>1.641</td>
<td>.114</td>
</tr>
</tbody>
</table>

*Difference Score (Average)

Table 7.25: Pre- and post-test comparisons for treatment participants whose scores worsened

<table>
<thead>
<tr>
<th></th>
<th>n</th>
<th>Pre (SD)</th>
<th>Post (SD)</th>
<th>Diff*</th>
<th>T</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>DASS Depression</td>
<td>13</td>
<td>5.62 (4.81)</td>
<td>5.08 (4.79)</td>
<td>.54</td>
<td>.342</td>
<td>.738</td>
</tr>
<tr>
<td>DASS Anxiety</td>
<td>13</td>
<td>3.46 (3.67)</td>
<td>4.46 (3.86)</td>
<td>-1.00</td>
<td>-1.347</td>
<td>.203</td>
</tr>
<tr>
<td>DASS Stress</td>
<td>13</td>
<td>9.69 (3.92)</td>
<td>8.23 (4.25)</td>
<td>1.46</td>
<td>1.180</td>
<td>.261</td>
</tr>
<tr>
<td>GWBI</td>
<td>13</td>
<td>51.95 (9.26)</td>
<td>60.77 (14.19)</td>
<td>-8.82</td>
<td>-2.128</td>
<td>.055</td>
</tr>
<tr>
<td>GHQ</td>
<td>11</td>
<td>21.00 (8.72)</td>
<td>15.55 (9.16)</td>
<td>5.45</td>
<td>2.300</td>
<td>.044</td>
</tr>
</tbody>
</table>

*Difference Score (Average)

Comparison of the pre and post-test scores for the control participants indicated that they did not significantly change on any of the measures. There was a trend toward worsening scores on all DASS measures, but an opposite trend, towards improvement on the GWBI and GHQ. Comparison of the treatment patients’ scores indicated a non-significant trend toward improvement on the DASS depression and stress and a non-significant trend towards worsening scores on the DASS anxiety. However, there were significant improvements in the treatment patients’ GWBI and GHQ scores.
Table 7.26: Post-test comparisons between control and treatment participants when control participants scores worsened at post-test

<table>
<thead>
<tr>
<th></th>
<th>n</th>
<th>Control (SD)</th>
<th>Treatment (SD)</th>
<th>Diff*</th>
<th>t</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>DASS Depression</td>
<td>25</td>
<td>12.12 (9.36)</td>
<td>3.20 (4.25)</td>
<td>8.92</td>
<td>4.227</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>DASS Anxiety</td>
<td>25</td>
<td>7.77 (8.27)</td>
<td>3.28 (3.31)</td>
<td>4.49</td>
<td>2.703</td>
<td>.012</td>
</tr>
<tr>
<td>DASS Stress</td>
<td>25</td>
<td>14.84 (8.83)</td>
<td>5.52 (4.89)</td>
<td>9.32</td>
<td>4.933</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>GWBI</td>
<td>24</td>
<td>49.58 (14.69)</td>
<td>65.63 (14.81)</td>
<td>-16.04</td>
<td>-3.449</td>
<td>.002</td>
</tr>
<tr>
<td>GHQ</td>
<td>25</td>
<td>28.84 (13.86)</td>
<td>11.68 (9.52)</td>
<td>13.16</td>
<td>3.821</td>
<td>.001</td>
</tr>
</tbody>
</table>

* Difference Score (Average)

Comparison of the controls’ post-test scores with their matched treatment patients’ post-test scores indicated that the control patients had significantly worse scores on all scales.

Table 7.27: Post-test comparisons between control and treatment participants when treatment participants scores worsened at post-test

<table>
<thead>
<tr>
<th></th>
<th>n</th>
<th>Control (SD)</th>
<th>Treatment (SD)</th>
<th>Diff*</th>
<th>t</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>DASS Depression</td>
<td>14</td>
<td>5.14 (6.89)</td>
<td>4.93 (4.63)</td>
<td>.22</td>
<td>.112</td>
<td>.912</td>
</tr>
<tr>
<td>DASS Anxiety</td>
<td>14</td>
<td>2.45 (4.82)</td>
<td>4.50 (3.71)</td>
<td>-2.05</td>
<td>-1.369</td>
<td>.194</td>
</tr>
<tr>
<td>DASS Stress</td>
<td>14</td>
<td>9.43 (6.09)</td>
<td>8.21 (4.08)</td>
<td>1.21</td>
<td>.652</td>
<td>.525</td>
</tr>
<tr>
<td>GWBI</td>
<td>14</td>
<td>58.93 (9.90)</td>
<td>60.00 (13.94)</td>
<td>-1.08</td>
<td>-.226</td>
<td>.825</td>
</tr>
<tr>
<td>GHQ</td>
<td>13</td>
<td>16.08 (4.53)</td>
<td>16.62 (8.76)</td>
<td>-.54</td>
<td>-.192</td>
<td>.851</td>
</tr>
</tbody>
</table>

* Difference Score (Average)

Unlike the control participants whose scores worsened, the post-intervention scores of the treatment participants did not differ significantly on any of the measures. There was a non-significant trend towards worse scores on the DASS depression and GHQ, and a non-significant trend towards better scores on the DASS stress and GWBI. This indicated that while they may have worsened on one or more of the scales, this was insufficient to significantly worsen their mental health at post-test when compared with matched controls, except on the DASS anxiety measure. This suggested an
advantage of receiving the treatment, as fewer treatment participants worsened at post-test, and of those who did, their post-test scores indicated better mental health than that exhibited by the control participants whose scores had worsened.

7.2.6 Qualitative results amongst treatment group patients

In addition to the above quantitative measures, several qualitative indices were used pre- and post-intervention, in an attempt to capture the unique “presenting problems” and the “changes made” in treatment by each patient (as outlined in the method). These included the “Problems to Goals” Sheet (Appendix 6.9) and a post-treatment “List of Things That Have Changed” compiled with the patient during the final treatment session. Each patient was therefore provided with an opportunity between the first and second sessions to reflect on what their core problems were; their specific daily difficulties and their goals in undertaking treatment. Post-treatment, they were encouraged to highlight what they believed had changed. Case study examples of these, as they applied to several patients, are provided in Appendix 6.10 not as conclusive data, but to illustrate the individualised nature of the work.

7.2.7 Patient Satisfaction Questionnaire

Treatment patients were asked to complete a Patient Satisfaction Survey (see Appendix 6.11) at the end of their treatment. Compliance rates were low as they relied on postal returns. In addition, since most of the clinical psychology registrars left the location of their placement shortly after completion, many responses were not chased up. However, the aim of the questionnaire was to obtain an understanding of whether the intervention was viewed positively by participants and met their needs. A total of 157 responses, 49 from Armidale patients and 108 from Bathurst patients, was used as the basis of the evaluation.
Table 7.28: Numbers of patients returning patient satisfaction questionnaires

<table>
<thead>
<tr>
<th>Research Centre</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Armidale</td>
<td>49</td>
<td>31.2</td>
</tr>
<tr>
<td>Bathurst</td>
<td>108</td>
<td>68.8</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>157</strong></td>
<td><strong>100.0</strong></td>
</tr>
</tbody>
</table>

The 49 Armidale patients represented a 56% response rate of those from Armidale who completed both the pre-test and post-test measures, whilst the 108 Bathurst patients represented 67% of the 161 Bathurst patients who completed both sets of indices. The following tables summarise their responses. In general, the responses were positive since most patients “strongly agreed” or “agreed” with the assertions about their treatment - as outlined below.

(NB. There were a number of items that did not receive a 100% response rate, whilst some others did. Percentages in tables below are based on the total number of those who responded to respond to the item.)

7.2.7.1 Responses

1. **I was pleased my doctor referred me to a clinical psychologist.**

<table>
<thead>
<tr>
<th>Pleased at referral</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly Agree</td>
<td>99</td>
<td>73.3</td>
</tr>
<tr>
<td>Agree</td>
<td>27</td>
<td>2.0</td>
</tr>
<tr>
<td>Neutral</td>
<td>9</td>
<td>6.7</td>
</tr>
<tr>
<td><strong>Total answering</strong></td>
<td><strong>135</strong></td>
<td><strong>100.0</strong></td>
</tr>
</tbody>
</table>

2. **The opportunity to see a clinical psychologist in my doctor’s practice was a helpful experience.**

<table>
<thead>
<tr>
<th>Helpful experience</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly Agree</td>
<td>110</td>
<td>81.5</td>
</tr>
<tr>
<td>Agree</td>
<td>24</td>
<td>17.8</td>
</tr>
<tr>
<td>Neutral</td>
<td>1</td>
<td>0.7</td>
</tr>
<tr>
<td><strong>Total answering</strong></td>
<td><strong>135</strong></td>
<td><strong>100.0</strong></td>
</tr>
</tbody>
</table>
3. Seeing the clinical psychologist helped to relieve my symptom(s) or problem(s).

<table>
<thead>
<tr>
<th>Relieved my symptoms</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly Agree</td>
<td>79</td>
<td>59.0</td>
</tr>
<tr>
<td>Agree</td>
<td>53</td>
<td>39.6</td>
</tr>
<tr>
<td>Neutral</td>
<td>2</td>
<td>1.5</td>
</tr>
<tr>
<td>Total answering</td>
<td>134</td>
<td>100.0</td>
</tr>
</tbody>
</table>

4. I felt listened to and understood by the clinical psychologist.

<table>
<thead>
<tr>
<th>Felt listened to</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly Agree</td>
<td>109</td>
<td>80.7</td>
</tr>
<tr>
<td>Agree</td>
<td>25</td>
<td>18.5</td>
</tr>
<tr>
<td>Neutral</td>
<td>1</td>
<td>0.7</td>
</tr>
<tr>
<td>Total answering</td>
<td>135</td>
<td>100.0</td>
</tr>
</tbody>
</table>


<table>
<thead>
<tr>
<th>Felt involved</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly Agree</td>
<td>95</td>
<td>70.4</td>
</tr>
<tr>
<td>Agree</td>
<td>40</td>
<td>29.6</td>
</tr>
<tr>
<td>Total answering</td>
<td>135</td>
<td>100.0</td>
</tr>
</tbody>
</table>

6. I felt I received the right treatment for my presenting problem.

<table>
<thead>
<tr>
<th>Felt I received right treatment</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly Agree</td>
<td>82</td>
<td>60.7</td>
</tr>
<tr>
<td>Agree</td>
<td>50</td>
<td>37.0</td>
</tr>
<tr>
<td>Neutral</td>
<td>3</td>
<td>2.2</td>
</tr>
<tr>
<td>Total answering</td>
<td>135</td>
<td>100.0</td>
</tr>
</tbody>
</table>

7. The clinical psychologist gave me some explanation and understanding of my condition.

<table>
<thead>
<tr>
<th>Some explanation</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly Agree</td>
<td>92</td>
<td>68.7</td>
</tr>
<tr>
<td>Agree</td>
<td>40</td>
<td>29.9</td>
</tr>
<tr>
<td>Neutral</td>
<td>2</td>
<td>1.5</td>
</tr>
<tr>
<td>Total answering</td>
<td>135</td>
<td>100.0</td>
</tr>
</tbody>
</table>

8. Because of therapy I am now able to deal more effectively with my problem(s).

<table>
<thead>
<tr>
<th>Able to deal effectively</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly Agree</td>
<td>67</td>
<td>50.0</td>
</tr>
<tr>
<td>Agree</td>
<td>59</td>
<td>44.0</td>
</tr>
<tr>
<td>Neutral</td>
<td>6</td>
<td>4.5</td>
</tr>
<tr>
<td>Disagree</td>
<td>2</td>
<td>1.5</td>
</tr>
<tr>
<td>Total answering</td>
<td>134</td>
<td>100.0</td>
</tr>
</tbody>
</table>
9. I would recommend this therapist to others.

<table>
<thead>
<tr>
<th>Would recommend</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly Agree</td>
<td>112</td>
<td>83.0</td>
</tr>
<tr>
<td>Agree</td>
<td>23</td>
<td>17.0</td>
</tr>
<tr>
<td>Total answering</td>
<td>135</td>
<td>100.0</td>
</tr>
</tbody>
</table>

10. I felt more comfortable seeing a clinical psychologist in the doctor’s practice rather than being referred to another place.

<table>
<thead>
<tr>
<th>More comfortable</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly Agree</td>
<td>91</td>
<td>58.3</td>
</tr>
<tr>
<td>Agree</td>
<td>39</td>
<td>25.0</td>
</tr>
<tr>
<td>Neutral</td>
<td>23</td>
<td>14.7</td>
</tr>
<tr>
<td>Disagree</td>
<td>2</td>
<td>1.3</td>
</tr>
<tr>
<td>Strongly disagree</td>
<td>1</td>
<td>.6</td>
</tr>
<tr>
<td>Total answering</td>
<td>156</td>
<td>100.0</td>
</tr>
</tbody>
</table>

In the above item it was noted that three patients disagreed with the assertion of greater comfort in the doctor’s practice and an additional 23 were apparently not sure (the latter may be because they had no previous experience of seeing a psychologist in another setting and hence had no basis for comparison).

11. I would have sought treatment from a psychologist even if the doctor had not referred me.

<table>
<thead>
<tr>
<th>Would have sought</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly Agree</td>
<td>9</td>
<td>5.7</td>
</tr>
<tr>
<td>Agree</td>
<td>30</td>
<td>19.1</td>
</tr>
<tr>
<td>Neutral</td>
<td>43</td>
<td>27.4</td>
</tr>
<tr>
<td>Disagree</td>
<td>57</td>
<td>36.3</td>
</tr>
<tr>
<td>Strongly Disagree</td>
<td>18</td>
<td>11.5</td>
</tr>
<tr>
<td>Total answering</td>
<td>144</td>
<td>100.0</td>
</tr>
</tbody>
</table>

It is interesting to note (as outlined in No. 11) that nearly half the patients believed that they would **not** have sought treatment without the Doctor’s referral and that an additional 27% were apparently unsure. Therefore only about a quarter of the treatment patients believed they would have sought/received treatment without this intervention, in spite of their overwhelmingly favourable attitude toward the treatment they received.
12. The doctor attended part of my first session.

<table>
<thead>
<tr>
<th>Doctor attended session</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>22</td>
<td>14.0</td>
</tr>
<tr>
<td>No</td>
<td>135</td>
<td>86.0</td>
</tr>
<tr>
<td>Total answering</td>
<td>157</td>
<td>100.0</td>
</tr>
</tbody>
</table>

13. If yes, was this helpful?

<table>
<thead>
<tr>
<th>Doctor helpful attendance</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>24</td>
<td>15.3</td>
</tr>
<tr>
<td>No</td>
<td>5</td>
<td>3.2</td>
</tr>
<tr>
<td>Total answering</td>
<td>29</td>
<td>18.5</td>
</tr>
<tr>
<td>Doctor did not attend</td>
<td>128</td>
<td>81.5</td>
</tr>
<tr>
<td>Total</td>
<td>157</td>
<td>100.0</td>
</tr>
</tbody>
</table>

In most cases, the doctor did not attend the patient’s first session with the psychologist. In the relatively few cases in which the Doctor did attend, the patients tended to find this helpful.

16. Had you received counseling or other treatment elsewhere for the same problems?

<table>
<thead>
<tr>
<th>Received Counseling Elsewhere</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>76</td>
<td>48.4</td>
</tr>
<tr>
<td>No</td>
<td>78</td>
<td>49.7</td>
</tr>
<tr>
<td>Total answering</td>
<td>154</td>
<td>98.1</td>
</tr>
<tr>
<td>System</td>
<td>3</td>
<td>1.9</td>
</tr>
<tr>
<td>Total</td>
<td>157</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Nearly half of the treatment patients stated that they had received counselling elsewhere for the same problems.

16. If so, was this provided by a:

<table>
<thead>
<tr>
<th>Previous provider</th>
<th>Frequency</th>
<th>Valid Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Counselor</td>
<td>14</td>
<td>28.6</td>
</tr>
<tr>
<td>Psychologist</td>
<td>18</td>
<td>36.7</td>
</tr>
<tr>
<td>GP</td>
<td>10</td>
<td>20.4</td>
</tr>
<tr>
<td>Psychiatrist</td>
<td>7</td>
<td>14.3</td>
</tr>
<tr>
<td>Total</td>
<td>49</td>
<td>100.0</td>
</tr>
<tr>
<td>System</td>
<td>108</td>
<td></td>
</tr>
</tbody>
</table>
17. Compared to this earlier treatment was the recently completed treatment:

<table>
<thead>
<tr>
<th>Comparison of treatment</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less helpful</td>
<td>27</td>
<td>35.5</td>
</tr>
<tr>
<td>About the same</td>
<td>16</td>
<td>20.0</td>
</tr>
<tr>
<td>More helpful</td>
<td>33</td>
<td>43.5</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>76</strong></td>
<td><strong>100.0</strong></td>
</tr>
<tr>
<td>System</td>
<td>81</td>
<td></td>
</tr>
</tbody>
</table>

The patients who had received counselling elsewhere had seen a variety of providers, including counsellors, psychologists, GPs and psychiatrists. Patients were split on the issue of whether the recently completed counselling in the GP’s office had been more or less helpful than the counselling they had received with the other provider, with 33 patients (43.5%) saying that it was more helpful, 27 (35.5%) saying it was less helpful and 16 (20%) saying that their experiences were roughly comparable.

18a. Would you seek the services of a clinical psychologist in a similar setting if there were a fee [of around $100 per session] involved?

<table>
<thead>
<tr>
<th>Would seek services</th>
<th>Frequency</th>
<th>Valid Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>52</td>
<td>40.3</td>
</tr>
<tr>
<td>No</td>
<td>77</td>
<td>59.7</td>
</tr>
<tr>
<td><strong>Total answering</strong></td>
<td><strong>129</strong></td>
<td><strong>100.0</strong></td>
</tr>
<tr>
<td>System</td>
<td>28</td>
<td></td>
</tr>
</tbody>
</table>

18b. Would such a fee be a problem?

<table>
<thead>
<tr>
<th>Fee a problem</th>
<th>Frequency</th>
<th>Valid Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>111</td>
<td>84.8</td>
</tr>
<tr>
<td>No</td>
<td>20</td>
<td>15.3</td>
</tr>
<tr>
<td><strong>Total answering</strong></td>
<td><strong>131</strong></td>
<td><strong>100.0</strong></td>
</tr>
<tr>
<td>System</td>
<td>25</td>
<td></td>
</tr>
</tbody>
</table>

The majority of the patients who responded to question 18 said that they would not seek services from a clinical psychologist if a fee of approximately $100 per session were involved. Although most patients appreciated the opportunity to spend up to six sessions with the psychologist in the GP’s offices, they did not judge themselves to be in a position to pay for the services.

7.2.7.2 Summary and Conclusions

The majority of patients who were treated by the clinical psychologists agreed with statements about the helpfulness of the sessions and the convenience of seeing the
psychologist within the doctors’ offices. Most believed that they had gained a greater understanding of their problems and that they were empowered by the treatment to deal more effectively with these problems. All of the responding patients said that they would recommend the psychologist they saw to others; virtually all said that they felt more comfortable seeing the psychologist in the doctor’s office than they would have felt elsewhere. However, nearly half would not have sought treatment if the doctor had not recommended it. The patients were similarly split on whether they had received treatment from another provider before their experience with the psychologists in the program. Of the patients who had received counselling elsewhere, there was again an approximately even split on the efficacy of the more recent treatment compared to the treatment received elsewhere. Finally, the issue of requiring a fee for treatment within the GP’s offices met with strenuous opposition, with 84% of patients saying that a fee of approximately $100 per session would be a problem for them. There appears therefore to be some ambivalence among the responding patients, with almost uniform appreciation of the services offered but almost uniform rejection of the option to pay for these services. (At the time of the research, there were extremely scarce options for publicly-funded services. It is only since November 2006 that Medicare rebates have been available for such services. On the basis of the information provided above, those who charge large gaps on top of scheduled fees would price themselves out of the market in rural and remote Australia.)

7.3 General Practitioners

(NB. For a summary of results from the sections below: 7.3 and 7.4 see Chapter 8: section 8.2.7).

7.3.1 Attitudes and Behavioural Changes

7.3.1.1 Preliminary/baseline survey of GP attitudes

As outlined in the method chapter, the “Clinical Psychologists in General Practice Survey” was mailed out to the 176 GPs in the NSW Central West Division of GPs. Of the 176 surveyed, 111 responded to the questionnaire (63% of the surveyed population). The
tables below provide specific data in relation to each question (n= “z” indicates numbers who did not answer questions).

7.3.1.1a) Key Points arising from pre-data

- 78% of GPs surveyed estimate that somewhere between 10% – 50% of their patients manifest mental health difficulties (Q3);
- 47.7% of GPs felt their formal training prepared them not at all, or not very well for working with mental health problems (Q4);
- Only 23% of GPs felt very comfortable dealing with mental health problems, 60% somewhat, 16% not very comfortable, 3% not at all (Q5).
- 81% of GPs felt they had inadequate time to see patients with mental health difficulties (Q6);
- 40% indicated they would not like to become more involved in the treatment of mental health problems (Q7);
- 51% of doctors estimated that they prescribe medication for between 30% - 70% of their patients with a mental health problem (Q8);
- Only 50% indicated they used other mental health professionals (Q9);
- GPs indicated they most frequently referred (55%) to “Counsellors” as distinct from other professional groups (Q10)
- Only 38% indicated knowledge of the difference between a psychologist and a clinical psychologist (Q11);
- 58% of doctors indicated they would prefer to refer to a clinical psychologist as their first or second choice (compared to 46% for psychiatrists) (Q12);
- Only 20% indicated that a clinical psychologist would be their 3rd or 4th choice (compared to 42% for psychiatrists);
- Main reasons why GPs have not referred patients to clinical psychologists include: there are no clinical psychologists available (47%); patients cannot afford treatment fees (62%) (Q13);
- 82% of GPs felt it would be useful to have a clinical psychologist as part of a multi-disciplinary team in their practice (50%; Very useful) (Q14).
7.3.1.1b) Data from specific questions

Questions 1: How long have you been a GP?

<table>
<thead>
<tr>
<th>Duration</th>
<th>Percentage</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>~ 1 year</td>
<td>13%</td>
<td>14</td>
</tr>
<tr>
<td>2 – 5 years</td>
<td>10%</td>
<td>11</td>
</tr>
<tr>
<td>6-10 years</td>
<td>9%</td>
<td>10</td>
</tr>
<tr>
<td>11 – 15 years</td>
<td>14%</td>
<td>16</td>
</tr>
<tr>
<td>16 – 20 years</td>
<td>18%</td>
<td>20</td>
</tr>
<tr>
<td>21-25</td>
<td>17%</td>
<td>19</td>
</tr>
<tr>
<td>26 – 30</td>
<td>5%</td>
<td>6</td>
</tr>
<tr>
<td>31-35</td>
<td>4%</td>
<td>5</td>
</tr>
<tr>
<td>&gt;36</td>
<td>6%</td>
<td>7</td>
</tr>
<tr>
<td>Z</td>
<td>3%</td>
<td>3</td>
</tr>
</tbody>
</table>

GP working years in the Central West District

Question 2: How long have you been working in your current practice?

<table>
<thead>
<tr>
<th>Duration</th>
<th>Percentage</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>~ 1 year</td>
<td>23%</td>
<td>25</td>
</tr>
<tr>
<td>2 – 5 years</td>
<td>23%</td>
<td>26</td>
</tr>
<tr>
<td>6-10 years</td>
<td>17%</td>
<td>19</td>
</tr>
<tr>
<td>11 – 15 years</td>
<td>8%</td>
<td>10</td>
</tr>
<tr>
<td>16 – 20 years</td>
<td>12%</td>
<td>13</td>
</tr>
<tr>
<td>21-25</td>
<td>7%</td>
<td>8</td>
</tr>
<tr>
<td>26 – 30</td>
<td>3%</td>
<td>3</td>
</tr>
<tr>
<td>31-35</td>
<td>2%</td>
<td>2</td>
</tr>
<tr>
<td>&gt;36</td>
<td>3%</td>
<td>3</td>
</tr>
<tr>
<td>Z</td>
<td>2%</td>
<td>2</td>
</tr>
</tbody>
</table>

Years GP's have worked in current practice
Question 3: What percentage of your patients do you estimate have mental health problems/difficulties as a significant component of their overall health?

<table>
<thead>
<tr>
<th>% of patients</th>
<th>% of GPs</th>
</tr>
</thead>
<tbody>
<tr>
<td>10%</td>
<td>14% (15)</td>
</tr>
<tr>
<td>10 – 30%</td>
<td>59% (65)</td>
</tr>
<tr>
<td>30 – 50%</td>
<td>19% (22)</td>
</tr>
<tr>
<td>50 – 70%</td>
<td>6% (7)</td>
</tr>
<tr>
<td>70% +</td>
<td>0%</td>
</tr>
<tr>
<td>Z</td>
<td>2% (2)</td>
</tr>
</tbody>
</table>

GP estimated percentage of patients seen with mental health problems

Question 4: Do you feel your formal training adequately prepares you for dealing with mental health problems?

a) Not at all 13% (14)
b) Not very 35% (39)
c) Somewhat 45% (49)
d) Very 6% (7)
e) Z 1% (2)
Question 5: How comfortable are you in dealing with mental health problems?

a) Not at all 3% (3)
b) Not very 13% (15)
c) Somewhat 60% (67)
d) Very 23% (25)
e) Z 1% (1)

![Doctors level of comfort in dealing with mental health problems](image)

Question 6: Do you feel you have adequate time to see patients with mental health difficulties?

a) Yes 14% (16)
b) No 81% (90)
c) Z 4% (4)
d) Depends on Problem 1% (1)

![Adequacy of time for GP's to see patients with mental illness](image)
Question 7: Would you like to become more involved in the treatment of mental health problems?

a) Yes 54% (61)
b) No 40% (43)
c) Z 5% (6)
d) I look after Whoever sees me 1% (1)

GP interest of further involvement in mental health treatment

Question 8: For what proportion of patients with a mental health problem do you estimate you prescribe medication as treatment?

- 10% 10% (12)
- 10 – 30% 34% (37)
- 30 – 50% 34% (38)
- 50 – 70% 17% (19)
- 70% + 3% (3)
- Z 2% (2)
Question 9: Do you most frequently prescribe medication for mental health problem?

a) As the sole treatment: 3% (3)
b) In conjunction with counselling provided by myself: 44% (50)
c) In conjunction with treatment provided by another mental health professional: 38% (42)
d) Combination of b & c: 13% (14)
e) Z: 2% (2)

Question 10: Please rank in order to whom you most frequently refer to for mental health issues.

<table>
<thead>
<tr>
<th>1st Choice</th>
<th>2nd Choice</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) Counsellor:</td>
<td>a) Counsellor:</td>
</tr>
<tr>
<td>55% (61)</td>
<td>14% (17)</td>
</tr>
<tr>
<td>b) Psychologist:</td>
<td>b) Psychologist:</td>
</tr>
<tr>
<td>11% (12)</td>
<td>24% (26)</td>
</tr>
<tr>
<td>c) Clinical Psychologist:</td>
<td>c) Clinical Psychologist:</td>
</tr>
<tr>
<td>13% (14)</td>
<td>17% (19)</td>
</tr>
<tr>
<td>d) Psychiatrist:</td>
<td>d) Psychiatrist:</td>
</tr>
<tr>
<td>11% (12)</td>
<td>22% (24)</td>
</tr>
<tr>
<td>e) Other:</td>
<td>e) Other:</td>
</tr>
<tr>
<td>6% (7)</td>
<td>4% (4)</td>
</tr>
<tr>
<td>f) Psyche/ClinPsyche</td>
<td>f) Z:</td>
</tr>
<tr>
<td>1</td>
<td>19% (21)</td>
</tr>
<tr>
<td>g) Z:</td>
<td>Z:</td>
</tr>
<tr>
<td>3% (4)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>3rd Choice</th>
<th>4th Choice</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) Counsellor:</td>
<td>a) Counsellor:</td>
</tr>
<tr>
<td>10% (12)</td>
<td>8% (9)</td>
</tr>
<tr>
<td>b) Psychologist:</td>
<td>b) Psychologist:</td>
</tr>
<tr>
<td>20% (22)</td>
<td>15% (16)</td>
</tr>
<tr>
<td>c) Clinical Psychologist:</td>
<td>c) Clinical Psychologist:</td>
</tr>
<tr>
<td>22% (24)</td>
<td>9% (10)</td>
</tr>
<tr>
<td>d) Psychiatrist:</td>
<td>d) Psychiatrist:</td>
</tr>
<tr>
<td>17% (19)</td>
<td>25% (28)</td>
</tr>
<tr>
<td>e) Other:</td>
<td>e) Other:</td>
</tr>
<tr>
<td>3% (3)</td>
<td>5% (5)</td>
</tr>
<tr>
<td>f) Z:</td>
<td>f) Z:</td>
</tr>
<tr>
<td>28% (31)</td>
<td>38% (43)</td>
</tr>
</tbody>
</table>

Most frequently referred to mental health professionals by GPs
Question 11: Do you know the difference between a Psychologist and a Clinical Psychologist?

<table>
<thead>
<tr>
<th></th>
<th>Yes: 38% (42)</th>
<th>No: 55% (62)</th>
<th>Z: 6% (7)</th>
</tr>
</thead>
</table>

Do GP’s understand the difference between a Clinical Psychologist and a Psychologist?

- 72% (80) of the GP’s surveyed did not elaborate on what a Clinical Psychologist was or did.
- 11% (12) of GP’s surveyed stated that a Clinical Psychologist had extra training in the management of specific mental health problems;
- 3% (3) stated that Clinical Psychologists provide treatment services;
- 5% (6) of the GP’s surveyed stated that Clinical Psychologists had extra training;
- 2% (2) GP’s stated that the Clinical Psychologist had counselling skills;
- 1 GP stated that Clinical Psychologists were more appropriate for psychological disorders;
- 1 GP utilised the words “industrial and medical” to describe the difference between a Psychologist and a Clinical Psychologist;
- 1 GP stated that Clinical Psychologists treated patients in a collaborative health care environment using the word “team”;  
- 1 GP stated that Clinical Psychologists are trained in cognitive evaluation and thought processes;  
- 1 GP stated that the Clinical Psychologist uses more long-term treatments per patient;  
- 1 GP stated that the Clinical Psychologists have a University degree in Psychology;  
- 1 GP stated that a Clinical Psychologist has post graduate experience and formal qualifications in dealing with clients (patients) 1 to 1 or in groups;  
- 1 GP stated that a psychologist is a more generic or general form of work in different areas such as counselling.
Question 12: Please rank in order which of the following you would prefer to refer to (putting aside cost, service availability, etc)

<table>
<thead>
<tr>
<th>1st Choice</th>
<th>2nd Choice</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) Counsellor: 20% (22)</td>
<td>a) Counsellor: 19% (21)</td>
</tr>
<tr>
<td>b) Psychologist: 10% (11)</td>
<td>b) Psychologist: 18% (20)</td>
</tr>
<tr>
<td>c) Clinical Psychologist: 35% (39)</td>
<td>c) Clinical Psychologist: 23% (25)</td>
</tr>
<tr>
<td>d) Psychiatrist: 26% (29)</td>
<td>d) Psychiatrist: 20% (23)</td>
</tr>
<tr>
<td>e) Psy/Clin Psy: 2</td>
<td>e) Psy/Clin Psy: 2% (2)</td>
</tr>
<tr>
<td>f) Psy/Couns: 0</td>
<td>f) Psy/Couns: 0</td>
</tr>
<tr>
<td>g) Other: 1</td>
<td>g) Other: 2% (2)</td>
</tr>
<tr>
<td>h) Z: 6% (7)</td>
<td>h) Z: 16% (18)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>3rd Choice</th>
<th>4th Choice</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) Counsellor: 21% (24)</td>
<td>a) Counsellor: 20% (22)</td>
</tr>
<tr>
<td>b) Psychologist: 23% (25)</td>
<td>b) Psychologist: 20% (22)</td>
</tr>
<tr>
<td>c) Clinical Psychologist: 15% (17)</td>
<td>c) Clinical Psychologist: 5% (6)</td>
</tr>
<tr>
<td>d) Psychiatrist: 20% (22)</td>
<td>d) Psychiatrist: 22% (24)</td>
</tr>
<tr>
<td>e) Psy/Clin Psy: 0</td>
<td>e) Psy/Clin Psy: 0</td>
</tr>
<tr>
<td>f) Psy/Couns: 1</td>
<td>f) Psy/Couns: 0</td>
</tr>
<tr>
<td>g) Other: 1</td>
<td>g) Other: 2% (2)</td>
</tr>
<tr>
<td>h) Z: 19% (21)</td>
<td>h) Z: 31% (35)</td>
</tr>
</tbody>
</table>

![GPs' preferred mental health professional for referral (putting other factors aside)](image-url)
Question 13: Please rank in order the main reasons why you may not have referred patients with mental health issues to a Clinical Psychologist.

<table>
<thead>
<tr>
<th>Choices</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) I can treat patient’s psychological problems myself:</td>
<td>5% (5)</td>
<td>11% (12)</td>
<td>4% (17)</td>
<td>15% (17)</td>
</tr>
<tr>
<td>b) I have no clear idea what a Clinical Psychologist can provide:</td>
<td>12% (13)</td>
<td>13% (14)</td>
<td>11% (12)</td>
<td>6% (7)</td>
</tr>
<tr>
<td>c) There are no Clinical Psychologists available:</td>
<td>36% (40)</td>
<td>11% (13)</td>
<td>8% (9)</td>
<td>7% (8)</td>
</tr>
<tr>
<td>d) Patients want drug treatment for psychological problems</td>
<td>2% (2)</td>
<td>6% (7)</td>
<td>9% (10)</td>
<td>22% (25)</td>
</tr>
<tr>
<td>e) Patients reject referral to any mental health specialist:</td>
<td>2% (2)</td>
<td>14% (15)</td>
<td>21% (23)</td>
<td>9% (11)</td>
</tr>
<tr>
<td>f) Patients can’t afford treatment fees:</td>
<td>34% (39)</td>
<td>28% (31)</td>
<td>8% (9)</td>
<td>5% (6)</td>
</tr>
<tr>
<td>g) Other:</td>
<td>1 0 0 0</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>h) Z:</td>
<td>8% (9)</td>
<td>17% (19)</td>
<td>28% (31)</td>
<td>34% (37)</td>
</tr>
</tbody>
</table>

Question 14: How useful would it be to have a Clinical Psychologist as part of a multidisciplinary team in your practice?

<table>
<thead>
<tr>
<th>Choices</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) Not at all:</td>
<td>5% (5)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b) Not very:</td>
<td>8% (9)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>c) Somewhat:</td>
<td>32% (36)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>d) Very:</td>
<td>50% (56)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>e) Z:</td>
<td>5% (5)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
7.3.1.2 Post Survey: Attitudes of GPs involved in the collaborative model of service delivery

The General Practitioners who had hosted the Clinical Psychologists in their surgeries were asked to complete a brief questionnaire about their experiences. Out of 27 GPs, 14 responded to the survey (ie. approximately 52%) – see Table 7.29.

### Table 7.29: Research centre/location of GP respondents

<table>
<thead>
<tr>
<th>Research Centre</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Armidale, Glen Innes, Inverell</td>
<td>6</td>
<td>42.9</td>
</tr>
<tr>
<td>Ballarat</td>
<td>1</td>
<td>7.1</td>
</tr>
<tr>
<td>Bathurst</td>
<td>7</td>
<td>50.0</td>
</tr>
<tr>
<td>Total</td>
<td>14</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Half the responses came from physicians in Bathurst and nearly half from physicians in practice in Armidale, Glen Innes or Inverell. Only one physician from a multi-doctor clinic in Ballarat responded. While the response rate was only 52% (given that there were 14 responses from 27 doctors contacted), there was in general at least one responding doctor from each practice. The following tables summarise their responses. In general, GPs were quite favourable toward the presence of the clinical psychologists in their practice and found them beneficial to their patients.
7.3.1.2a) *Analysis of GP responses to General Practitioners’ Questionnaire*

1. **Have you found having a clinical psychologist/clinical psychology registrar within your practice helpful for patients with mental health difficulties?**

<table>
<thead>
<tr>
<th>Helpful to patients</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Somewhat</td>
<td>3</td>
<td>21.4</td>
</tr>
<tr>
<td>Very</td>
<td>11</td>
<td>78.6</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>14</strong></td>
<td><strong>100.0</strong></td>
</tr>
</tbody>
</table>

Comments included the following:

1. “Very useful to have rapid availability of psychological services, to be able to discuss care locally.”
2. “Both from the patient’s perspective and from the doctor’s.”
3. “Rapid referral of patients and a team approach has alleviated a lot of stress for the referring doctor.”
4. “Provided valuable, expert therapy which could not have been offered otherwise without compromising the service to other patients.”

1. **Do you think your patients have been helped by the clinical psychologist(s) located within your practice?**

<table>
<thead>
<tr>
<th>Patients have been helped</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not much</td>
<td>1</td>
<td>7.1</td>
</tr>
<tr>
<td>Somewhat</td>
<td>2</td>
<td>14.3</td>
</tr>
<tr>
<td>Very much</td>
<td>11</td>
<td>78.6</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>14</strong></td>
<td><strong>100.0</strong></td>
</tr>
</tbody>
</table>

Comments included the following:

1. “There has been excellent feedback from patients.”
2. “Rapid assessment/accurate diagnosis/time-limited treatment all allow for speedy management.”
3. “With trained intervention recovery has often been achieved in less time.”

1. **Do you think that the provision of clinical psychology services within your practice has improved mental health service delivery for your patients?**

<table>
<thead>
<tr>
<th>Improved MH service</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Somewhat</td>
<td>4</td>
<td>28.6</td>
</tr>
<tr>
<td>Very much</td>
<td>10</td>
<td>71.4</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>14</strong></td>
<td><strong>100.0</strong></td>
</tr>
</tbody>
</table>

Comments included the following:

1. “To be able to use a psychologist whenever needed rather than if affordable and available has been great.”
2. “It increased the range of services we could offer.”
1. Please rank in order which of the following professionals you would prefer to refer patients to (putting aside issues of cost, availability, etc.). Please code 1=most preferred to 5=least preferred.

Note that to determine the rank for the combined group of GPs (N=14), each GP’s rank for that profession was multiplied by the number of GPs according that rank. Since 1=most preferred, the profession with the lowest sum of N*rank is the most preferred; hence the following listing is from most preferred to least preferred.

<table>
<thead>
<tr>
<th>Overall rank for 13 GPs</th>
<th>Sum of N*rank</th>
<th>Rank</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Psychologist</td>
<td>17</td>
<td>1</td>
</tr>
<tr>
<td>Psychologist</td>
<td>32</td>
<td>2</td>
</tr>
<tr>
<td>Psychiatrist</td>
<td>38</td>
<td>3</td>
</tr>
<tr>
<td>Counsellor</td>
<td>43</td>
<td>4</td>
</tr>
</tbody>
</table>

Overall, it was found that clinical psychologists were the profession to which GPs would most prefer to refer patients whilst counsellors were least preferred. One GP stated that there would be different patient indications for referral to a psychiatrist than a psychologist but that most often a clinical psychologist was the type of person required.

The GPs were also asked to rate the value of the clinical psychologists in their practice on seven dimensions, as shown below.

| 5a. GPs have benefited from the personal support of sharing care with a clinical psychologist. |
|-----------------------------------------------|------------------|------------------|
| Benefited from sharing care                   | Frequency        | Percent          |
| Strongly Agree                                | 8                | 57.1             |
| Agree                                         | 6                | 42.9             |
| Total                                         | 13               | 100.0            |

| 5b. Ready opportunity of feedback from the clinical psychologist was valuable. |
|-----------------------------------------------|------------------|------------------|
| Feedback was valuable                         | Frequency        | Percent          |
| Strongly Agree                                | 5                | 35.7             |
| Agree                                         | 9                | 34.3             |
| Total                                         | 14               | 100.0            |

| 5c. The opportunity to introduce your patients to the clinical psychologist was valuable. |
|-----------------------------------------------|------------------|------------------|
| Introduction valuable                         | Frequency        | Percent          |
| Strongly Agree                                | 6                | 42.9             |
| Agree                                         | 6                | 42.9             |
| Not sure                                      | 2                | 14.3             |
| Total                                         | 14               | 100.0            |
5d. GPs benefited from the collaboration in developing a “case management model of care”.

<table>
<thead>
<tr>
<th>Benefited from model</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly Agree</td>
<td>4</td>
<td>28.6</td>
</tr>
<tr>
<td>Agree</td>
<td>7</td>
<td>50.0</td>
</tr>
<tr>
<td>Not sure</td>
<td>2</td>
<td>14.3</td>
</tr>
<tr>
<td>Disagree</td>
<td>1</td>
<td>7.1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>14</strong></td>
<td><strong>100.0</strong></td>
</tr>
</tbody>
</table>

5e. GP’s skills in working with patients with emotional/psychological disturbances increased.

<table>
<thead>
<tr>
<th>Skills increased</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly Agree</td>
<td>3</td>
<td>21.4</td>
</tr>
<tr>
<td>Agree</td>
<td>6</td>
<td>42.9</td>
</tr>
<tr>
<td>Not sure</td>
<td>4</td>
<td>28.6</td>
</tr>
<tr>
<td>Disagree</td>
<td>1</td>
<td>7.1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>14</strong></td>
<td><strong>100.0</strong></td>
</tr>
</tbody>
</table>

5f. GP confidence in working with patients with emotional/psychological disturbances increased.

<table>
<thead>
<tr>
<th>Confidence increase</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly Agree</td>
<td>3</td>
<td>21.4</td>
</tr>
<tr>
<td>Agree</td>
<td>7</td>
<td>50.0</td>
</tr>
<tr>
<td>Neutral</td>
<td>3</td>
<td>21.4</td>
</tr>
<tr>
<td>Disagree</td>
<td>1</td>
<td>7.1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>14</strong></td>
<td><strong>100.0</strong></td>
</tr>
</tbody>
</table>

5g. The clinical psychologist reduced the amount of time I needed to spend with particular patients.

<table>
<thead>
<tr>
<th>Reduced time</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly Agree</td>
<td>7</td>
<td>50.0</td>
</tr>
<tr>
<td>Agree</td>
<td>5</td>
<td>35.7</td>
</tr>
<tr>
<td>Neutral</td>
<td>1</td>
<td>7.1</td>
</tr>
<tr>
<td>Disagree</td>
<td>1</td>
<td>7.1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>14</strong></td>
<td><strong>100.0</strong></td>
</tr>
</tbody>
</table>

In the above set of items, it is obvious that virtually all of the GPs appreciated the opportunity to share care of patients with the Clinical Psychologist and that they valued the Psychologist’s feedback. However, there were a couple of GPs who were unsure whether psychologists helped them increase their skills or confidence in working with patients with mental health problems.
6a. The clinical psychologist provided a valuable option for more accessible psychological services.

<table>
<thead>
<tr>
<th>Valuable option</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly Agree</td>
<td>9</td>
<td>64.3</td>
</tr>
<tr>
<td>Agree</td>
<td>5</td>
<td>35.7</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>14</strong></td>
<td><strong>100.0</strong></td>
</tr>
</tbody>
</table>

6b. This project gave the clinical psychologist more understanding of the role of GPs in the social and emotional care of patients.

<table>
<thead>
<tr>
<th>More understanding</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly Agree</td>
<td>5</td>
<td>35.7</td>
</tr>
<tr>
<td>Agree</td>
<td>8</td>
<td>57.1</td>
</tr>
<tr>
<td>Not sure</td>
<td>1</td>
<td>7.1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>14</strong></td>
<td><strong>100.0</strong></td>
</tr>
</tbody>
</table>

Most of the GPs agreed that the collaboration between the Clinical Psychologist and the GP provided both professions with a greater understanding of each other’s role. They were unanimous in stating that they would like to see this service continued, as shown below.

6c. Would you like to see the provision/continuation of clinical psychology services to your general practice?

<table>
<thead>
<tr>
<th>Like to see services</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>14</td>
<td>100.0</td>
</tr>
<tr>
<td>No</td>
<td>0</td>
<td>0.0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>14</strong></td>
<td><strong>100.0</strong></td>
</tr>
</tbody>
</table>

When GPs were asked to outline their perceptions of what it had been like to be involved in the “Clinical Psychology in General Practice Project”, their final comments included the following:

(1) “Great idea!”
(2) “Extremely useful. It was an absolute luxury to have the facility to refer cases. The use of medication was more effective and probably need for long-term medication was reduced. Many patients felt more confident, better able to cope with problems.”
(3) “Extremely positive experience for myself and for the patients. I hope that this service can be continued indefinitely.”
(4) “I have learnt how much a clinical psychologist can help my mental health patients. Previously cost constraints had prevented patients accessing clinical psychologists.”
(5) “My experience of working on this project has been most positive. I have been able to quickly assess patients with confidence and refer them to the psychologist for appropriate time-limited therapy. The majority of patients on reassessment are much improved and speak
positively of the intervention. It is wonderful to treat patients effectively in a team environment before major psychological or psychiatric disorders evolve.”

(6) “It has been an invaluable service to the patients and appreciated by all. It reduced demand on the health service.”

(7) “In my multi-doctor clinic, all the GPs felt the value of learning from the psychologist, being able to refer without financial issues, and we liked the fact that the clinical psychologist understood and appreciated the GP’s role.”

7.3.1.2b) Conclusions

As shown by the positive comments and the largely favourable responses to the items, GPs seemed to appreciate collaborating with the clinical psychologists who had been invited into their practices. Several stated that all the important players (the patients, the psychologists and the GPs themselves) benefited from the project, and as one GP said, it would be wonderful if the project could be continued indefinitely.

7.4 Clinical Psychology Registrars

7.4.1 Registrar placement questionnaire

As outlined in the method chapter, rather than tabulate each individual registrar’s placement evaluation form at the end of each placement, a questionnaire requesting feedback on their placement experience was sent to all 22 psychological registrars who took part in the project in Bathurst, Armidale and Ballarat between 2001 and 2004. All 22 registrars responded yielding a 100% response rate (some of these results are summarised in the method chapter, providing demographics for the clinical psychology registrars).

Table 7.30 indicates the gender of those participating in the Project. About three-quarters of the responding registrars were female, their ages ranging from 23 to “50+” (see Table 7.31). The majority were in their 20s or 30s.
### Table 7.30: Gender of clinical psychology registrars

<table>
<thead>
<tr>
<th>Gender</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>4</td>
<td>18.2</td>
</tr>
<tr>
<td>Female</td>
<td>18</td>
<td>81.8</td>
</tr>
<tr>
<td>Total</td>
<td>22</td>
<td>100.0</td>
</tr>
</tbody>
</table>

### Table 7.31: Age of clinical psychology registrars

<table>
<thead>
<tr>
<th>Age Category</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>20 to 29</td>
<td>7</td>
<td>31.8</td>
</tr>
<tr>
<td>30 to 39</td>
<td>10</td>
<td>45.5</td>
</tr>
<tr>
<td>40 to 49</td>
<td>4</td>
<td>18.5</td>
</tr>
<tr>
<td>50 and above</td>
<td>1</td>
<td>4.5</td>
</tr>
<tr>
<td>Total</td>
<td>22</td>
<td>100.0</td>
</tr>
</tbody>
</table>

7.4.1.1 Responses to registrar placement questionnaire

1. **Which placement did you undertake?**

<table>
<thead>
<tr>
<th>Placement Undertaken</th>
<th>Full- or Part-time</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Full-Time</td>
<td>Part-time</td>
</tr>
<tr>
<td>MPsych</td>
<td>8</td>
<td>6</td>
</tr>
<tr>
<td>Number</td>
<td>57.1%</td>
<td>42.9%</td>
</tr>
<tr>
<td>DPsych</td>
<td>5</td>
<td>2</td>
</tr>
<tr>
<td>Percent</td>
<td>71.4%</td>
<td>28.6%</td>
</tr>
</tbody>
</table>

Fourteen of the registrars were in a Master’s program in Psychology, and seven were in a Doctoral program in Psychology. Nearly two-thirds (13 of the 22) registrars were full-time students.

2. **What year of your degree were you in whilst on placement on the project?**

<table>
<thead>
<tr>
<th>Year of Degree</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>First</td>
<td>8</td>
<td>36.4</td>
</tr>
<tr>
<td>Second</td>
<td>5</td>
<td>22.7</td>
</tr>
<tr>
<td>Third</td>
<td>7</td>
<td>31.8</td>
</tr>
<tr>
<td>Fourth</td>
<td>2</td>
<td>9.1</td>
</tr>
<tr>
<td>Total</td>
<td>22</td>
<td>100.0</td>
</tr>
</tbody>
</table>
Registrars were fairly evenly spread across their first, second and third years of study, with two in a fourth year of study.

3. **At which university were you studying?**

<table>
<thead>
<tr>
<th>University</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ballarat</td>
<td>4</td>
<td>18.2</td>
</tr>
<tr>
<td>CSU</td>
<td>9</td>
<td>40.9</td>
</tr>
<tr>
<td>La Trobe</td>
<td>1</td>
<td>4.5</td>
</tr>
<tr>
<td>Macquarie</td>
<td>1</td>
<td>4.5</td>
</tr>
<tr>
<td>New England</td>
<td>3</td>
<td>13.6</td>
</tr>
<tr>
<td>Newcastle</td>
<td>3</td>
<td>13.6</td>
</tr>
<tr>
<td>South Australia</td>
<td>1</td>
<td>4.5</td>
</tr>
<tr>
<td>Total</td>
<td>22</td>
<td>100.0</td>
</tr>
</tbody>
</table>

The largest number of students (nine) were studying at Charles Sturt University, while four were studying at Ballarat and three each at the Universities of New England and Newcastle. One student was studying at each of the following universities: La Trobe, Macquarie and the University of South Australia.

3. **Were you a registered psychologist at the time of your placement?**

<table>
<thead>
<tr>
<th>Reg. Psych.?</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>16</td>
<td>72.7</td>
</tr>
<tr>
<td>No</td>
<td>6</td>
<td>27.3</td>
</tr>
<tr>
<td>Total</td>
<td>22</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Nearly three-quarters of the registrars were Registered Psychologists whilst in the placement.

4. **Location of your placement**

<table>
<thead>
<tr>
<th>Location/General Practice</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Armidale, Inverell, Glen Innes</td>
<td>1</td>
<td>4.5</td>
</tr>
<tr>
<td>Kandos/Rylstone</td>
<td>1</td>
<td>4.5</td>
</tr>
<tr>
<td>Ballarat Group Ballarat</td>
<td>1</td>
<td>4.5</td>
</tr>
<tr>
<td>Gillies Street, Ballarat</td>
<td>1</td>
<td>4.5</td>
</tr>
<tr>
<td>Rusden Street, Armidale</td>
<td>2</td>
<td>9.1</td>
</tr>
<tr>
<td>Drummond Street, Ballarat</td>
<td>2</td>
<td>9.1</td>
</tr>
<tr>
<td>George Street, Bathurst</td>
<td>7</td>
<td>31.9</td>
</tr>
<tr>
<td>Russell Street, Bathurst</td>
<td>7</td>
<td>31.9</td>
</tr>
<tr>
<td>Total</td>
<td>22</td>
<td>100.0</td>
</tr>
</tbody>
</table>
As outlined in the method chapter, fourteen of the 22 registrars were placed in Bathurst, with seven at George Street and seven at Russell Street. Two registrars each were placed at Rusden Street in Armidale and at Drummond Street in Ballarat. One registrar was at Ballarat Group, one more at Gillies Street, Ballarat and one at clinics in Kandos and Rylstone, NSW. Finally, one registrar divided her time among practices in Armidale, Inverell and Glen Innes. Since the registrar in Kandos and Rylstone was supervised in Bathurst, a total of 15 registrars had Bathurst supervisors, four had Ballarat supervisors, and three had supervisors in Armidale.

5. Please indicate whether or not the following goals were important to you in your placement:

<table>
<thead>
<tr>
<th>Placement goal</th>
<th>N Yes</th>
<th>% Yes</th>
<th>N No</th>
<th>% No</th>
</tr>
</thead>
<tbody>
<tr>
<td>i. Develop confidence in Clin. Psych.’s role in GP setting</td>
<td>22</td>
<td>100</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>ii. Enhance clinical skills in treatment of various disorders</td>
<td>22</td>
<td>100</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>iii. Develop collaborative prof. relationship with GP</td>
<td>21</td>
<td>94</td>
<td>1</td>
<td>6</td>
</tr>
<tr>
<td>iv. Promote Clinical Psych. in public health field</td>
<td>19</td>
<td>86</td>
<td>3</td>
<td>14</td>
</tr>
<tr>
<td>v. Perform as scientist practitioner in primary care setting</td>
<td>20</td>
<td>91</td>
<td>2</td>
<td>9</td>
</tr>
<tr>
<td>vi. Other</td>
<td>6</td>
<td>27</td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>

Virtually all of the registrars were enthusiastic about achieving each of the goals listed.
The following are **other goals listed under Question 5.vi.**

<table>
<thead>
<tr>
<th>Question No.</th>
<th>Question Description</th>
<th>Response</th>
<th>N Respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>5.vi</td>
<td>Other placement goals</td>
<td>Understanding issues in a rural/regional setting</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Become confident dealing w range of problems</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Prepare reports for shared care service delivery</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Work with skilled GP as supervisor</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Better understanding of chronic disease and its psychological implications</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Develop time management skills</td>
<td>1</td>
</tr>
</tbody>
</table>

**6. 7, 8a Please rate the following aspects of your placement (1=Poor to 5=Excellent)**

<table>
<thead>
<tr>
<th>Q</th>
<th>Aspect of Placement</th>
<th>1 Poor</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5 Exc.</th>
</tr>
</thead>
<tbody>
<tr>
<td>6a</td>
<td>Information provided</td>
<td>0</td>
<td>1</td>
<td>5</td>
<td>10</td>
<td>6</td>
</tr>
<tr>
<td>6b</td>
<td>Organisation and planning</td>
<td>1</td>
<td>0</td>
<td>5</td>
<td>13</td>
<td>3</td>
</tr>
<tr>
<td>7a</td>
<td>Supervision</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>9</td>
<td>1</td>
</tr>
<tr>
<td>7b</td>
<td>Theory/Practice</td>
<td>0</td>
<td>0</td>
<td>3</td>
<td>11</td>
<td>8</td>
</tr>
<tr>
<td>7c</td>
<td>Clinical advice</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>14</td>
<td>7</td>
</tr>
<tr>
<td>7d</td>
<td>Guidance given</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>11</td>
<td>9</td>
</tr>
<tr>
<td>7e</td>
<td>Methods of teaching</td>
<td>0</td>
<td>3</td>
<td>5</td>
<td>7</td>
<td>7</td>
</tr>
<tr>
<td>7f</td>
<td>Provision of feedback</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>11</td>
<td>8</td>
</tr>
<tr>
<td>8a</td>
<td>Overall rating of placement experience</td>
<td>0</td>
<td>2</td>
<td>1</td>
<td>6</td>
<td>13</td>
</tr>
</tbody>
</table>

Registrars were very favourable about most aspects of their placement. They were particularly pleased by the availability and approachability of their supervisor. One registrar was disappointed by organisation and planning, and three were not pleased by methods of teaching, but overall 13 of the 22 respondents rated their placement experience as “excellent”.
The following were comments made about supervision:

<table>
<thead>
<tr>
<th>Question No.</th>
<th>Question Description</th>
<th>Response</th>
<th>N Respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>7</td>
<td>Comments on supervision</td>
<td>Supervision was plentiful and very useful</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td></td>
<td>GP surgery was not well organised</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Would have benefited from more supervision since placement over 3 centres</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td></td>
<td>GP not positive toward idea of psychologists</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Enjoyed sitting in on cases w senior psychologist</td>
<td>1</td>
</tr>
</tbody>
</table>

While the following were comments about the clinical experience:

<table>
<thead>
<tr>
<th>Question No.</th>
<th>Question Description</th>
<th>Response</th>
<th>N Respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>8</td>
<td>Comments on clinical experience</td>
<td>I have not completed another placement yet</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Workload was too heavy: 7 patients/day</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Pressures due to limited time of placement</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Autonomy was one of the best aspects</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td></td>
<td>I enjoyed it most of all my counselling placements</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td></td>
<td>No opportunity to observe other professionals</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Although I felt isolated, the placement was beneficial &amp; productive</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Having a day just for observation was important in breaking up workload</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Community appreciated the service and made word-of-mouth referrals</td>
<td>1</td>
</tr>
</tbody>
</table>

8b. Intensity of the work load

<table>
<thead>
<tr>
<th>The work load was:</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Too demanding</td>
<td>5</td>
<td>27.8</td>
</tr>
<tr>
<td>Adequate</td>
<td>17</td>
<td>72.2</td>
</tr>
<tr>
<td>Under demanding</td>
<td>0</td>
<td>0.0</td>
</tr>
<tr>
<td>Total</td>
<td>22</td>
<td>100.0</td>
</tr>
</tbody>
</table>

None of the registrars found the work load “under demanding”, although five (or 28%) found it too demanding. The remaining 17 registrars were satisfied with their work load.
8c) Compared to other clinical placement experiences, how does this one rank?

<table>
<thead>
<tr>
<th>Comparison of placement to others</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Worst placement</td>
<td>0</td>
<td>0.0</td>
</tr>
<tr>
<td>2</td>
<td>2</td>
<td>9.1</td>
</tr>
<tr>
<td>3</td>
<td>3</td>
<td>13.6</td>
</tr>
<tr>
<td>4</td>
<td>8</td>
<td>36.4</td>
</tr>
<tr>
<td>5 Best placement</td>
<td>8</td>
<td>36.4</td>
</tr>
<tr>
<td>No other placement to compare to</td>
<td>1</td>
<td>4.5</td>
</tr>
<tr>
<td>Total</td>
<td>22</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Eight of the 22 registrars (or 36%) considered the placement to be the best one they had experienced, while an additional eight gave it a 4 out of 5. One person claimed to have no other placement with which to compare the one in question.

9a. Do you think that the provision of psychological services within the General Practice setting improves mental health delivery for patients?

<table>
<thead>
<tr>
<th>Psychological services improve MH delivery?</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>21</td>
<td>95.5</td>
</tr>
<tr>
<td>Don't Know</td>
<td>1</td>
<td>4.5</td>
</tr>
<tr>
<td>Total</td>
<td>2</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Virtually all of the registrars responded ‘yes’ to this question. When asked to elaborate, they made the following comments:

<table>
<thead>
<tr>
<th>Question No.</th>
<th>Question Description</th>
<th>Response</th>
<th>N Respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>9a</td>
<td>Comments on service delivery</td>
<td>Patients more willing to attend because of confidence in Dr.</td>
<td>7</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Easier to maintain communication w GPs on site</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Conducting sessions in GP office minimises stigma of seeing a psychologist</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Clients feel supported in an ongoing way</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Particularly successful w recently diagnosed patients</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td></td>
<td>This model should be available to all GP practices in all states</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Patient load so heavy I couldn't find time to do my notes &amp; reports</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Some difficulty not having a usual room allocated to me</td>
<td>1</td>
</tr>
</tbody>
</table>
9b) Working with GP was beneficial to professional practice?

<table>
<thead>
<tr>
<th></th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>19</td>
<td>86.4</td>
</tr>
<tr>
<td>No</td>
<td>1</td>
<td>4.5</td>
</tr>
<tr>
<td>Don't Know</td>
<td>2</td>
<td>9.1</td>
</tr>
<tr>
<td>Total</td>
<td>22</td>
<td>100.0</td>
</tr>
</tbody>
</table>

The majority of registrars (19 of 22) found that working with the GP benefited their professional practices. The following were some comments they made when asked to elaborate:

<table>
<thead>
<tr>
<th>Question No.</th>
<th>Question Description</th>
<th>Response</th>
<th>N Respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>9b</td>
<td>Comments on benefits of working w GP</td>
<td>Greater appreciation for GPs in practice</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Better understanding of psych. issues in a GP practice</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Sometimes difficult to access GPs to discuss issues</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Gave GPs opportunity to learn more about psychologists</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Highlighted interaction of psych. and medical problems</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Drs. supportive of practice in conjunction w medication</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td></td>
<td>I probably didn't make the most of this aspect</td>
<td>1</td>
</tr>
</tbody>
</table>

9c) Comments from patients about this psychological service within the general practice setting were generally:

<table>
<thead>
<tr>
<th>Quality of patient comments</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very positive</td>
<td>17</td>
<td>77.3</td>
</tr>
<tr>
<td>Positive</td>
<td>5</td>
<td>22.7</td>
</tr>
<tr>
<td>Neutral</td>
<td>0</td>
<td>0.0</td>
</tr>
<tr>
<td>Negative</td>
<td>0</td>
<td>0.0</td>
</tr>
<tr>
<td>Very negative</td>
<td>0</td>
<td>0.0</td>
</tr>
<tr>
<td>Total</td>
<td>22</td>
<td>100.0</td>
</tr>
</tbody>
</table>

All registrars considered patient comments about the service to be positive or very positive. The registrars elaborated as follows:
Chapter 7: Results

<table>
<thead>
<tr>
<th>Question No.</th>
<th>Question Description</th>
<th>Response</th>
<th>N Respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>9c</td>
<td>Comments on patient views</td>
<td>Free service accessible to clients w financial constraints</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Many clients said they wouldn't have gotten help except thru this venue</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Clients pleased to be seen in same venue in which saw GP</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Many clients made significant gains in small number of sessions</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Client feedback questions were generally very positive</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Clients appreciated lack of waiting time to see a psychologist</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Still completing my placement; look forward to feedback at end of placement</td>
<td>1</td>
</tr>
</tbody>
</table>

Questions 9d, 9e and 9f were open-ended, with responses summarised in the table below:

<table>
<thead>
<tr>
<th>Question No.</th>
<th>Question Description</th>
<th>Response</th>
<th>N Respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>9d</td>
<td>Aspects beneficial to learning</td>
<td>Diversity of presenting problems allowed me to develop my skills</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Learning to use my own judgment but still having access to support</td>
<td>7</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Managing a large caseload</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td></td>
<td>I developed my organisational as well as my clinical skills</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Client feedback survey beneficial to my understanding my practice</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Received information on medications from the GPs</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Developing ability to write brief reports to referring GP</td>
<td>1</td>
</tr>
<tr>
<td>9e</td>
<td>Particular strengths of placement</td>
<td>Opportunity to watch GPs and clinical supervisor in client work</td>
<td>7</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Accessible &amp; available in a rural area</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Primary referral source at finger tips for consultation &amp; clarification</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Acceptance by the GPs of the psychologist's role</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Diversity of client problems</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Developing of time management skills</td>
<td>1</td>
</tr>
</tbody>
</table>
Chapter 7: Results

<table>
<thead>
<tr>
<th>Question No.</th>
<th>Question Description</th>
<th>Response</th>
<th>N Respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>9f</td>
<td>Aspects to improve</td>
<td>More suitable for a final placement; otherwise greater supervision required</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Communication between registrar and some of the GPs</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Need greater orientation, formal meeting w GPs at start of placement</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Would have liked placement to be longer</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Sometimes difficult not to have peers to discuss with</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Would have liked less paperwork</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Room I used in practice was cold &amp; difficult for clients to access</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Wish therapy rooms could be made less medical &amp; more conducive to therapy</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td></td>
<td>More opportunities to observe other disorders</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Would have liked better support from GP's clerical staff</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Smoother handover from previous registrar would have been helpful</td>
<td>1</td>
</tr>
</tbody>
</table>

9g) **Did you achieve the required goals and objectives during this placement?**

<table>
<thead>
<tr>
<th>Placement goal to achieve</th>
<th>N Yes</th>
<th>% Yes</th>
<th>N No</th>
<th>% No</th>
</tr>
</thead>
<tbody>
<tr>
<td>i. Develop confidence in Clin. Psych.’s role in GP setting</td>
<td>21</td>
<td>96</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>ii. Enhance clinical skills in treatment of various disorders</td>
<td>22</td>
<td>100</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>iii. Develop collaborative prof. relationship with GP</td>
<td>20</td>
<td>91</td>
<td>2</td>
<td>9</td>
</tr>
<tr>
<td>iv. Promote Clinical Psych. in public health field</td>
<td>21</td>
<td>96</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>v. Perform as scientist practitioner in primary care setting</td>
<td>22</td>
<td>100</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>vi. Other</td>
<td>10</td>
<td>91</td>
<td>1</td>
<td>9</td>
</tr>
</tbody>
</table>

The vast majority of the registrars achieved each of the objectives they set out to achieve. When asked to comment on the goals they had achieved, they offered the following additional comments:
The registrars were asked about whether they were currently working or planning to work in a primary care setting. Responses are summarised below:

**9h) Are you, as a consequence of this placement, now working in a primary care setting?**

<table>
<thead>
<tr>
<th>Working in a primary care setting?</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>4</td>
<td>19.0</td>
</tr>
<tr>
<td>No</td>
<td>17</td>
<td>81.0</td>
</tr>
<tr>
<td>Total</td>
<td>21</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Only four registrars were currently working in a primary care setting. Three of these were working in a rural setting and one in a metropolitan one.

**9j) If you are not currently working in primary care, are you planning/hoping to work in this setting in the future?**

<table>
<thead>
<tr>
<th>Planning to work in a primary care setting?</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>15</td>
<td>85.0</td>
</tr>
<tr>
<td>No</td>
<td>3</td>
<td>15.0</td>
</tr>
<tr>
<td>Already working in a primary care setting</td>
<td>3</td>
<td>N/A</td>
</tr>
<tr>
<td>Total</td>
<td>21</td>
<td>100.0</td>
</tr>
</tbody>
</table>
9k) If you are planning to work in a primary care setting, in which geographic setting would it be?

<table>
<thead>
<tr>
<th>Geographic setting of planned work experience</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Metropolitan</td>
<td>6</td>
<td>28.6</td>
</tr>
<tr>
<td>Rural</td>
<td>4</td>
<td>19.0</td>
</tr>
<tr>
<td>Regional</td>
<td>4</td>
<td>19.0</td>
</tr>
<tr>
<td>Any of these</td>
<td>1</td>
<td>4.8</td>
</tr>
<tr>
<td>Not applicable</td>
<td>6</td>
<td>28.6</td>
</tr>
<tr>
<td>Total</td>
<td>18</td>
<td>100.0</td>
</tr>
</tbody>
</table>

The majority of registrars who were not currently working in a primary care setting planned to do so in the future. They were approximately evenly split among metropolitan, rural and regional settings.

Finally, when asked to make “other general comments”, the registrars offered the following:

<table>
<thead>
<tr>
<th>Question No.</th>
<th>Question Description</th>
<th>Response</th>
<th>N Respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>10</td>
<td>Other general comments</td>
<td>Very good placement; I benefited greatly from it</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Hopefully this will become a dominant model of psych. care in future</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Gained an appreciation for counselling and particularly paediatric assessment</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td></td>
<td>One GP told me none of his patients were depressed and that he thought that psychology was a waste of time</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td></td>
<td>One disadvantage was running out of time to provide clients with 6 sessions, especially those referred in the last few weeks.</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Psych. should be for everyone and not just for the mentally ill; we can all benefit from the “life examined”; healthy strategies are preventative</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Placement was supported by one practice in Ballarat but not by another one</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td></td>
<td>At the time I felt overwhelmed &amp; not very confident, but the interaction with the GPs was what made this placement different</td>
<td>1</td>
</tr>
<tr>
<td>Question No.</td>
<td>Question Description</td>
<td>Response</td>
<td>N Respondents</td>
</tr>
<tr>
<td>-------------</td>
<td>-------------------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------</td>
<td>---------------</td>
</tr>
<tr>
<td></td>
<td>Some patients had chronic &amp; significant MH issues that made me wish I had had more clinical experience behind me</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td></td>
<td>The practicum was completed 18 months ago, so hard to remember all details</td>
<td>1</td>
<td></td>
</tr>
</tbody>
</table>

7.4.1.2 Conclusions

Almost all of the 22 registrars found their placements to be highly beneficial experiences for themselves, their patients and for the GPs with whom they interacted. Several stated that they were proud to be involved in a project that was innovative as well as inherently useful and that they hoped that the collaborative approach would become a model for mental health care throughout Australia. There were very few negative comments (although there appeared to be a few GPs who were not as receptive to the placements as others). All told, respondents were overwhelmingly favourable about their experiences, as indicated by the desire of most of them to continue in similar placements/work settings. The fact that placements took place in rural settings was seen as a great advantage for most registrars since many had as one of their goals a better understanding of patient treatment in rural and remote areas.
8.1 Overview

The aim of the current study was to evaluate the effectiveness of providing clinical psychology services in the primary care setting as an adjunct to previously available general practice medical services for common mental disorders. A collaborative model of care, involving GPs and clinical psychologists, was trialed in three geographic locations in Australia: Bathurst, Ballarat and Armidale, entailing treatment by clinical psychology registrars (mostly later year interns) of referred patients with common mental disorders (primarily depression and anxiety) in the primary care setting. Treatment group patients’ levels of improvement on a number of mental health indices were monitored and compared with a control group of patients surveyed in the general practice waiting room. In addition, matched-pairs of treatment and control patients were compared pre- and post-treatment. Additional parameters of patient, GP and clinical psychology registrar satisfaction with the model were included as part of the study.

Three key predictions underpinned the study:

1) patients undertaking treatment in primary care would do significantly better under a shared-care, collaborative model involving both GPs and clinical psychologists, than under GP treatment alone.

2) GPs involved in collaborative care would find the model both helpful to themselves and of more value to their patients than straightforward medical care provided by GPs alone (ie. that significant “value added” was created through involvement of clinical psychologists in collaborative care).

3) clinical psychology registrars undertaking these primary care internships would find their placement experiences of significant value in preparing for work in the general practice setting, and more of them would opt for work in primary care as a consequence.
The results suggest that clinical psychologists working with GPs in primary care can have a positive effect on the mental health of patients identified by their GP as being psychologically distressed – ie. the collaborative model of care provides “value added” to GP treatment alone in the treatment of patients with common mental disorders. Comparison of the intervention group before intervention with the normative control group, which was drawn from a similar demographic population, indicated significantly higher levels of psychological disturbance in the treatment group. Average scores in the intervention group improved markedly on all measures (DASS, GHQ and GWI) after the intervention, with no significant difference between the intervention and the normative comparison group at follow-up. Similarly, in the matched-pair comparison of 48 patients drawn from both groups (96 in total), whilst there was no difference between pre-test scores (matching was successful), a significant difference was found between the post-test scores of the intervention group whose scores on all indices had improved significantly, when compared to the matched control group whose results essentially did not change.

In addition, in terms of patient, GP and registrar satisfaction with the shared care model, all groups manifest highly positive attitudes to and perceptions of the model of collaborative care. These responses suggest that it may be an optimal model of care to articulate nationally beyond the original confines of the three research locations, and that initial government financial support should be continued. Further, the model provides shared care arrangements assisting GPs with their mental health load of patients with common mental disorders for whom treatment was previously unavailable. Finally, it suggests that primary care practicums for clinical psychology students provides placement opportunities enabling them to learn about the complexities, demands and rewards of working in the general practice setting – an optimal environment in which to treat as many patients as possible and provide early psychological intervention.
8.2 Summary of Findings

8.2.1 Pre-test results

Given high attrition and relatively low return rates - with 106 patients less in the treatment sub-group and 100 less in the control sub-group from initial totals - the key concern of whether subjects who completed the study were substantially different from those who started the study, needed to be explored. In particular, if those initially referred to the treatment group were measurably more severely affected than treatment patients who completed the study, this would create a significant methodological problem. Comparisons of pre-tests, however, both within the intervention group (between the 309 initial participants and the 203 patients who completed both sets of measures) and control group (198 vs. 98) confirmed that the treatment group sub-sample was equivalent to and representative of the total referred group on all measures, whilst control patients who took the pre-test and those who completed both pre- and post-tests differed a little, with scores for the control sub-group of 98 participants tending to be slightly lower than those in the original group, in most cases by less than one score point (see Table 7.2). Whilst these differences were not significant, the trend reinforced the notion that the control group was in fact a normative comparison group and hence did not create a further design problem.

8.2.2 Potential confounding factors

8.2.2.1 Gender, age and socioeconomic status

Retrospective analysis of demographic variables of gender, age and socioeconomic status of the Bathurst treatment and control groups (see Figures 6.2 and 6.3) indicated that there were no significant differences between groups, nor between total groups and sub-groups who completed pre- and post-measures on these potential confounder variables. At follow-up there was found to be no gender-determined responsiveness to treatment amongst the treatment group, indicating that the collaborative model of care was equally appropriate for both males and females.
8.2.2.2 Treatment effect, geographic location and gender

Analyses of variance (ANOVAS) were done to assess whether main effects of the treatment vs. control condition were confounded by any geographically-determined differences (ie. at the Bathurst, Armidale and Ballarat locations) and additionally whether gender differences (mentioned above) contributed to an interactive effect. The first ANOVA analysed pre-test scores across three factors: condition (1,2 - ie. treatment vs. control), location (1,2,3 – ie. Bathurst, Armidale and Ballarat) and gender (1,2 – male vs. female). The second compared difference scores (ie. difference between pre-test and post-test) by these same three factors (see Appendices 7.3a and 7.3b). In both analyses, the factor of statistical significance was “condition”, whilst location and gender had little bearing on the results (ie. an insignificant impact). There were, however, some two way interactions (condition by research centre/location) which were found to be significant for some of the measures.

These results again confirmed the significant impact of the treatment intervention across all measures, with location providing some interactive effect, suggesting that some training locations and/or supervisors were more effective than others.

8.2.2.3 Medication

In addition, analysis of data from patients on whom medication status was known and on whom pre- and post-test data were available, indicated that neither the treatment or control group showed any significant effects of medication on any of the difference scores between pre- and post-measures. Whilst caution needs to be exercised in interpreting and generalising these results due to small group sizes, the results are interesting for several reasons:

a) no significant impact of medication was found;

b) the data suggest that the significant treatment effects found in the data are due to psychological intervention rather than pharmacological treatment.
8.2.3 Pre- and post-test comparisons of treatment and control groups

8.2.3.1 Statistical analyses

On initial measures, treatment and control groups were found to differ significantly on all indices at the 0.001 level with treatment group patients showing significantly higher means (ie. more disturbance) on all measures of pathology (DASS sub-scale and GHQ scores), and inversely lower on the General Wellbeing Index (see table 7.8). Interestingly, whilst 13.2%, 15.3% and 8.1% of controls were found to be in the “severe” and “very severe” ranges for the DASS sub-scales of depression, anxiety and stress (respectively), 50.5%, 51% and 41.4% of treatment patients were found to be within these ranges. (These control patients were deemed not at risk by their GPs and hence not referred to the treatment group.)

At follow-up, results indicated that all mean pathology scores had reduced significantly for the treatment group (at the 0.001 level), with 79%, 74.7% and 80.6% of patients now being within the “normal” and “mild” ranges for depression, anxiety and stress respectively (“normal”: 73%, 65.7% and 70.6% and “mild”: 6%, 9%, and 10% - see Tables 7.10 and 7.12). This suggested that, as aimed for, the intervention had resulted in the patients’ level of mental disorder improving to predominantly within the normal range. There are, however, several other interpretations that need to be canvassed. One is that the scores of the treatment group would have improved over time anyway; an additional explanation being that the results reflect the regression to the mean phenomenon (ie. “the statistical phenomenon that extreme scores on any measure will, over time for purely statistical reasons, revert to less extreme scores when next tested” -Trochim, 2006). This required further exploration.

Pre- and post-test comparisons and t tests for the control group also showed improvements, with three of the differences being significant - one at the 0.005 level, two at the 0.05 level - and two marginally significant (see Table 7.11). Whilst approximately two-thirds of the control patients scored in the normal range on each of the DASS measures at pre-test, by the end of the program this had increased to about three-quarters of the patients being within the normal range.
Several possible explanations exist for this improvement. Firstly, the attention of the GP to their mental wellbeing may have effected some improvement in the patients, even without intervention by a psychologist. Secondly, the act of completing the surveys for a second time may have led to increased self-awareness and a possible lessening of any symptoms of depression or anxiety that may have been present during the first assessment – indeed. Alternatively, the results may again have reflected the regression to the mean phenomenon, ie. that the post-test measures reflected a move of all scores towards the “normal” mean. However, if the project did effect some modest improvement in mood for control group patients, this was a fortuitous by-product of their involvement.

8.2.3.2 Graphic representations

As Pocock, Travison and Wruck (2008) assert, given “the mind’s preference for information conveyed in pictorial format”, “graphical display of data is amongst the most powerful tools available for communicating medical research findings”. Graphic representations of the pre- and post-test results for both groups clearly convey the relative shift between groups. The histograms in Figures 7.3, 7.4 and 7.5 illustrate that, whilst at pre-test the treatment and control groups were clearly discrepant, at post-test on all three DASS sub-scales they were almost indistinguishable from each other.

8.2.3.3 Simple sign test

The simple sign test (see Table 7.6) further indicated clear group differences, with the treatment group manifesting greater improvement than the control as follows: 80.8% of treatment patients vs. 50% of controls showed improvement on the depression sub-scale, 79.3% vs. 44.9% in anxiety scores and 81.8% vs. 51% in stress scores (these included improvements of as little as one point, hence the large representation of the control group). Inversely, 29.6% of controls worsened vs. 10.3% of treatment patients on the depression sub-scale, 28.6% vs. 12.8% on anxiety and 37.8% vs. 11.8% on stress; whilst those who “remained the same” were as follows: 20.4% of controls vs. 8.9% of treatment group on depression, 26.5% vs. 7.9% on anxiety, and 11.2% vs. 6.4% on stress. Further analysis of results from treatment group patients within the
“clinical range” (ie. whose anxiety, depression or stress was the most acute, their scores being in the “moderate”, “severe” and “extremely severe” levels on the DASS at pre-test), indicated that nearly 90% of them improved after treatment on all scales, with only small percentages remaining the same or getting worse.

8.2.3.4 Conclusions

In conclusion, results suggested that the reduction in post-test scores was more significant for the treatment group, supporting the hypothesis that the intervention had a positive impact, greater than that observed when patients received treatment from their GP alone. However, further analysis was necessary to confirm that this was as a result of the treatment provided to the intervention group through the study. As outlined previously, it may be for example, that those patients whose scores were elevated at pre-test would naturally score lower upon re-testing, as there may be a natural “tendency towards normalisation”.

8.2.4 Matched pair analysis

8.2.6.1 Pre- and post-test comparisons

To determine whether the above was the case, and to gain confidence in the validity of the results, a matched-pair analysis was done in which control and treatment participants were matched on their pre-scores, with any post-test score difference then being attributable to the intervention and not to factors related to the initial difference between the groups (ie. not being comparable on initial scores). A further phase of the analysis was therefore done by including a matched pair comparison. As outlined in the method and results chapters, forty-eight pairs were drawn from both the treatment and normative comparison groups on the basis of matched pre-test scores on all three DASS sub-scales. On all initial measures they were comparable (see Tables 7.16 & 7.17). Comparison post-treatment, using a paired samples t-test revealed that there was a significant difference between the control and treatment participants on all scales (all at the 0.001 level), with treatment patients scoring significantly lower on the DASS depression, anxiety and stress scales, as well as on the GHQ. They also
scored significantly higher on the GWBI – indicating that the collaborative intervention had markedly improved the well-being of the treatment patients.

8.2.6.2 Comparison of patients in both groups whose scores worsened

In a more detailed examination of the sub-groups of patients whose scores worsened on one or more measures/sub-scales, comparison of treatment and controls (see Tables 7.26 and 7.27) indicated the following:

a) when control participants’ (n=25) scores worsened, it was found that they significantly worsened on all scales;

b) when treatment patients’ (n=14) scores worsened on one or more scales, post-intervention scores were not significantly different from pre-scores, indeed insufficient to significantly worsen their mental health;

c) fewer treatment participants in the matched-control pairs worsened at post-test and, of those who did, their overall scores across all measures indicated better mental health than control participants whose scores worsened across most measures at the same time.

As outlined in the results chapter, these additional findings also suggested an advantage of receiving the treatment, as fewer treatment participants worsened at post-test, and of those who did, their combined post-test scores indicated overall better mental health than that exhibited by the control participants whose scores had worsened.

8.2.6.3 Conclusions

Whilst the findings above confirm an intervention effect, caution needs to be exercised in interpreting these results as the matched-pairs were a select group of participants drawn from the sample population, not a randomised sub-sample. The treatment participants in the analysis of pairs necessarily had less severe levels of depression, anxiety and stress than some other treatment patients in order to find a match for the control participants, who as a group, had significantly lower scores (see
Tables 7.8, 7.10 and 7.11 above). The only conclusion that may be confidently drawn from the analysis of matched pair results is that the intervention seems to be effective for treating those with conditions of lesser severity. It is therefore not possible to confidently generalise this finding to those patients suffering more from severe forms of these disorders.

8.2.7 Questionnaires/surveys

8.2.7.1 Overview

Data from questionnaires exploring patient, GP and registrar perception of the shared care model indicate that all groups held positive attitudes to and perceptions of collaborative care, suggesting that it may be an optimal model of care to articulate more widely. Whilst not rigorous in terms of response rates – there was an average 62% return across groups of patients surveyed; a 63% return of GPs surveyed pre-trial and a 52% GP response rate post-trial; whilst 100% return from the 22 registrars surveyed – responses received were predominantly positive and illustrate views of those participating in the project.

8.2.7.2 Patient satisfaction questionnaire

8.2.7.2a) Findings

The Patient Satisfaction Questionnaire was returned by 56% (49) of the Armidale patients and 67% (108) of the Bathurst patients. Most patient responses were in the “strongly agreed” or “agreed” categories as follows: 75.3% (126 treatment group patients) strongly agreed (73.3%) or agreed (2%) that they were pleased their doctor had referred them to a clinical psychologist; 99.3% (134) found seeing a clinical psychologist at their doctor’s practice a helpful experience with 83.3% (130) indicating they were more comfortable receiving these sessions in the doctor’s practice than elsewhere and 98.6% (132) indicating it had helped to relieve their symptoms; 99.2% (134) felt listened to and understood by the clinical psychologist with 100% (135) feeling involved in their assessment and treatment and 98.6% (132) indicating that they had been given some explanation and understanding of their condition; 100% strongly agreed (60.7%) and agreed (37%) that they had received the
right treatment for their presenting problem; 94% (126) strongly agreed (50%) and agreed (44%) that because of therapy there were better able to deal effectively with their problems. Interestingly, nearly half (47.8%) of the patients responding believed they would not have sought treatment without the doctor’s referral and an additional 27% were unsure. Only about a quarter of the treatment patients (24.8% - 39 patients) believed they would have sought/received treatment without this intervention, in spite of their favourable attitude toward the treatment they had received.

For most patients (86% - 135 patients), due to being occupied elsewhere in the practice, the doctor did not attend the patient’s first session with the psychologist despite this being part of the collaborative model. In the relatively few cases (14% - 22 patients) in which the doctor did attend, the patients tended to find this helpful. The patients who had received counselling elsewhere had seen a variety of providers, including counsellors, psychologists, GPs and psychiatrists. Patients who had received earlier treatment elsewhere (45% of the total – 76 patients) were split on the issue of whether the recently completed intervention in the GP’s office had been more or less helpful than counselling received from the earlier provider with 43.5% (33) saying that it was more helpful, 35.5% (27) saying it was less helpful and 20% (16) saying that their experiences were roughly comparable. There was not an opportunity to elaborate on these mixed perspectives - some issues from which are discussed below.

In relation to costs of treatment, the majority of patients (59.7% - 77 patients) indicated that they would not seek the services of a clinical psychologist if a fee (of approximately $100 per session) were involved, with 84.7% (111 patients) saying such a fee would be a problem. Although most patients appreciated the opportunity to spend up to six sessions with the psychologist in the GP’s offices, they did not judge themselves to be in a position to pay for the services.

8.2.7.2b) Summary

In summary, the majority of patients who were treated by the clinical psychologists agreed with statements about the helpfulness of the sessions and the convenience of seeing the psychologist within the doctors’ offices. Most believed that they had
gained a greater understanding of their problems and that they were empowered by the treatment to deal more effectively with these problems. All of the responding patients said that they would recommend the psychologist they saw to others; virtually all said that they felt more comfortable seeing the psychologist in the doctor’s office than they would have felt elsewhere. However, nearly half would not have sought treatment if the doctor had not recommended it. The patients were similarly split on whether they had received treatment from another provider before their experience with the psychologists in the program. Of the patients who had received counselling elsewhere, there was again an approximately even split on the efficacy of the more recent treatment compared to the treatment received elsewhere. Finally, the issue of requiring a fee for treatment within the GP’s offices met with strenuous opposition, with 84% of patients saying that a fee of approximately $100 per session would be a problem for them. There appears therefore to be some ambivalence among the responding patients, with almost uniform appreciation of the services offered but almost uniform rejection of the option to pay for these services. At the time of the research, there were very few options for publicly-funded psychological services. Only since November, 2006 have Medicare rebates been available for these services. On the basis of the information provided above, those who currently charge large gaps on top of scheduled fees would price themselves out of the market in rural and remote Australia.

8.2.7.3 GP questionnaires

8.2.7.3a) Pre-trial: “Clinical Psychology in General Practice Survey”

Findings from the pre-trial questionnaire sent to local GPs - of whom 63% (111) responded out of a total of 176 - indicated that, whilst approximately 78% of the GPs responding (87) thought somewhere between 10-50% of their patients manifest mental health difficulties, approximately 48% (53) felt their training ill-equipped them for working with mental health issues. Only 23% (26) indicated they felt “very comfortable” dealing with these issues, 60% (67) indicating “somewhat”, with 19% (21) feeling “uncomfortable” or “not at all comfortable” with these presentations. Most GPs (81% - 90) said that they had inadequate time to see these patients, with 40% (44) indicating they did not wish to become involved with mental health
treatment; 51% (57) estimating that they would prescribe medication for (ranging between 30%-70%) these patients. Only 50% (56) indicated they used other mental health professionals at all, with most (55% - 31) referring to “counsellors” as distinct from other professional groups. Only 38% (42) indicated that they knew the difference between a clinical psychologist and psychologist but 58% (64) indicated referring to a clinical psychologist as their first or second choice of health professional, in contrast to 42% (47) for psychiatrists (at the time, this may have been confounded by psychiatry being the only publicly-funded mental health speciality available). Eighty-two percent of the GPs surveyed (91) indicated that it would be useful to have a clinical psychologist as part of a multi-disciplinary team in their practice, giving lack of availability of clinical psychologists (47% of respondents – 52) and patients being unable to afford treatment fees (in 62% - ie. 69) as the key reasons they were not referring patients to them.

8.2.7.3b) Post-trial questionnaire

The General Practitioners who had hosted the Clinical Psychologists in their surgeries were asked to complete a brief questionnaire about their experiences. Out of 27 GPs, 14 responded to the survey (ie. an approximate 52% response rate). Half of the responses came from physicians in Bathurst who had been involved from the project since its beginning, nearly half of the responding doctors were from Armidale, Glen Innes or Inverell, with only one physician from a multi-doctor clinical in Ballarat responding. Despite a low response rate, (14 responses from 27 doctors contacted by post) there was at least one doctor responding from each practice.

Of those GPs responding, approximately 79% (11) found having a clinical psychologist within the practice “very helpful” for patients with mental health difficulties (the remaining 21% “somewhat”). Again, 79% indicated that their patients had been helped “very much” by the service located within the practice, with 71% of doctors (10) saying that mental health service delivery in their practice had improved “very much”, with 27% (4) doctors saying “somewhat”. Post-trial, the GPs indicated that clinical psychologists were ranked first amongst mental health professionals they would prefer to refer to, with 100% of the doctors saying they had benefited from the personal support of sharing care with a clinical psychologist (8
doctors “strongly agreeing”, 6 “agreeing”); that the ready opportunity for feedback from the clinical psychologist was valuable (5 “strongly agree”ing, 9 “agree”ing. Most “agreed” (6) or “strongly agreed” that the opportunity to introduce their patients to the clinical was of value; 79% “strongly agreed (4) and “agreed” (7) that they had benefited from the collaborative “case management model of care”; 64% indicated their skills in working with patients with psychological disturbances had increased (with 29% still not sure); 71.4% said their confidence with this sort of work had increased; 85.7% said that the clinical psychologist reduced the amount of time they needed to spend with these patients; 100% indicated that the clinical psychologist provided a valuable option for more accessible psychological services and 93% indicated that the project gave them more understanding of the role of GPs in the social and emotional care of patients. One hundred percent of GPs responding indicated that they would like to see the continuation of clinical psychology services within their general practice, with qualitative comments endorsing this saying that co-location of services had been “extremely useful”, “extremely positive”, “invaluable” and “appreciated by all”. Being able to refer “without financial issues” had been of enormous help, as had the psychologist being able to understand and appreciate the GP’s role.

In summary, as outlined in the results section and as shown by the positive comments and the favourable responses to survey items, GPs seemed to appreciate collaborating with the clinical psychologists who had been invited into their practices. In general, GPs were favourable toward the presence of the registrars in their practice and found their interventions beneficial to their patients.

8.2.7.4 Clinical psychology registrar questionnaire

8.2.7.4a Findings

Findings from the registrar placement questionnaire, which had a 100% response rate from the 22 clinical psychology registrars undertaking clinical internships through the project, indicated the following: Registrars were very favourable towards most aspects of their placement. Overall 13 of the 22 respondents rated their placement experience as “excellent” with an additional 6 rating it 4 on Likert Scale from 1 to 5
(5 being “excellent”). They were particularly pleased by the availability and approachability of their supervisors with only one registrar being disappointed by organisation and planning, and three not pleased by methods of teaching. None of the registrars found the work load “under demanding”, although five (27.8%) found the work load too demanding, which may have reflected that 8 of the 22 registrars were in first year – not optimal for this complex internship. The remaining 17 registrars were satisfied with their work load. Eight of the 22 registrars (or 36%) considered the placement to be the best one they had experienced, while an additional eight gave it a 4 out of 5. One person claimed to have no other placement with which to compare the one in question. 95.5% (21) registrars indicated that they believed psychological services in the general practice setting improves mental health service delivery for patients; 86.4% (19) said working with GPs was beneficial to professional practice; all registrars considered patient comments about the service to be positive (5) or very positive (17). The vast majority of the registrars achieved the objectives they set out to achieve (ie. developing confidence in the role, enhancing clinical skills, developing collaborative relationships with GPs, developing the scientist-practitioner role in the primary care setting, promoting clinical psychology in public health). When asked to comment further, they offered the following additional comments: “would recommend this placement”, it “builds confidence in working with a range of ages and disorders”, “discovered the rewards of offering short therapy” and developed a “better appreciation of psychological implications of chronic disease”. When asked about whether they were currently working or planning to work in a primary care setting, four registrars were found to be currently working in a primary care setting (several part-time), with three of these working in a rural setting and one in a metropolitan area. The majority were not currently working in primary care but fifteen of the remaining registrars (85% of the total) indicated that they now wished to do so, with 8 (36%) planning to work in regional or rural areas as a consequence of their placement.

8.2.7.4b) Summary

Almost all of the 22 registrars found their internship to provide highly beneficial experiences for themselves, their patients and for the GPs with whom they interacted. Several stated that they were proud to be involved in a project that was innovative as
well as inherently useful and that they hoped that the collaborative approach would become a model for mental health care throughout Australia. There were very few negative comments (although there appeared to be a few GPs who were not as receptive to the placements as others). All told, respondents were overwhelmingly favourable about their experiences, as indicated by the desire of most of them to continue in similar placements/work settings. The fact that placements took place in rural settings was seen as a great advantage for most registrars since many had as one of their goals a better understanding of patient treatment in rural and remote areas.

8.3 Strengths and limitations of the study

8.3.1 Overview

As indicated in the study rationale outlined in the method chapter, when the “Clinical Psychology in General Practice Project” first began in 1998, empirical trials in primary care providing rigorous evidence of the effectiveness of collaborative mental health-care interventions were lacking - and indeed are still rare in Australia. As Winefield and Chur-Hansen (2004) indicated in their review of the empirical literature, “controlled evaluation studies are required to show the costs and benefits of integrated primary health care to all participants” including both the distressed clients themselves and the professional caregivers. The research outlined in this dissertation fulfils these requirements, providing some of the first empirical data (collected between 2001 and 2004) in Australia aimed at evaluating the impact of collaborative care on:

a) patients presenting in the primary care context with common mental disorders,

b) GPs at the “coal-face” in providing mental health care in the general practice setting - frequently the “first port of call” for many patients, and

c) trainee clinical psychologists undertaking internships in the general practice setting where they are co-located with general practitioners.
8.3.2 Measures

A range of outcome variables enabled a more thorough investigation of the impact of treatment – all of which provided endorsement of the main findings. The indices used included the DASS (and its sub-scales of depression, anxiety and stress), the GHQ and the GWBI, and all measured different things: the DASS asking the patient to evaluate how they felt over the past week; the GHQ measuring changes in experience over the past few weeks; whilst the GWBI provided a composite measure of wellbeing (which was inversely related to the others – ie. expected to increase as scores on measures of pathology declined). The latter was used to assess whether changes in wellbeing and quality of life mirrored (albeit in reverse) changes in mental dysfunction scores, a strong emphasis in psychological treatment being the growth of positive behaviours and experiences, not just diminution in pathology.

8.3.3 Patient numbers

A further advantage of the present study was the relatively large size of the comparison groups. Whilst not fulfilling initial expectations promised at pre-test when the treatment and control groups had 309 and 198 patients in them respectively, the numbers of those who completed the study ie. filled out both sets of questionnaires, was still large at 203 and 98 respectively. These numbers compare favourably with those in other empirical trials.

8.3.4 Control groups

8.3.4.1 Normative comparison group

The main limitation of the study - also its strength - was that, being an “action research” project in the “real world” (Robson, 2002), it was not feasible to randomly allocate patients to comparable treatment and control groups. This would have provided comparable control data from patients reflecting similar levels of mental disorder at pre-test. However, given that the study was an effectiveness rather than efficiency trial, a randomized controlled design was deemed unnecessary for the purposes of the study. A variety of additional concerns also generated the need for an alternative control methodology. Duty of care to patients required that those surveyed
Chapter 8: Discussion and Conclusions

in the waiting room who were found to have measures on the mental health indices in the “extremely severe” range were referred by their GP for immediate psychological treatment (after the doctor was alerted to their scores). This inevitably skewed the means of the treatment group towards greater pathology, whilst leaving the control group in the lower ranges, determining that the average scores of the two groups differed. This action was based on the presumption by the GPs that this would give these patients a better outcome having been provided with immediate treatment for their condition – a somewhat problematic assumption given that the research results were not yet available. However, neither the GPs, nor the psychologists involved, were prepared to randomly allocate these potentially at risk people. This process therefore determined that the control group became a normative comparison group of normal patients visiting their GP for treatment at the time of survey.

The rationale for this action research was to provide a collaborative care framework which would be of assistance to GPs in managing their demanding mental health caseload. The demands of experimental random allocation of patients by the doctors to alternative treatment and control groups whilst managing and treating a randomised “control” group of patients including those in the “extremely severe” category, in addition to their normal workload in general practice - would have negated this aim. It was therefore important to decide upon a pragmatic design alternative that did not involve the doctors in assessment, random assortment/allocation to groups and additional treatment. The aim was therefore to find a research paradigm that kept this original objective of ameliorating, rather than increasing the GPs’ already demanding workload. The normative comparison group was found to be the optimal solution, given these at times conflicting priorities for research soundness, duty of care towards patients and amelioration of the GPs’ workload.

8.3.4.2 Matched pairs

The matched pair analysis enabled comparison of two groups that were comparable on all scores at pre-test, enabling a controlled trial analysis of the impact of treatment. This confirmed findings from the larger trial. However, given that to match pairs across both the treatment and control groups required selection of the 48 pairs from within the overlap of the two larger groups which fell within the normal range, this
limited results. As outlined above, caution therefore needs to be exercised in interpreting these results as the matched-pairs were not a randomised sub-sample drawn from the larger sample population – rather a select group of participants sorted on the basis of scores. However, when the sub-group of treatment patients in the “clinical range” (ie. those whose scores on the DASS measures were in the “moderate”, “severe” or “extremely severe” ranges), were assessed pre- and post-test and the simple sign test applied to their results, nearly 90% of them improved after treatment with only small percentages remaining the same or getting worse (see Figure 7.6). Whilst not shown to be significant, and whilst also potentially explicable in terms of regression to the mean, this did suggest that those in the clinical range also showed improvement after the treatment intervention, not just those with conditions of lesser severity.

8.3.5 Completion rates

The relatively low completion rates (66% of the intervention group and 49% of the control group) may also have biased the results. However, it was found that the intervention subgroup with complete data had similar initial scores and sex ratios to the larger group from which it was drawn, suggesting comparability. This was also true for the control group again suggesting comparability and that the sub-samples of those who completed both sets of measures were representative of the larger groups from which they were drawn.

8.3.6 Potential confounding variables

As outlined above, a number of possible confounders (eg. sex, age and socioeconomic status) may also have limited the comparison between the groups. However, data collected on the Bathurst sample for both intervention and control groups indicated that there were no significant differences either between the treatment and control groups or between the initial larger groups of those who completed pre-tests only and the smaller sub-samples of those whom completed both pre- and post-tests. At post-test, none of these variables were found to determine outcomes, the impact of treatment being the main effect variable.
8.4 Future directions and opportunities for further research

The current study has highlighted the need to continue such evaluation studies in the general practice setting to ensure the development of optimal models of care for those suffering from mental disorders in the community.

Long-term efficacy of the model of treatment needs to be established with extended measurement of outcomes and treatment gains over post-treatment periods of a minimum of six months to a year to establish whether improvements are maintained. Given that set-backs induced by new stressors in peoples’ lives are a normal occurrence, stress inoculation and set-back prevention need to be included as part of treatment and follow-up.

Future research may also include comparison between different practitioners and professionals involved in collaborative models of care. Findings from the patient satisfaction questionnaire indicated that those patients who had received earlier treatment elsewhere (45% of the total – 76 patients) were split on the issue of whether the recently completed intervention in the GP’s office had been more or less helpful than the intervention received previously. Comparison of different groups of professional practitioners undertaking mental health interventions in primary care needs to be included in longer term studies.

A further area of fruitful enquiry would focus on parameters of cost in relation to the shared care framework. The current research provided little evidence in relation to cost-effectiveness of the model of care. Parameters of medication prescribed (types, duration of use, cost to the PBS) and numbers of GP sessions (pre-and post-treatment for treated patients, compared to equivalent patients with common mental disorders without collaborative care) and related Medicare costs need to be included. These accurate cost measures would enable evaluation of whether:

a) collaborative care diminishes consumption and hence PBS subsidy/cost of medication;

b) GP consults (and hence costs against Medicare) diminish as a consequence of collaborative psychological intervention;
c) Medicare costs of psychological intervention (ie. now set at $674.70 – with $112.45 scheduled fee per session over six sessions for a 2710 referral) are less than those outlined above, ie. medication costs and extra/additional GP consults often consequent upon unresolved psychological issues.

Finally, given that approximately 25% of the treatment group, although referred by GPs, were in the normal rather than the clinical range, further research needs to be done on the more clinically disturbed end of the spectrum to establish whether the positive results apply to the more severely disturbed. An attempt was made to do this in the current study by analysing outcomes (via the simple sign test) for the “upper” 50% of the treatment group, and results indicated that outcomes were highly positive relative to controls. However, further research needs to be done on establishing the efficacy of the model with greater levels of disturbance (ie. those in the “severe” and “extremely severe” ranges on the indices).
Chapter 9

FURTHER DEVELOPMENTS

Over the past decade and particularly since 2001, the Australian Government has made significant investments in mental health reform. The underlying aims and desired outcomes of these reforms are reiterated in the most recent National Action Plan on Mental Health (2006-2011) as follows:

- Reduce the prevalence and severity of mental illness in Australia;
- Reduce the prevalence of risk factors that contribute to the onset of mental illness and prevent longer term recovery;
- Increase the proportion of people with an emerging or established mental illness who are able to access the right health care and other relevant community services at the right time, with a particular focus on early intervention.

(Council of Australian Governments, 2006c.)

The research evaluation undertaken in this thesis is relevant to several of these core objectives.

9.1 Australian Government mental health initiatives

A number of key federal government initiatives from 2001 onwards have supported the provision of and access to psychological services in the community as an adjunct to primary care. The More Allied Health Services initiative (2001) was designed specifically to increase access to allied health in rural communities and has done so, according to Roufeil and Lipzker (2007). Other initiatives, such as the Better Outcomes in Mental Health Care program, have also resulted in increased availability of services in regional, rural and remote parts of Australia. The latest Better Access to Mental Health Care Initiative created under the COAG mental health reforms in 2006, is still being assessed to establish whether it has had an appreciable impact on shortages in RRR areas.
9.1.1 More Allied Health Services Program

The More Allied Health Services (MAHS) program was established in 2001 to “help rural communities gain better access to allied health services and to address rural health workforce shortages”, via linkages between allied health care services and general practice. The program was part of the Federal Government’s Regional Health Strategy announced in the 2000-2001 budget in which $562 million was allocated over four years to increase the numbers of medical practitioners and better health services in rural areas. Funding was made available to local Divisions of General Practice with at least 5% of their population living within rural, remote and metropolitan (RRMA) areas 4-7 for allied health services linked to general practice. The program therefore focuses the provision of additional services to rural communities.

Seven years later, funding continues to be provided to and managed by eligible rural Divisions of GPs, “thereby recognizing and enhancing the important role that Divisions play in improving health outcomes for communities at the local level” (Commonwealth Department of Health & Ageing, 2008a). Sixty-six Divisions of General Practice are currently eligible for MAHS funding and use it to provide clinical care by allied health professionals in their rural communities.

By 2005-2006, 179 full-time equivalent (FTE) allied health professionals were funded through the MAHS program, with an estimated 66,717 patients receiving approximately 97,264 services during the course of the year (ie.370 individual patients per FTE allied health worker). Psychologists, diabetes and asthma educators, podiatrists and speech pathologists continue to be employed under the scheme. Even though employment of psychologists has predominated under MAHS, the initiative was not specifically focused on mental health service delivery. However, in the majority of locations it has been used for this purpose due to the pressing need for these services in rural communities. This has been the case since its inception in 2001 (a breakdown of national data on service delivery under MAHS from July 2005 to June 2006 is provided in Appendix 9.1).
MAHS funding was used in several placement locations in the “Clinical Psychology in Rural General Practice Project” to fund and employ clinical psychology registrars (all of whom were registered psychologists) whilst on placement through the project. Ongoing employment opportunities arose in these locations after placement requirements were fulfilled (eg. at Rylstone and Kandos).

There is considerable evidence that MAHS has made successful inroads on rural health workforce needs by increasing the local supply of allied health professional services. In relation to psychological services (acknowledged as one of the main services provided), these increased from 35.6 full time equivalent positions (FTE) in 2004-2005 to 45.8 FTE across the country in 2005-2006. A variety of employment arrangements are supported under MAHS resulting in shared role arrangements and retention of local allied health providers, either through salaried positions or private practice arrangements located in rural areas. Division of General Practice reports indicate that most MAHS positions (57 to 60 per cent) are either directly employed by the Divisions, or contracted for a set time from another service. The flexibility of the program has increased service delivery by adapting to the requirements of local areas and has, as a consequence, decreased waiting times for assistance and enabled people to access services who would otherwise not be able to afford consultations (DoHA, 2007).

9.1.2 Better Outcomes in Mental Health Care Initiative

More specifically focused on direct mental health care provision, the Better Outcomes in Mental Health Care program (BOiMHC) was introduced in July 2001 to facilitate consumer access to primary mental health care. It had three main components: “focused psychological strategies” provided by GPs; “access to allied psychological services” (ATAPS) provided by allied health professionals, and “GP psych support” enabling GPs to access psychiatrists for patient management advice. The initiative was focused on the key role of GPs in managing mental health problems in the community and permitted those eligible (a sub-section of GPs who had fulfilled BOiMHC training requirements) to refer patients with mental disorders to allied health professionals, including psychologists. For the first time, the initiative provided full funding for team arrangements - not just for referring GPs and other medical
specialists - enabling patients to access psychological services for six sessions of evidence-based mental health care, with the option of re-referral for a further six sessions following a mental health review by the referring GP. Again, the funding was Division-based with 69 Access to Allied Health projects being funded during the first twelve months, 15 of these being viewed as pilot programs. The 15 initial projects included one based at the NSW Central West Division of General Practice which arose from and operated in parallel with the “Clinical Psychology in General Practice Project”, employing the first two registrars trained by the project. These pilot programs recruited 136 individual allied health professionals (primarily psychologists) and involved ten agencies, with a total of 387 GP referring 2,036 consumers during the pilot phase (Pirkis, Blashki, Headey, Morley & Kohn, 2003).

Most recent reporting on BOiMHC (Fletcher, Bassilios, Pirkis, Kohn, Blashki & Burgess, 2008) indicates that there are currently 108 Access to Allied Psychological Services (ATAPS) projects being conducted by 114 Divisions of General Practice, all of which have been progressively funded through four funding rounds. Figures indicate that between 1 July 2003 and 31 December 2007, approximately 7,776 GPs referred consumers to 2,665 allied health professionals, the numbers of referring GPs increasing from 453 in the July-September quarter, 2003 to 2,720 in July-September 2006 (Fletcher et al., 2008). Numbers of referring GPs decreased after the October-December 2006 quarter, coinciding with the introduction of the new Council of Australian Governments Better Access initiative launched in November 2006 which provided an alternative source of allied health care. Similar trends for allied health professionals under ATAPS, with numbers increasing from 135 in July-September 2003 to 1,426 practitioners in the equivalent quarter in 2006, with a decline in numbers beyond this point, again coinciding with the advent of Better Access (Fletcher et al, 2008). This later initiative finally deemed clinical psychologists and other registered allied health professionals (psychologists, mental health nurses and other) directly eligible for Medicare rebates in the provision of mental health/psychological services in the community.

Despite this decline in figures, ATAPS is perceived as a “cornerstone of mental health service provision in Australia”, having “gained considerable momentum and succeeded in attracting substantial numbers of GPs and allied health professionals enabling delivery of services to significant numbers of consumers” (Fletcher et al.,
2008). The majority of consumers have been found to be women with common mental disorders who have been unable to access mental health care in the past. The treatment sessions are largely individually delivered, CBT-based sessions of around one hour in length – very similar to those pioneered in the current project and discussed with the Department of Health and Aged Care (now Health and Ageing) in 1999 when first grant submissions were made.

Current evaluation of ATAPS indicates that after the initial decline in consumer, allied health provider and referring GP numbers following the advent of Better Access, the decreases have now leveled out with substantial numbers of providers still involved in provision of evidence-based care to consumers (Fletcher et al., 2008). This may be due to employment arrangements via Divisions of GPs providing something different/additional to privately-based service provision under Medicare. Salaried position arrangements available under MAHS which provide infrastructure support and supervision for practitioners by Divisions of GPs, are a desirable part of workforce arrangements not provided under Better Access. Given that they differ in a number of significant ways, it is suggested by the MAHS evaluation team that the two programs are now “operating in a complementary fashion to meet the mental health service needs of Australians” (Commonwealth Department of Health & Ageing 2008a).

9.1.3 Clinical Psychology in General Practice Project

The project outlined in this dissertation was one of a number of Commonwealth initiatives undertaken in these years of transition to early intervention in primary care for mental health disorders. Initially proposed to the Department of Health and Ageing in mid-1999, funding of $346,000 over two years was confirmed in late 2000, the commencement date for the research being January 2001. The project therefore evolved in parallel with the larger funding initiatives and provided a model of early intervention in primary care reflected in and rolled out on a larger stage under MAHS and BOiMHC via Divisions of General Practice.

Following successful conclusion of the initial research evaluation (reported to the Commonwealth in six monthly reports – see Appendix 9.2 in Disk 2 appended to the
thesis), further funding of $425,000 (total $771,000) was made available to the project in 2003. The second phase was focused primarily on the development of a training framework for clinical psychology registrars. This also necessitated the development of a mental health workforce plan as, without professional working opportunities and options available for registrars after graduation, a training model would be incomplete. In November 2003 a proposal for national articulation of the training and mental health workforce development model involving clinical psychologists and GPs was formulated from the project and was submitted to the then Minister for Health and Ageing, The Honourable Tony Abbott as a budget submission for the 2004 Federal Health Budget (see Appendix 9.3 for the Submission). The proposed model entailed a combination of salaried positions based in Divisions of GPs using a hub-of-the-wheel approach in providing outreach services to numbers of general practices in each region. In addition, inclusion of clinical psychology under Medicare was proposed to enable locally-based private clinical psychologists to be enrolled and contribute to the specialist mental health workforce.

In the April 2004 Federal Government Health Budget, other health priorities prevailed – but the model had been introduced and some aspects of it came to fruition three years later.

9.1.4 Lead up to COAG’s Better Access Initiative in November 2006

In late 2005 and early 2006 a number of significant events raised the profile of mental health in Australia and presented a unique opportunity “for psychology to be better recognized for what it has to offer for the treatment of people with mental health disorders” (Littlefield, 2006). The political climate finally enabled clinical psychology to be recognized as a mental health specialty in parallel with psychiatry, thereby furthering the objectives outlined in the current dissertation – ie. that clinical psychology become a permanent part of the collaborative primary mental health care workforce under the public health system. Community interest in mental health was both heightened and focused by these events, which included: the release of the Mental Health Council of Australia’s “Not for Service” report in October 2005; the Cornelia Rau Case (ie. the significant public outcry and publicity following her wrongful detention); the Senate inquiry into Australia’s mental health system which
again called for sweeping changes to mental health services across the nation; and the Productivity Commission’s report on Australia’s health workforce released in January, 2006. All of these factors – outlined in greater detail below - were instrumental in ensuring mental health was a high priority item on the agenda of the Council of Australian Governments’ meeting in February 2006 - having been placed there by the Prime Minister.

9.1.4.1 “Not for Service” Report

The *Not for Service Report*, launched by the Mental Health Council of Australia and the Brain and Mind Research Institute in October, 2005, summarised findings from a new national review of Australian mental health service delivery. Initiated in 2004 in response to ongoing community criticism of experiences of mental health care, the main goal was to “capture the current critical themes in mental health care from the perspective of those who use and deliver its services on a daily basis” (MHCA & BMRI, 2005a). The report was based on a combination of quantitative and qualitative national data. In making its recommendations, the report highlighted the need for:

- recognition by all Australian governments that mental health reform is a national priority;
- real leadership at the most senior political and bureaucratic levels to drive change through a whole-of-government response;
- real and sustained increases in the overall funding for mental health care services over the next five years to align mental health and disability burden with funding;
- an emphasis on accountability at all levels on a nationally consistent basis to ensure funding is delivered and the impacts and outcomes of the investment are available to the Australian community on a timely basis; and
- urgent and resolute action to address the looming crisis in the mental health care workforce (MHCA & BMRI, 2005a).
The report indicated that the drive for national mental health reform emerged in the early 1990’s (as outlined in Chapter 3), coinciding with the adoption by the United Nations of the Principles for the Protection of People with Mental Illness and the Improvement of Mental Health Care (UN General Assembly Resolution 46/119, 17 December 1991; United Nations, 1991), which emphasised community-based care options and respect for the basic rights of persons with mental illness. It also suggested that, whilst there had been a trend towards deinstitutionalisation, one of the “positive changes since the 1993 Burdekin Report was published”, this had not been accompanied by corresponding supports for those with mental disorders in the community, nor a move towards a mental health care system that “delivers the highest attainable standard of health care”. The report served as a “wake up call (to prompt) our politicians into bringing about real change” (Ozdowski in MHCA &BRMI, 2005).

9.1.4.2 Detention of Cornelia Rau

The case of Cornelia Rau, which coincided with the Mental Health Council of Australia national enquiry, endorsed the emphases outlined in the “Not for Service” report. Cornelia Rau is an Australian resident and German citizen who disappeared on 17 March 2004 from Manly Hospital where she had been admitted as a psychiatric patient. It was revealed in February 2005 that she had been unlawfully detained for ten months in prison at the Brisbane Women's Correctional Centre and later at Baxter Detention Centre, having been classified as a suspected illegal immigrant or non-citizen by the Immigration Department when she refused to reveal her true identity. Her detention became the subject of a government inquiry which was later expanded to investigate over 200 other cases of suspected unlawful detention by the Australian government's Department of Immigration and Multicultural and Indigenous Affairs (DIMIA). It was observed at the time that the effects of detention on Ms Rau, combined with the failure of authorities to provide her with appropriate treatment, "should prompt reform in the provision of psychiatric care to all detainees as a fundamental duty of care" (The Age, 2005). The case, which highlighted the known links between mental illness and the inflammatory issue of mandatory detention, created considerable anger in the community and the inquiry provided a platform for the public discussion of both issues.
9.1.4.3 Senate inquiry into the nation's mental health system

On the 8 March 2005, the Senate created a Select Committee on Mental Health to conduct a wide-ranging inquiry, the aims of which were to compile an overall picture via community submissions and public hearings around the country about how mental health policies and care were performing and how they could be improved. Convening one week later on the 15 March 2005 the committee’s key terms of reference for the inquiry included the following:

- the extent to which the National Mental Health Strategy has achieved its aims and objectives (12 years after its inception) and the barriers to progress;
- the adequacy of various modes of care for people with a mental illness, in particular, prevention, early intervention, acute care, community care, after hours crisis services and respite care;
- opportunities for improving coordination and delivery of funding and services at all levels of government to ensure appropriate and comprehensive care is provided throughout the episode of care (i.e. better articulation of different sectors of care);
- the role and adequacy of training and support for primary carers in the treatment, recovery and support of people with a mental illness;
- the role of primary health care in promotion, prevention, early detection and chronic care management;
- opportunities for reducing the effects of iatrogenesis and promoting recovery-focused care through consumer involvement, peer support and education of the mental health workforce, and for services to be consumer-operated;
- the adequacy of education in de-stigmatising mental illness and disorders and in providing support service information to people affected by mental illness and their families and carers;
- the potential for new modes of delivery of mental health care, including e-technology.
- the special needs of groups such as children, adolescents, the aged, Indigenous Australians, the socially and geographically isolated and of people with complex and comorbid conditions and drug and alcohol dependence;
the adequacy of data collection, outcome measures and quality control for monitoring and evaluating mental health services at all levels of government and opportunities to link funding with compliance with national standards; and

- the current state of mental health research, the adequacy of its funding and the extent to which best practice is disseminated. (Senate Select Committee, 2005 - this is not a complete list, but highlights objectives relevant to the current research).

The first report was tabled on 30 March 2006 and the final report: “A national approach to mental health: From crisis to community” was released on 28 April 2006. What the inquiry again revealed was “deeply disturbing gaps in planning, delivery and evaluation of mental health services” reflecting “not a failure of policy (but) a failure of implementation and delivery” (Mental Health Council, May 2005).

The concluding phase of the inquiry ran in parallel with the Council of Australian Government deliberations in early 2006 which led to the landmark Federal Health Budget in April 2006 in which large increases in federal funding for mental health initiatives were announced.

9.1.4.4 Productivity Commission's report on Australia's health workforce

In parallel with the above developments, the Productivity Commission’s report “Australia’s Health Workforce” was released on 19 January 2006. The report presented the findings of a federal government study which examined issues impacting on the health workforce, such as the supply of and demand for health workforce professionals - the aim being to propose solutions to ensure “continued delivery of quality healthcare over the next 10 years” across the country (Australian Government Productivity Commission, 2006). It identified major health care access problems faced by the Australian community, concluding that changes are needed if Australia’s health workforce is to become more efficient and effective. In releasing the report, the Commissioner, Mike Woods indicated that: ‘Lasting gains can only be achieved if the current fragmented delivery of services is overcome and if professional and regulatory rigidities and other barriers to innovation are removed”.

He also stated that “workforce shortages and the increasing demands of an ageing
community are placing mounting pressures on Australia’s health care system. Improving preventative health care, increasing the number of training places and retaining more of those currently employed are all important strategies, but they don’t go far enough” (Productivity Commission, 2006). The report concluded that reforms are needed in the way the health workforce is utilised and health services delivered, and recommended “an extension of Medicare rebates to make better use of non-medical health professionals” (Littlefield, 2006).

Whilst not specifically focused on mental health, the recommendations of the Report were timely and coincided with the other factors outlined above, which led to the “whole of government” deliberations, resulting in the COAG reforms outlined below.

### 9.1.5 Council of Australian Governments (COAG)

At the 10 February 2006 COAG meeting, the Prime Minister and State Premiers addressed mental health as an issue of national significance. Not long after the release of the “Not for Service” report in October 2005, it became apparent that the report had triggered the issue of mental health being placed on the agenda of the forthcoming meeting. It also became apparent that this was perhaps the best opportunity in 20 years (certainly in 13 years since the Burdekin Report) for significant change to be achieved in the sector. Numerous submissions were tendered prior to the meeting, including one emerging from the project outlined in this dissertation (see Appendix 9.4 for all documents associated with the COAG submission: “Early Intervention for Mental Illness: Primary Care Psychological Services”). In addition, the author co-wrote an editorial opinion piece (“op. ed”) published in “The Australian” two days prior to the COAG meeting (see Appendix 9.4d; Leeder, 2007).

The communiqué following the meeting (COAG, 2006a) recognized mental health as a major problem and indicated that senior officials had been asked to prepare a mental health action plan by the next COAG meeting (July 2006) which was to include:

- a renewed focus on promotion, prevention, early detection and intervention;
- getting the balance right between hospital care, community and primary care;
• improving and integrating the care system to enable the right care to be accessed at the right time, including mental health services, primary care, general practice, etc.;
• addressing structural issues such as workforce changes including the roles of different professions;
• increasing the role of psychologists and other health professionals in primary care;
• increasing the health workforce available to address mental health issues.

9.1.6 National Action Plan on Mental Health

The initial COAG meeting resulted in the then Prime Minister John Howard announcing shortly afterwards a $1.9 billion increase in funding over the next five years for the mental health system and a public endorsement, including new public health funding, of psychology’s role in mental health service delivery. In May 2006, the then federal Minister for Health and Ageing announced the increased allocation as part of a National Action Plan on Mental Health involving all governments (COAG, 2006c) which was endorsed by COAG at its 14 July 2006 meeting. The plan represented “a commitment to deliver mental health services in a more integrated way – between governments, and between the government and non-government sectors” (COAG communiqué, 2006b). Key components of the plan included a series of new initiatives, to be implemented over a five year period, focused on promotion, prevention and early intervention, improving mental health services, providing better coordinated care, and building workforce capacity.

9.1.6.1 Better Access to Mental Health Care

The Better Access to Psychiatrists, Psychologists and General Practitioners initiative under the National Action Plan was “developed to provide people in the community with better access to mental health care and to encourage team based treatment in the community with allied health professionals working alongside GPs, psychiatrists and mental health nurses” (MHPA, 2007). The program aimed to address mental disorders more effectively, providing $507 million over five years to enable availability of
increased mental health services under the Medicare Benefits Schedule (MBS). Its focus was to encourage GPs to work more closely with psychiatrists, clinical psychologists, psychologists, social workers and occupational therapists. One key aim was to enable psychiatrists to “see additional new patients (for assessment) and be more readily accessible to treat patients with more complex and long term mental health care needs” (Australian Government Department of Health & Ageing, 2006), with evidence-based psychological interventions for common mental disorders being provided by clinical psychologists and other allied health professionals.

Essentially, the new funding extended and strengthened the earlier Better Outcomes (BOiMHC) initiative outlined above, enabling GPs, psychiatrists and paediatricians to use MBS item numbers 2710, 2712 and 2713 to refer patients to psychologists and other allied health professionals for mental health treatment, and to develop more integrated mental health care plans for their patients. The most significant change was that the new initiative finally, after decades of accumulated evidence about the effectiveness of psychological interventions and public lobbying, extended Medicare/MBS items to psychologists in two categories: general psychology and specialist clinical psychology (Dunbar, Hickie, Wakeman & Reddie, 2007).

Treatment under the new arrangements are structured under a six-plus-six session framework (as initiated in the project outlined in this dissertation and used in BOiMHC) with a maximum of 12 individual sessions - including a mental health review and re-referral (under a 2712 referral) after the initial six sessions (under the 2710 referral). Under rare circumstances for complex disorders, this total can be expanded to 18 sessions (2713) - still well short of the 52 sessions per year psychiatrists are entitled to see patients for, many of whom fall into the same diagnostic categories.

The aim was to establish evidence-base time-limited treatment, with direct accountability ties back to referring GPs enabling them to remain informed about the progress of their patient. All patients assessed as having a mental disorder are eligible for these new services, the key focus being on the high prevalence/common mental disorders that frequently present in general practice: depression, anxiety, adjustment and substance use disorders, etc. (Dunbar et al., 2007).
9.1.6.2 Evaluation of Better Access to psychology

The response to the inclusion of psychological services under the federal public health system has been positive (Dunbar et al., 2007; Hickie & McGorry, 2007). Evaluation of the first six months of its operation in July 2007 (Crosbie & Ronsenberg, 2007) indicated that the initiative had resulted in a significant uptake of Medicare items for psychological services since its launch on 1 November 2006 and that the new MBS items were already having a real impact (Crosbie & Rosenberg, 2007). Medicare statistics for the first seven months indicated a strong demand for psychology treatment services from the community. During this period, a total of 595,131 individual psychology services had been provided by psychologists, including 406,144 general psychology items and 188,987 clinical psychology items (Littlefield, 2007), whilst general practitioners had lodged 296,803 items for the preparation of mental health care plans involving both treatment planning and referral for psychological services.

Whilst demand for these new services revealed a huge unmet need which was finally being addressed, concerns were aired at this early stage about a number of issues. Firstly, the rate of up-take was higher than expected with $78 million having been spent in the first seven months (over budget), with $52 million spent on services for women and $26 million on men. Perhaps more important than this gender skew was the age distribution of services - “while 75% of all mental disorders commence before the age of 25 years, these new services (were) not reaching this most at-risk and hard to reach group” (Crosbie & Rosenberg, 2007). Additionally, the geographic distribution of the services was not even, with some states making much higher levels of claims than others (Crosbie & Rosenberg, 2007) and a concentration of psychological services in metropolitan areas leaving rural and remote Australia again relatively under-serviced (Littlefield, 2007). Some psychologists and psychiatrists also charged higher fees under the new arrangements, leaving patients with large out-of-pocket costs, and less than optimal bulk billing rates (Commonwealth Department of Health & Ageing, 2008c).

Follow-up data from the Department of Health and Ageing in April 2008 indicated that in the first 14 months of operation, 2.7 million Medicare subsidised primary care
mental health services had been provided by more than 30,000 psychiatrists, GPs, clinical psychologists and other allied mental health care professionals (registered psychologists, social workers and occupational therapists). These have been provided to more than 726,000 people with mental illness across Australia (Department of Health & Ageing, 2008) with those referred to allied mental health professionals receiving an average of 4-5 treatment sessions. Data indicated that 79% of Medicare claims under Better Access were for urban areas, again suggesting the ongoing barriers that Australians living in rural and remote areas face in gaining access to primary care mental health services (Department of Health & Ageing, 2008). Statistics also showed that bulk-billing rates varied between professions, with GPs bulk-billing over 90% of mental health services nationally, whilst psychiatrists and clinical psychologists have bulk-billing rates of about 30% (higher in rural and remote areas). A discrepancy, however, was found between the professions in terms of average patient co-payments, with psychiatrists charging on average more than $65 above the scheduled fee; whilst clinical psychologists charge on average approximately $28, GPs falling within an average range of $16-19 per service, depending on the service provided.

Most recently, just prior to and in the lead-up to the April 2008 Federal Health Budget, there were calls in the press (Hickie, 2008; Russell, 2008) for a redirection of funds away from these new services, claiming the issues outlined above - geographic maldistribution, gender inequalities, new practitioners charging large co-payments, low levels of bulk-billing etc. – suggested that the services were not working or meeting need (see Appendix 9.5 for a submission written in response to these articles). However, the budget was silent on these issues, with Better Access left to run whilst a full and detailed evaluation is done during the first five years of its implementation.

The Department of Health and Ageing has indicated that Better Access is one of a number of initiatives providing improved primary mental health care and that it will be strengthened by new moves including the introduction of new GP super clinics (incorporating collaborative care between mental health professions), an increase in total funding by $20 million over five years for ATAPS (to trial telephone-based counseling and other rural support initiatives focusing on areas and populations in
need) and, in addition, a National Advisory Council on Mental Health to be created to provide the Government with independent advice from experts on mental health reform (DoHA, 2008). Amongst other stipends, the MHPA (the Mental Health Professionals’ Association) has been provided with new funding to run a series of “Mental Health Interdisciplinary Networking Workshops” across the nation. These are aimed at facilitating mental health professionals, as part of their professional development commitment, to build multidisciplinary teams focused on developing ways of working optimally to meet patients’ needs in each local/regional setting.

9.2 Overview of recent changes

Aspects of mental health service delivery in Australia have been transformed over the past decade and particularly since 2001. Whilst endorsing the provision of community-based early intervention for those suffering from mental health disorders, the first and second five year National Mental Health Strategies (1993 and 1998) did not effect significant change in this regard. Key priority areas including the relationship between mental health services and the general health sector, primary care services, promotion and prevention, articulating mental health services with other sectors and appropriate development of the mental health workforce all still required further action by the year 2000. Whiteford, Buckingham and Manderscheid (2002) maintained that “major structural reform was achieved but there was limited evidence that these changes had been accompanied by improved service quality.”

Since 2001 with the advent of MAHS, BOiMHC and finally Better Access, significant gains have been made in diversifying and strengthening the mental health workforce by including the specialist profession of clinical psychology under the public health system in parallel with psychiatry. In addition, the inclusion of the other allied health professions of general psychology, mental health nursing, social work and occupational therapy in a stepped care approach has increased the workforce and facilitated greater equity of access in terms of geographic distribution (these professions, including clinical psychology, largely mirroring the distribution of the Australian population at large).
Significant primary health care reform has occurred over recent years with the development of collaborative approaches to care in a number of different areas including mental health. It is known that interprofessional collaboration – ie. moving “beyond models where physicians (doctors) are regarded as healthcare’s lone rangers” (Thornhill, Dault & Clements, 2008 in press) – results in improvements in both quality and safety (Barrett, Curran, Glynn & Godwin, 2008, in press; Christensen, et al., 2008). The evidence indicates that teams are less likely to make mistakes than are individuals and that collaboration leads to “more timely referrals among different professionals, increases patient satisfaction and improves patients’ access to self-management of care” (Thornhill, Dault & Clements, 2008). It is also asserted that interprofessional collaboration can lead to cost benefits, particularly when earlier intervention prevents the development of more serious disorders.

### 9.3 Workforce development recommendations arising from the dissertation

The research and evaluation project outlined in the current dissertation was one of Australia’s first empirical trials of collaborative mental health care in the general practice setting. The research instigated at a local rural level acceptance of publicly-funded collaborative care between GPs and appropriately trained psychologists now operative across Australia. Co-location of mental health practitioners in the primary care setting - the entryway for most patients into the healthcare system – was trialed successfully in this project. New facilities, such as the GP super-clinics, are not necessarily essential since many general practices welcome collaborative care for patients and are frequently able to make practical arrangements enabling co-location of other professions.

The trial indicated positive outcomes and value-added for patients, GPs and clinical psychologists in the provision of mental health treatment - in this case co-located - relative to traditional medical care alone. It also suggested that a coherent training and workforce development model was needed to articulate the framework nationally. A proposal was therefore put in late 2003 (see Appendix 9.3) the key components of which were:
a) **salaried appointment of clinical psychologists** in Divisions of General Practice across Australia to provide evidence-based outreach services to general practices within each region (one full-time in all Divisions of General Practice across the country; two full-time in the larger Divisions). These practitioners would provide outreach through general practice-based treatment in each region; supervision of clinical psychology registrars (who would increase the treatment capacity of each Divisional area); delivery of psycho-educational & skills training programs within the community, etc.

b) **limited** inclusion under Medicare for appropriately trained psychologists - similar to the funding of psychiatrists but time-limited and accountable - for clinicians in private practice working closely with GPs to meet patient need.

c) **stipended primary care internships for clinical psychology registrars** in general practice, under supervision with salaried clinical psychologists (in addition to the already promised 200 university training places).

d) **coordinating infrastructure via the 121 local Divisions of GPs**: including Clinical Program Managers (in addition to clinicians mentioned above) to coordinate the framework and provide services such as data collection, liaison with GPs and general practice managers, running of the service delivery framework etc. – it was suggested that this cannot be done by busy clinicians.

e) a centralised quality control and **Psychology Workforce Development & Training Centre** similar to GPET: General Practice Education and Training (Australia).

Some components of this model have been developed under Better Access (ie. public health funding for services via Medicare; increased allocation of university training places and scholarships for clinical psychologists); others have been implemented by default in Divisions of General Practice via continuation of MAHS and ATAPS where a variety of employment options are available for practitioners. However, there is still fragmentation and no coherent psychological workforce development model in place to facilitate rational and equitable roll-out of services across the country, nor to develop initiatives to counteract the current gender and geographic skew in services.
The above proposal, combining salaried positions and Medicare-funded private practice was designed with these issues in mind.

A substantial challenge facing mental health service delivery in regional, rural and remote Australia is to develop a sufficiently large, sustainable and diversified workforce that can assist local communities to build local solutions responsive to local problems (Roufeil & Lipzker, 2007). This can be done via systematic development of salaried positions located in Divisions of General Practice - and particularly those in rural areas – in addition to Medicare rebates for those practicing in the private sector. Currently, salaried positions providing mental health service outreach in each region are left at the discretion of each Division of General Practice, rather than there being a federal government emphasis on this being a requirement, and a coherent framework developed and implemented nationally.

It is also important to ensure that new clinical psychology graduates have already had thorough supervised experience in the primary care sector prior to graduation. The Australian Psychological Society, the accrediting body for clinical masters and doctoral programs across Australia, has still not insisted on the implementation of compulsory primary care teaching modules and general practice placements as part of training. This is two years after public health endorsement via Medicare funding of primary care as the most likely location of employment for many graduates, and eight years after the first placements of this kind were successfully piloted through the “Clinical Psychology in General Practice Project”. Course content needs to be proactively managed in response to health service priorities.

There is ample opportunity to move beyond this relatively haphazard approach to mental health service delivery in our community. Federal government specifications for new funding and improved requirements for training by accrediting bodies are key to implementing these changes.
9.4 Future Research Directions

There are several key research directions which emerge from the effectiveness study described in this dissertation. First and foremost is the need for a follow-up efficiency trial. As Andrews (1999) and Andrews et al (2007) indicate, optimal mental health service delivery requires that criteria for good treatment are defined and treatments then assessed for *efficacy* (i.e. superiority to control group comparisons with no intervention), *effectiveness* (i.e. does the treatment still work when used by the average clinician with the average patient?) and *efficiency* (what level of resources are needed to produce benefit; i.e. is the intervention therefore cost effective?). The current study endorses previous efficacy studies which highlight that evidence-based psychological treatments, combined with medication when required, provide significant “value added” when compared to GP treatment alone – i.e. improved patient treatment outcomes. In addition, the results described in this thesis indicate the effectiveness of collaborative mental health service delivery involving GPs working with clinical psychologists and clinical psychology registrars in the average general practice setting. It is suggested that a key focus of further study be on a full cost-benefit evaluation of this collaborative model of care, as compared to GP treatment alone (or no treatment at all – which has been and continues to be the case for many Australians with common as well as low prevalence mental disorders).

In addition, a crucial focus for further research would be a comparative analysis of the relative efficacy of service delivery provided by clinical psychologists vs. psychiatrists, other allied health professionals (including registered psychologists, mental health nurses, and social workers), and others included under the new Better Access arrangements.

Findings from both areas of research would facilitate and be crucial in determining optimal allocation of the new resources provided for mental health service delivery in Australia.
REFERENCES


References


References


Australian Institute of Health & Welfare (AIHW). (2007). Mental Health Services in Australia 2004-05. AIHW Cat. no. HSE 47 (Mental Health Series no. 9). Canberra: AIHW.


Mental Health Council of Australia. (2005b). Not a failure of policy, it is a failure of implementation and delivery. *Submission to the Senate Select Committee on Mental Health*, May.


NSW Health Workforce Development and Leadership Branch. (2003). Profile of the psychologist labour force in NSW.


References


References


APPENDIX A:
DISKS (APPENDED AT END OF THESIS)

A.1 Data Files and Annotated Document Containing Tables,
Analyses and the Syntax Producing Them.

A.2 Commonwealth Reports (see also Appendix 9.2).
APPENDIX B:
PUBLISHED ARTICLES


Also attached:

Paper at the 9th NSW Rural Mental Health Conference: "Clinical Psychology in General Practice Project: An early intervention approach to mental health service delivery in rural primary care."
Clinical psychology in general practice: a cohort study

Robyn F Vines, Jeffrey C Richards, Don M Thomson, Margaret Brechman-Toussaint, Michelle Klunin and Louise Vesely

ABSTRACT

Objective: To evaluate whether a collaborative model of mental healthcare involving general practitioners and clinical psychologists benefits patients with common mental disorders in primary care.

Design and participants: Cohort study of 276 general practice patients with mental health problems receiving collaborative treatment from clinical psychologists and GPs compared with a normative sample of 198 patients attending the same general practice surgeries.

Setting: Nine general practices in three regional cities (Bathurst, Armidale and Ballarat) and two single-doctor practices in two rural and remote townships (Rylstone and Trundle). Data were collected in Bathurst, Rylstone and Trundle during 2001 and 2002 and in Ballarat and Armidale in 2002.

Intervention: Full assessment, case formulation and “focussed psychological interventions” relevant to the patient’s condition.

Main outcome measures: Level of psychological dysfunction assessed before and after the intervention, using the DASS (Depression, Anxiety and Stress Scales), GHQ (General Health Questionnaire) and GWBI (General Well Being index) scales.

Results: After the intervention, average scores in the treatment group decreased significantly (P < 0.001) on all DASS and GHQ measures and increased on the GWBI, indicating a positive change in the patients’ mental health. The follow-up scores of the treatment and normative groups did not differ significantly on any of these measures.

Conclusion: Preliminary findings suggest that collaborative care involving GPs and clinical psychologists provides significant gains in patients’ mental health.

MJA 2004; 181: 74-77

METHODS

The Clinical Psychology in General Practice Project, which began in 1998, is testing the efficacy of introducing clinical psychology services into the medical general practice setting in rural and regional areas and developing a model of early intervention by psychologists for primary care patients with common mental illnesses. Before the project, GPs in the Central West of New South Wales managed most mental health issues on their own, with sporadic access to limited mental health services within the region. This is also the case for GPs working in other non-metropolitan regions in Australia.

Data on the collaborative model were collected during a 2-year trial (2001-2002) from nine group general practices in three regional cities (Bathurst and Armidale in NSW, and Ballarat in Victoria), and two solo practices in two rural and remote NSW townships (Rylstone and Trundle).

Patient selection

Any patient with a common mental illness (primarily depression and/or anxiety), whom participating GPs felt might benefit from psychological intervention, was eligible. Once consent was obtained, the patient was referred by the GP to the “in-house” clinical psychologist or clinical psychology registrar (allocated in the general practice) for psychological intervention in collaboration with the GP. If feasible, an initial, short, joint consultation between the patient, GP and clinical psychologist/registrar was held before a full psychological assessment.

Intervention

The intervention comprised six sessions (six more if needed, for more complex conditions) — full assessment, case formulation and choice of the relevant “focussed
1 Comparison of scores of intervention and control participants completing initial and follow-up mental health measures

<table>
<thead>
<tr>
<th>Measure</th>
<th>n</th>
<th>Initial mean score (SD)</th>
<th>Follow-up mean score (SD)</th>
<th>Difference in mean score</th>
<th>95% CI of difference</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>A: Intervention group</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>DASS Depression</td>
<td>176</td>
<td>20.38 (12.03)</td>
<td>7.30 (9.49)</td>
<td>13.08</td>
<td>11.30–14.85</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>DASS Anxiety</td>
<td>177</td>
<td>15.03 (10.95)</td>
<td>6.40 (8.04)</td>
<td>8.63</td>
<td>7.23–10.03</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>DASS Stress</td>
<td>177</td>
<td>22.71 (10.86)</td>
<td>10.56 (10.12)</td>
<td>12.15</td>
<td>10.51–13.79</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>General Health Questionnaire (total)</td>
<td>173</td>
<td>39.35 (17.09)</td>
<td>17.34 (14.12)</td>
<td>21.81</td>
<td>19.23–24.39</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>General Well Being Index</td>
<td>178</td>
<td>36.27 (15.93)</td>
<td>59.12 (16.56)</td>
<td>−22.85</td>
<td>−25.61–−20.09</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>B: Control group</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>DASS Depression</td>
<td>97</td>
<td>7.46 (9.06)</td>
<td>6.02 (7.72)</td>
<td>1.44</td>
<td>0.08–2.79</td>
<td>0.37</td>
</tr>
<tr>
<td>DASS Anxiety</td>
<td>97</td>
<td>6.51 (9.03)</td>
<td>4.96 (6.92)</td>
<td>1.65</td>
<td>0.49–2.64</td>
<td>0.003</td>
</tr>
<tr>
<td>DASS Stress</td>
<td>97</td>
<td>10.21 (9.10)</td>
<td>9.10 (8.10)</td>
<td>1.11</td>
<td>−0.03–2.33</td>
<td>0.65</td>
</tr>
<tr>
<td>General Health Questionnaire (total)</td>
<td>95</td>
<td>22.07 (13.86)</td>
<td>18.95 (12.10)</td>
<td>3.12</td>
<td>−0.20–5.44</td>
<td>0.19</td>
</tr>
<tr>
<td>General Well Being Index</td>
<td>93</td>
<td>56.78 (18.81)</td>
<td>59.45 (16.01)</td>
<td>−2.67</td>
<td>−5.38–0.01</td>
<td>0.051</td>
</tr>
</tbody>
</table>

*Difference in means = mean initial score minus mean follow-up score. DASS = Depression, Anxiety and Stress Scale.

psychological interventions” for the patient’s condition (eg, individually targeted and tailored cognitive behaviour therapy), which were then provided. All clinical psychology registrars were closely supervised by a senior clinical psychologist. Patients were seen by the psychologists pro bono. Ongoing face-to-face discussion and consultation between GPs and clinical psychologists occurred during the course of the patients’ treatment.

Normative comparison group

We considered random allocation of patients requiring treatment for mental illness to intervention or control groups. However, both for logistical and ethical reasons (ie, duty of care to patients clearly requiring psychological intervention), this was not done. Members of the comparison group were patients who had not been referred for psychological treatment by their GP, but were attending the same general practice. If any of the comparison participants scored within the severe to extremely severe ranges on the Depression, Anxiety and Stress Scales (DASS)10 or General Health Questionnaire (GHQ),11 the GP referred them for psychological intervention as part of the intervention group. This, of course, skewed the initial scores of the comparison group on the mental health measures towards the normal range. Our comparison “control” group was therefore a normative sample drawn from a similar demographic population attending the GPs’ surgeries.

Data collection

Measures: Both intervention- and control-group patients were asked to complete three validated mental health measures: the DASS, the GHQ and the General Well Being Index (GWBI).12 DASS subscores measure depression (mild to moderate severity 12–20; severe to extremely severe 27–42); anxiety (mild to moderate 9–14; severe to extremely severe 20–42); and stress (mild to moderate 16–26; severe to extremely severe 34–42).

The GHQ has four seven-item subscales: somatic symptoms, anxiety, social functioning and depression. A clinical threshold score lies between 16 and 20, from summed scores over the four subscales. No clinical threshold score exists for the General Well Being Index, a 22-item measure of general well-being, which correlates inversely with the DASS and GHQ.

The intervention group completed all three mental health measures at their first session and again after their final treatment session with the psychologist. The control group completed initial mental health measures at the time of recruitment and were sent the same measures to complete 8 weeks later, which was about the same time interval as those receiving the intervention.

Ethics approval

The study was approved by the Charles Sturt University, University of Ballarat, University of New England and University of Sydney ethics committees in 2001.

Statistical methods

We used SPSS for all the statistical analyses.13 There were two major issues of interest:

- Whether, within the intervention group, the initial scores on the mental health measures differed significantly from the follow-up scores; and
- Whether the scores on the initial and follow-up mental health measures differed significantly between the control and intervention groups.

The total scores and subscores of DASS and GHQ, and GWBI were assumed to be normally distributed for each group on each testing occasion. To answer the first question a paired-samples t-test was used which yielded a difference in means, a 95% confidence interval of this difference, and a two-tailed measure of the significance of the t-test. An independent-samples t-test was used to answer the second question, which once again yielded a difference in means, a 95% confidence interval of this difference, and a two-tailed test of significance of the t-test. Equal variances were assumed.

Because differences between intervention and control groups may have been confounded by demographic variables such as age, sex and socioeconomic status, the intervention and control groups from the Bathurst practice were compared to determine whether they differed on these parameters, as data were retrospectively available only for Bathurst patients. Cross-tabulations
were calculated for these demographic variables and a Pearson $\chi^2$ test with a two-tailed test of significance was used to determine whether the differences between the intervention and control groups were significant.

**RESULTS**

**Intervention group**

By the end of 2002, 276 patients had received treatment through the project. We estimated that the consent/participation rate was high (about 95%), although no formal record was kept of consent rates. Sixty-six per cent of these patients ($n = 191$) completed initial and follow-up measures: 123 (69%) were female and 58 (32%) were male. Patients completing both initial and follow-up measures were representative of the total group in terms of both sex ratio and initial scores on the measures. The 66% return rate (i.e., 34% loss to follow-up) was the result of a number of factors, including our early emphasis on providing healthcare rather than insisting on the questionnaires being completed. Some dependence on postal returns after the final treatment session resulted in further attrition.

On the initial measures, 51% (of the 276 intervention participants) scored at the extremely severe or severe level for both depression and anxiety, while 42% scored within this range for stress. There was a high degree of comorbidity within these illnesses (e.g., 67% of participants with an extremely high level of depression also had an extremely high level of anxiety).

Twenty-two patients (9%) appeared to be in the normal range on all three DASS measures, suggesting either an unnecessarily high referral rate by GPs, or that the measures were not detecting conditions that GPs were unable to assess clinically.

After treatment, average scores had improved significantly on all DASS, GHQ and GWBI measures (Box 1A).

**Control group**

Owing to the difficulties associated with control recruitment (outlined above) and postal returns for control-group follow-up assessment, the control group was smaller than the intervention group, with 198 participants. Of these, 129 (65%) were female and 69 (35%) were male. Ninety-seven participants (49%) completed both initial and follow-up measures. Of the 198 control-group participants, 126 (64%), 116 (59%) and 124 (63%) scored in the normal range for depression, anxiety and stress, respectively. Mean scores on the follow-up measures in the control group were not significantly different from those on the initial measures (Box 1B).

**Comparison of intervention and control groups**

Comparison of initial measures across the intervention and control groups indicated a significant difference between groups, with the intervention group manifesting significantly higher scores on the DASS and GHQ and significantly lower on the GWBI (Box 2A).

Comparison of follow-up measures showed that there were no significant differences between the intervention group and the control group (Box 2B). Comparison based on demographic data. The Bathurst control group did not significantly differ from the Bathurst intervention group on the basis of sex, age or income level, as shown by the Pearson $\chi^2$ at the end of each cross-tabulation in Box 3. There were slightly higher percentages of younger patients and patients in the lowest-income quintile in the intervention group, but over all the cross-tabulation percentages were roughly comparable.

**DISCUSSION**

Our results suggest that clinical psychologists working with GPs in primary care can have a positive effect on the mental health of patients identified by their GP as being psychologically distressed. Comparison before intervention with a normative sample of people drawn from a similar demographic population indicated, as expected, significantly higher levels of psychological disturbance in the intervention group. Average scores in the intervention group significantly improved on all measures (DASS, GHQ and GWBI) after the intervention, with no significant difference between the intervention
### 3 Comparison of intervention and control groups from Bathurst on the basis of demographic data

<table>
<thead>
<tr>
<th>Attribute</th>
<th>Control group</th>
<th>Intervention group</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number (%)</td>
<td>Number (%)</td>
<td></td>
</tr>
<tr>
<td><strong>Sex</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>30 (28.8%)</td>
<td>42 (24.3%)</td>
<td>72</td>
</tr>
<tr>
<td>Female</td>
<td>74 (71.2%)</td>
<td>131 (75.7%)</td>
<td>205</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>104</td>
<td>173</td>
<td>277</td>
</tr>
<tr>
<td>$\chi^2 = 0.71; P = 0.40$</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| Age             |           |                    |       |
| 15-29           | 14 (15.7%) | 35 (24.8%)         | 49    |
| 30-39           | 20 (22.5%) | 33 (23.4%)         | 53    |
| 40-49           | 23 (23.8%) | 34 (24.1%)         | 57    |
| 50-59           | 14 (15.7%) | 24 (17.0%)         | 38    |
| 60-81           | 18 (20.2%) | 15 (10.6%)         | 33    |
| **Total**       | 89         | 141                | 230   |
| $\chi^2 = 5.77; P = 0.22$ |           |                    |       |

| Income quintile (based on address)* |           |                    |       |
| Lowest                       | 10 (10.2%)| 25 (16.8%)         | 35    |
| Second                       | 41 (41.8%)| 56 (37.6%)         | 97    |
| Third                        | 23 (23.5%)| 45 (30.2%)         | 68    |
| Fourth                       | 8 (8.2%)  | 14 (9.4%)          | 22    |
| Highest                      | 5 (5.1%)  | 6 (4.0%)           | 11    |
| Unknown address              | 11 (11.2%)| 3 (2.0%)           | 14    |
| **Total**                    | 98        | 149                | 247   |
| $\chi^2 = 12.15; P = 0.03$ |           |                    |       |

*For the income quintile, we used Australian Bureau of Statistics index of economic resources (family income and expenditure, family assets and dwelling size) (Socio-Economic Indexes for Areas [SEIFA]). This index is grouped into quintiles, with Bathurst's population covering all five. We allocated control- and treatment-group patients to quintiles on the basis of their address as shown on surgery records.

and the normative comparison group at follow-up.

The main limitation of the study was that we could not randomly allocate patients to control and treatment groups. This would have provided comparable control data in patients with similar levels of mental disorder. Further, relatively low completion rates for the follow-up questionnaires (66% of the intervention group and 49% of the control group) may have biased the results. However, it was found that the intervention subgroup with complete data had similar initial scores and sex ratios to the larger group from which it was drawn, suggesting comparability. This was also true for the control group. A number of possible confounders (eg, sex, age and socioeconomic status) may have limited the comparison between groups. However, data collected on the Bathurst sample (both intervention and control groups) indicated that there were no significant differences between the groups.

Our preliminary findings suggest that this collaborative model of mental healthcare involving GPs and clinical psychologists provides positive gains for patients with common mental disorders and that current government support for such services should be continued.

**ACKNOWLEDGEMENTS**

Thanks are due to the Australian Department of Health and Ageing for its generous support of this project over 5 years. We would also like to thank the GPs involved in our trial of the collaborative model. Without their encouragement the research would not have been possible.

**COMPETING INTERESTS**
None identified.

**REFERENCES**

Clinical Psychology in Rural General Practice: A PILOT OF A COLLABORATIVE MODEL OF MENTAL HEALTH SERVICE DELIVERY*

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

Prevalence of Mental Disorders in Australia

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

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

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

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

**FIGURE 1:**

![Diagram showing prevalence of mental health disorders](image)


These figures show that comorbidity in mental health and substance use disorders, or co-occurrence of more than one mental disorder, is highly prevalent but remains largely un-addressed. The high rates of comorbidity have a number of implications for treatment and management.)
For older adults, the prevalence of mental disorders drops to 6% among those aged 65 years and over, although an additional 6.1% are estimated to have dementia, which is strongly age-related and increases in incidence significantly with age after this time from 1.6% of 65 to 70 year-olds, to 39% of 90-94 year-olds (see National Action Plan for Promotion, Prevention and Early Intervention for Mental Health, 2000; Sawyer, Arney, Baghurst, Clark, Graetz, Kosky, Nurcombe, Patton, Prior, Raphael, Rey, Whaites, & Zubrick, 2000).

Patterns of Care

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

The detection of psychological symptoms in primary care patients

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

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

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

- the possible stigma associated with such a label (Aloizos et al., 1998; Hennrikus & Sanson-Fisher, 1988); and
- the perceived likelihood that recognition of the condition does not improve treatment outcomes (Chamberlin et al., 1999; Hennrikus & Sanson-Fisher, 1988; Ormell et al., 1996). Many GPs do not feel confident to treat mental disorders, and mental health facilities are often difficult to access if a mental disorder is diagnosed. It is hypothesised therefore that, in these circumstances, "treatable conditions" are more readily focused upon.
Patient perceptions that the role of their GP is to attend to physical rather than psychological symptoms have also been found to inhibit the likelihood of detection, (Andrews, Chancellor, & Mant, 1977; Bridges & Goldberg, 1984). In one study (Robinson and Roter, 1999) it was found that 83% of patients opted not to disclose psychological symptoms to their GP. Similarly, Andrews and colleagues (1977) determined that patients suffering anxiety and depression were generally reluctant to disclose their emotional needs to their GP, preferring to present physical symptoms such as prolonged fatigue and sleep disturbance, as more appropriate. Patients' choice to present physical rather than psychological symptoms has therefore contributed to the low detection rate of psychological disturbance in patients.

Recent Health Policy

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

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

Best Practice

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

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

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

ADDRESS FOR CORRESPONDENCE:

Robyn Vines
Director
Psychological Services Centre
Charles Sturt University
rvines@csu.edu.au
The “GP Project”

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

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

The Aims of the Project are to:

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

The model of collaborative service delivery consists of:

- the provision of Clinical Psychology services in the Medical General Practice setting, preventing the need for articulation of assessment/treatment to another specialist setting as is usually required (either a public facility; such as Community Health or private practice setting). Patient attrition, which often occurs at this point, is therefore minimised.
- “in-house” referral of patients whom the General Practitioner feels could benefit from psychological intervention for either:
a) psychological issues, or
b) physiological issues with a psychological dimension. Most referrals within the project are envisaged to be cases of high prevalence disorders of depression and anxiety.

- an initial joint session between the patient, General Practitioner and Clinical Psychologist at the commencement of the psychological assessment to facilitate:
  a) establishment of rapport between the psychologist and patient through endorsement by the GP whom the patient frequently knows well;
  b) opportunity for the patient to communicate to both professionals their own perception of the presenting problem/condition and its background;
  c) opportunity for both professions to provide a formulation of the patient's condition and to explain treatment options;
  d) communication between the GP and psychologist about the patient's condition, presenting issues/problems and background;
  e) obtaining of patient consent for cross-professional communication to continue whilst the patient is in psychological treatment and access to medical notes by the psychologist;
  f) appreciation by both professions of their alternative and complementary ways of formulating patient difficulties/presenting conditions.

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

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

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

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

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

- Formal written feedback/letters to the referring doctor:
  a) after the assessment session;
  b) at conclusion of treatment: summarising gains made both on objective indices and patient-generated problem list.

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

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

FIGURE 2:

**Diagrammatic Model Presenting Design of the Current Project**

*(Overview of the Structure and Phases of the Project)*

**Stage One**

- 2001

**Stage Two**

- 2002

**Evaluation of GPs and Students**

**CONTROL**

- Three practices
- Random audits to provide matched controls

**CONTROL**

- Seven practices
- Random audits to provide matched controls

Total patients = 496

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

FIGURE 3:
For each patient a number of quantitative and qualitative measures are being used as follows:

**Patient Parameters**

<table>
<thead>
<tr>
<th>Demographic Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age:</td>
</tr>
<tr>
<td>Sex:</td>
</tr>
<tr>
<td>Presenting Problem:</td>
</tr>
<tr>
<td>Has help been received before:</td>
</tr>
<tr>
<td>Medication:</td>
</tr>
<tr>
<td>Duration of medication use:</td>
</tr>
</tbody>
</table>

**PRE-MEASURES**

a) **DASS**
   - Depression
   - Anxiety
   - Stress
   - Composite

b) **GHQ (health)**
   - Composite

c) **GWBI**
   - Composite

d) **Subjective list of PROBLEMS**

**POST-MEASURES**

a) **DASS**
   - Depression
   - Anxiety
   - Stress
   - Composite

b) **GHQ**
   - Composite

c) **GWBI**
   - Composite

d) **Subjective list**
   - "Things that Have Changed" (6-18 sessions of treatment)

**No. of sessions:**

e) **Patient Satisfaction Questionnaire**
General Practitioner of the incidence of psychological problems presenting in the General Practice setting.

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

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

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

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

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

ADDRESS FOR CORRESPONDENCE:
Robyn Vines
Director
Psychological Services Centre
Charles Sturt University
rvines@cstu.edu.au
Clinical Psychology in Rural General Practice:

SOME INITIAL OBSERVATIONS

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

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

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

Location of Psychological Services within the Practice setting

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

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

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

A beneficial aspect of the placement for us as students was the ability to work within a GP surgery and to develop a deeper understanding of the constraints and demands upon them and the best ways to contact and liaise with them. One Practice had a policy of having a common confidential morning tea session for the GPs that included the Registrar. This was particularly beneficial in feeling part of the team and enabled the Registrar to talk to the GPs about their patients' progress or any issues that were arising within psychotherapy that the GP needed to know about.
The Project specified a maximum of six-ten sessions for any patient. Whilst the ratio of sessions varied for each Registrar, across our sample approximately 50% utilised either five or six sessions. Others reported significant change in less than six sessions and treatment concluded. Of these between 15% and 24% attended four sessions. The percentage of patients who did not take up the initial session was less than 10% across this sample. Overall there was a less than 10% attrition rate. This is not to say the issue of attendance was without frustration. A number of the patients who were experiencing concurrent physical illnesses required frequent postponements, making it difficult to complete treatment for some individuals in the time constraints of the placement.

**Patient Features**

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

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

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

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

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

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

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

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

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

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

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

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

Supervision

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

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

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

Some Concluding Thoughts

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

This type of short-term focused evidence-based therapy is one that is highly suited to both the GP setting and is demonstrated to be of benefit to the majority of patients referred.
question remains: how to fund the provision of such services, as the majority of people referred to the Registrars indicated an inability to pay fees? This remains the most significant issue to be resolved.

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

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

REFERENCES


Australian Psychological Society. (2000). The Role of Psychological Treatments in Managing High Prevalence Mental Health Disorders. APS: Melbourne


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

Robyn Vines
Centre for Rural and Remote Mental Health, University of Newcastle

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

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

History of the project:

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

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

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

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

Further funding under the Better Outcomes in Mental Health Care (BOMHC) Access to Allied Health Initiative has enabled the trial, via the CWDP, of four different funding models for psychological services found to be feasible in the Clinical Psychology in General Practice Project:
- Clinical Psychology Registrar stipends;
- Salaried positions within Divisions of GPs;
- Patient voucher systems;
- Direct funding for group treatment programs.

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

(Continued on page 4)
The aims of the Project have been to:

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

Interim results:

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

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

Current developments:

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

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

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

References:


Contact Details:
Robyn Vines
Clinical Psychologist/Senior Lecturer
Mental Health Education
Centre for Rural and Remote Mental Health
University of Newcastle, Orange
Email: robyn.vines@mwhhs.nsw.gov.au

Senior Research Fellow
Charles Sturt University, Bathurst
Email: rvines@csu.edu.au
Editorial: Introducing Carmel McCarthy, new PARC Research Officer

Eleanor Jackson Bowers
Research Librarian, PARC

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

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

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

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

In order to achieve this PARC have received funding to employ our new Research Officer Carmel McCarthy who comes to us with a health education background and research experience in education and organisational...
THE CLINICAL PSYCHOLOGY IN GENERAL PRACTICE PROJECT:
Developing a new Collaborative Model of Mental Health Service Delivery involving Clinical Psychologists in the General Practice setting.


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

OVERVIEW:
The Clinical Psychology in General Practice Project is developing a Collaborative Model of Mental Health Service Delivery involving the placement of Clinical Psychologists in the General Practice setting. The Project involves Clinical Psychologists/Clinical Psychology Registrars from Charles Sturt University (CSU), Ballarat University, the University of New England and University of Newcastle piloting the provision of psychological services in a number of General Practices in three regional areas of NSW and Victoria. During the two-year course of Phase 1 of the Project, 19 Clinical Psychology Registrars have been trained in the primary care setting. Their placements have entailed:
- observation of General Practitioners, sessions with patients;
- assessing, diagnosing and treating approximately 20-30 patients each in the primary care setting;
- analysing patient pre and post treatment results;
- making qualitative observations of the Model and of the General Practice setting during the course of the placement.

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

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

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

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

Further funding under the Better Outcomes in Mental Health Care (BOMHC) Allied Health Initiative has enabled the trial of four different funding models for psychological services found to be feasible in the Clinical Psychology in General Practice Project:
- Clinical Psychology Registrar stipends;
- Salaried positions within Divisions of GPs;
- Patient voucher systems;
- Direct funding for group treatment programs.

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

AIMS of the PROJECT are to:
- Service patient needs in rural locations where access to specialist help is often limited;
- Facilitate early intervention, thereby preventing both the development of greater severity of the presenting condition and greater frequency of use of medical services;
- Support GPs with the diagnosis, management and treatment of patients presenting with:
  a) psychological issues;
  b) physiological issues with a psychological dimension;
- Support ongoing Continuing Medical Education for GPs 'in situ' by providing learning outcomes for GPs whilst working collaboratively with the profession of Clinical Psychology;
- Develop appropriate funding models to facilitate ongoing provision of this method of service delivery in locations where fee paying may not be a viable source of monetary support;
- Provide an innovative generic model of mental health service delivery which can be articulated nationally;
- Offer training opportunities for post graduate students in Clinical Psychology.

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

RESULTS

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

At the time of initial assessment:
• 48.7% (88) scored within the extremely severe (36.5%) or severe (12.2%) range for anxiety;
• 49.2% (89) scored within these ranges (32.6% and 16.6%) for depression;
• 42.5% (77) scored within these ranges (20.4% and 22.1%) for stress.

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

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

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

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

BIBLIOGRAPHY.

Contact Details:
Chief Investigator Robyn Vines
Senior Research Fellow
Charles Sturt University (vines@csu.edu.au)
Conjoint Senior Lecturer
Centre for Rural and Remote Mental Health
University of Newcastle (robyn.vines@mwhs.nsw.gov.au)

287
Clinical Psychology in General Practice Project: An early intervention approach to mental health service delivery in Rural Primary Care

Author: Robyn Vines MSc, FAPS

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

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

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

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

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

During the three year course of Phase 1 of the Project, 20 Clinical Psychology Registrars have been trained in the primary care setting. Their placements have entailed:

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

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

- post-treatment measures for patients in the collaborative treatment group showed a positive and significant (at the 0.01 level or greater) change in the Mental Health of the patients;
- the control group (ie “treatment as usual via GP”) also showed, on average, a significant improvement on mental health indices;
• matched pair comparison between treatment and control groups indicated a highly significant difference between controls’ and treatment participants’ scores on all scales post treatment with the treatment group showing a greater improvement.

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

Continuing Developments:
In the Central West of NSW, further funding under the More Allied Health Services and the Better Outcomes in Mental Health Care (BOMHC) Allied Health Initiatives has enabled the trial of four different funding models for psychological services, found to be feasible in the Clinical Psychology in General Practice Project:
• Clinical Psychology Registrar stipends;
• Salaried positions within Divisions of GPs;
• Patient voucher systems;
• Direct funding for group treatment programs.

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

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

References:


APPENDIX C:
CHAPTER 6: METHOD

6.1 Patient survey from pilot study (see section 6.2.1)
6.2 GP survey from pilot study (see section 6.2.2)
6.3 National Primary Care Research Group
6.4 Patient/intervention group consent form
6.5 Control group consent form
6.6 Depression Anxiety and Stress Scales (DASS)
6.7 DASS Profile Sheet
6.8 General Health Questionnaire (GHQ)
6.9 General Well Being Index (GWBI)
6.10 Problems to Goals Sheet
6.11 Case study examples of qualitative indices
6.12 Patient Satisfaction Questionnaire
6.13 Clinical Psychologists in General Practice Survey
6.14 General Practitioner follow-up Questionnaire
6.15 Clinical Psychology Form: Treatment plan and discharge summary
6.16 Evaluation of Placement Experience Questionnaire
6.17 Clinical psychology registrars’ questionnaire
6.18 Client Case Register used on placement
6.19 GP Patient Referral Form
Clinical Psychologists in General Practice

APPENDIX 6.1

Questionnaire

The opportunity to see a Clinical Psychologist in my doctor’s practice:

a) Was a helpful experience
   Strongly agree  Agree  Not sure  Disagree  Strongly disagree

b) My problem improved after seeing the Clinical Psychologist
   Strongly agree  Agree  Not sure  Disagree  Strongly disagree

c) I liked being able to see a Clinical Psychologist in my Doctor’s practice
   Strongly agree  Agree  Not sure  Disagree  Strongly disagree

d) I felt more comfortable seeing a Clinical Psychologist in the Doctor’s practice rather than being referred to another place
   Strongly agree  Agree  Not sure  Disagree  Strongly disagree

e) The Doctor explained the clinical psychologist’s role to me
   Yes  No  Not sure

f) The Doctor attended part of my first session with the Clinical Psychologist
   Yes  No

g) If Yes, was this helpful?
   Yes  No

Please Comment: ________________________________

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________
h) The Clinical Psychologist was easy to talk to

| Strongly agree | Agree | Not sure | Disagree | Strongly disagree |

i) The Clinical Psychologist gave me some explanation/understanding of my condition

| Strongly agree | Agree | Not sure | Disagree | Strongly disagree |

j) I felt involved in my assessment and/or treatment

| Strongly agree | Agree | Not sure | Disagree | Strongly disagree |

k) I feel I received the right treatment for my presenting problems

| Strongly agree | Agree | Not sure | Disagree | Strongly disagree |

l) I received adequate follow-up

| Strongly agree | Agree | Not sure | Disagree | Strongly disagree |

m) Did you find the fees a problem?
   No       Yes       Undecided

Do you have any comments about the fees?

........................................................................................................................................
........................................................................................................................................

Are there any other comments you would like to make generally?

........................................................................................................................................
........................................................................................................................................
........................................................................................................................................
........................................................................................................................................

Thank you very much for filling out this survey.
Clinical Psychologists in General Practice

APPENDIX 6.2

22 March 2000

Dear Russell Street Doctor

The Clinical Psychologist in General Practice Project has been trialed in your practice over the past 12 months. Before we establish a second phase, i.e. placement of a further Clinical Psychologist who is undergoing a Masters or PPsych studies, in a General Practice, we need to review and evaluate the success and relevance of the project to date.

We invite you to comment on the project by filling in this confidential questionnaire. Your perceptions of the project are very important and your input will ensure any future developments meet the needs of GPs and their patients.

1. **Value to patients.** (Please circle the most appropriate answer)

   a) Patients have benefited from extra professional support and counselling
      - Strongly agree
      - Agree
      - Not sure
      - Disagree
      - Strongly disagree

   b) Management of patients with *acute* emotional/psychological disturbance improved
      - Strongly agree
      - Agree
      - Not sure
      - Disagree
      - Strongly disagree

   c) Management of patients with *non-acute* emotional/psychological disturbance improved
      - Strongly agree
      - Agree
      - Not sure
      - Disagree
      - Strongly disagree

   d) Patients’ compliance with treatment plans improved
      - Strongly agree
      - Agree
      - Not sure
      - Disagree
      - Strongly disagree

   e) Patients exhibited an improvement in healthier behavior patterns
      - Strongly agree
      - Agree
      - Not sure
      - Disagree
      - Strongly disagree

   f) Patients reduced their need for long term medication
      - Strongly agree
      - Agree
      - Not sure
      - Disagree
      - Strongly disagree
2. **Value to GPs**

a) GPs have benefited from the personal support of sharing care with a Clinical Psychologist

<table>
<thead>
<tr>
<th>Strongly agree</th>
<th>Agree</th>
<th>Not sure</th>
<th>Disagree</th>
<th>Strongly disagree</th>
</tr>
</thead>
</table>

b) Ready opportunity of feedback from the Clinical Psychologist was valuable

<table>
<thead>
<tr>
<th>Strongly agree</th>
<th>Agree</th>
<th>Not sure</th>
<th>Disagree</th>
<th>Strongly disagree</th>
</tr>
</thead>
</table>

c) The opportunity to introduce your patient to the Clinical Psychologist was valuable

<table>
<thead>
<tr>
<th>Strongly agree</th>
<th>Agree</th>
<th>Not sure</th>
<th>Disagree</th>
<th>Strongly disagree</th>
</tr>
</thead>
</table>

d) GPs benefited from the collaboration in developing a “case management model of care”

<table>
<thead>
<tr>
<th>Strongly agree</th>
<th>Agree</th>
<th>Not sure</th>
<th>Disagree</th>
<th>Strongly disagree</th>
</tr>
</thead>
</table>

e) GP’s *skills* in working with patients with emotional/psychological disturbances increased

<table>
<thead>
<tr>
<th>Strongly agree</th>
<th>Agree</th>
<th>Not sure</th>
<th>Disagree</th>
<th>Strongly disagree</th>
</tr>
</thead>
</table>

f) GP *confidence* in working with patients with emotional/psychological disturbances increased

<table>
<thead>
<tr>
<th>Strongly agree</th>
<th>Agree</th>
<th>Not sure</th>
<th>Disagree</th>
<th>Strongly disagree</th>
</tr>
</thead>
</table>

g) The Clinical Psychologist reduced the amount of time you need to spend with particular patients

<table>
<thead>
<tr>
<th>Strongly agree</th>
<th>Agree</th>
<th>Not sure</th>
<th>Disagree</th>
<th>Strongly disagree</th>
</tr>
</thead>
</table>

3. **Role of the Clinical Psychologist**

a) The Clinical Psychologist provided a valuable option for more accessible psychological services

<table>
<thead>
<tr>
<th>Strongly agree</th>
<th>Agree</th>
<th>Not sure</th>
<th>Disagree</th>
<th>Strongly disagree</th>
</tr>
</thead>
</table>

b) This project gave the Clinical Psychologist more understanding of the role of GPs in the social and emotional care of their patients

<table>
<thead>
<tr>
<th>Strongly agree</th>
<th>Agree</th>
<th>Not sure</th>
<th>Disagree</th>
<th>Strongly disagree</th>
</tr>
</thead>
</table>

c) Would you like to see the Clinical Psychologist in General Practice project continue in your practice?

- Yes
- No

Any other comments:  ____________________________________________________________

______________________________________________________________________________

294
APPENDIX 6.3

National Primary Care Research Group:
was responsible for determining the research protocols and indices used in the “Clinical Psychology in Rural General Practice Project”. All were practicing psychologists at the time of the research and were expert in psychological assessment.

- **Professor Bob Montgomery**: at the time of the research, Bob was Professor of Psychology at Canberra University. He is currently President-Elect of the Australian Psychological Society and is in independent practice on the Gold Coast in clinical, health and forensic psychology, as well as organisational consulting.

- **Associate Professor Alan Ralph**: is a Principal Research Fellow in the School of Psychology at the University of Queensland. He is a practicing clinical psychologist and was on the Board of Directors of the Australian Psychological Society when the research began.

- The late **Professor Jeff Richards**: when the research began, Jeff was Professor of Psychology at Ballarat University. He was one of the key investigators during the study and operative in ensuring successful piloting of clinical psychology registrarships in primary care in the Ballarat area. He subsequently became Professor of Primary Care Research in the School of Primary Health Care, Faculty of Medicine, Nursing and Health Sciences at Monash University. (The Project was transferred to Monash when the author moved overseas in late 2004.)

- **Professor Don Thomson**: As co-Chief Investigator on the Project, Don was involved in research design from the beginning. During the time over which the project ran, Don was Professor of Psychology at Charles Sturt University. He has subsequently moved to Deakin University, Burwood Campus in Melbourne.

- **Associate Professor Helen Winefield**: is Program Coordinator, Master of Psychology (Health) at the University of Adelaide. At the time of her involvement on the project she was operative in establishing a trial placement of one full-time clinical psychologist in general practice in Adelaide. She subsequently has continued to pioneer and work in the field of primary care psychology in Australia.

- **Ms. Robyn Vines**: (the author) was Chief Investigator and Director of the “Clinical Psychology in Rural General Practice Project” (2001-2004). For the duration of the project she was Senior Lecturer in Clinical Psychology at Charles Sturt University; Senior Lecturer (later Adjunct) at the Centre for Rural and Remote Mental Health, University of Newcastle; and on the Board of Directors (Director of Branch and Regional Operations - 1998-2002) of the Australian Psychological Society. Following 3 years overseas she has resumed clinical practice as a full-time clinical psychologist in Bathurst, NSW and is currently Hon. Senior Research Fellow in the Department of General Practice, School of
Primary Health Care, Faculty of Medicine, Nursing and Health Sciences at Monash University.

- **Mr. Brian Williams**: is a practicing clinical psychologist and has worked closely with Professor Winefield on primary care trials in general practice in Adelaide since 2001. They developed one of the first Better Outcomes in Mental Health Care programs in South Australia and were of great assistance with the project and choice of assessment indices at the beginning of the research.

Whilst not all members of the National Primary Care Research Group have been included in the formal Acknowledgements at the beginning of this thesis – thanks are warmly extended to them all for their contribution in the early stages of planning.

Robyn Vines  
30th June, 2008
APPENDIX 6.4
PATIENT/INTERVENTION GROUP CONSENT FORM

CLINICAL PSYCHOLOGY IN GENERAL PRACTICE PROJECT

CONSENT FORM

I, ____________________________________________, give consent to my participation in the research project: Name

(please print)

“Clinical Psychology in General Practice”

In giving my consent I acknowledge that:

1. The procedures required for the project have been explained to me, and any questions I have about the project have been answered to my satisfaction;

2. I have read the Subject Information Statement and have been given the opportunity to discuss the information and my involvement in the project with family and/or friends;

3. I am aware of the risks and inconveniences associated with the project;

4. I am aware that during the course of my treatment the Clinical Psychologist may need to access my medical notes, with the approval of my General Practitioner, in order to establish whether I am on any medication;

5. I understand that I can withdraw from the study at any time, without affecting my treatment or my relationship with the researcher(s) now and in the future;

6. I understand that my involvement is strictly confidential and no information about me will be used in any way which reveals my identity.

Signed: ___________________________________________ Date: ________________________________

Name: ___________________________________________ Date: ________________________________

Witness: _________________________________________ Date: ________________________________

Name: ___________________________________________
APPENDIX 6.5
CONTROL GROUP CONSENT FORM

CONSENT FORM

Dear Patient,

Charles Sturt University in conjunction with the Commonwealth Department of Health and Aged Care is currently involved in a research project entitled “Clinical Psychology in Rural General Practice”. The research aims to provide the community with access to a Clinical Psychologist within the General Practice for the treatment of stress, anxiety and depression.

Currently, many patients have received treatment and have found the service provided to them to be beneficial. However, in order to assess the treatments being provided we also need to survey patients who are not currently receiving treatment to see if there is any difference in their recovery rate, if they do suffer from stress, anxiety or depression. To meet our research obligations we therefore need the cooperation of the general public to take part in this research project.

If you are interested in helping us to find out if this service is beneficial to the community please fill out the consent form below and answer the attached questionnaires. If you are interested to participate and have signed the consent form we will send out some follow up questionnaires in six weeks time. All questionnaires are bound by strict ethics guidelines, and all information supplied is kept strictly confidential. Access to your medical notes is only to determine if your medication has any impact on your well being in terms of stress, anxiety or depression.

Thank you for your assistance. If you have any questions about the study please contact us on (02) 6338 4694.

Professor Don Thomson
Professor of Psychology
Charles Sturt University

Robyn F. Vines
Clinical Psychologist
Charles Sturt University

Please circle yes or no.

I consent that my survey data can be used as part of the research project YES / NO

I would be willing for my medical notes to be accessed by the researcher in an entirely confidential way YES / NO

I am willing for follow-up questionnaires to be sent to me in approximately six weeks’ time YES / NO

Name

Doctor’s Name

Address

Signature Date

298
APPENDIX 6.6
DASS

Please read each statement and circle a number 0, 1, 2 or 3 which indicates how much the statement applied to you over the past week. There are no right or wrong answers. Do not spend too much time on any statement.

The rating scale is as follows:

<table>
<thead>
<tr>
<th>Number</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Did not apply to me at all</td>
</tr>
<tr>
<td>1</td>
<td>Applied to me to some degree, or some of the time</td>
</tr>
<tr>
<td>2</td>
<td>Applied to me to considerable degree, or a good part of the time</td>
</tr>
<tr>
<td>3</td>
<td>Applied to me very much, or most of the time</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Number</th>
<th>Statement</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>I found myself getting upset by quite trivial things</td>
</tr>
<tr>
<td>2</td>
<td>I was aware of dryness of my mouth</td>
</tr>
<tr>
<td>3</td>
<td>I couldn't seem to experience any positive feeling at all</td>
</tr>
<tr>
<td>4</td>
<td>I experienced breathing difficulty (eg, excessively rapid breathing breathlessness in the absence of physical exertion)</td>
</tr>
<tr>
<td>5</td>
<td>I just couldn't seem to get going</td>
</tr>
<tr>
<td>6</td>
<td>I tended to over-react to situations</td>
</tr>
<tr>
<td>7</td>
<td>I had a feeling of shakiness (eg, legs going to give way)</td>
</tr>
<tr>
<td>8</td>
<td>I found it difficult to relax</td>
</tr>
<tr>
<td>9</td>
<td>I found myself in situations that made me so anxious I was most relieved when they ended</td>
</tr>
<tr>
<td>10</td>
<td>I felt that I had nothing to look forward to</td>
</tr>
<tr>
<td>11</td>
<td>I found myself getting upset rather easily</td>
</tr>
<tr>
<td>12</td>
<td>I felt I was using a lot of nervous energy</td>
</tr>
<tr>
<td>13</td>
<td>I felt sad and depressed</td>
</tr>
<tr>
<td>14</td>
<td>I found myself getting impatient when I was delayed in any way (eg, lifts, traffic lights, being kept waiting)</td>
</tr>
<tr>
<td>15</td>
<td>I had a feeling of faintness</td>
</tr>
<tr>
<td>16</td>
<td>I felt that I had lost interest in just about everything</td>
</tr>
<tr>
<td>17</td>
<td>I felt I wasn't worth much as a person</td>
</tr>
<tr>
<td></td>
<td>I felt that I was rather touchy</td>
</tr>
<tr>
<td>18</td>
<td>I perspired noticeably (eg, hands sweaty) in the absence of high temperatures or physical exertion</td>
</tr>
<tr>
<td>19</td>
<td>I felt scared without any good reason</td>
</tr>
<tr>
<td>20</td>
<td>I felt that life wasn’t worthwhile</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>
**Reminder of rating scale:**

<table>
<thead>
<tr>
<th></th>
<th>Did not apply to me at all</th>
<th>Applied to me to some degree, or some of the time</th>
<th>Applied to me to considerable degree, or a good part of time</th>
<th>Applied to me very much, or most of the time</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

|   |                                                                 |                                                                 |                                                                 |                                                                 |
| 22| I found it hard to wind down                                      | 0 | 1 | 2 | 3 |
| 23| I had difficulty in swallowing                                    | 0 | 1 | 2 | 3 |
| 24| I couldn't seem to get any enjoyment out of the things I did      | 0 | 1 | 2 | 3 |
| 25| I was aware of the action of my heart in the absence of physical  | 0 | 1 | 2 | 3 |
|   | exertion (eg. sense of heart rate increase, heart missing a beat) |     |     |     |     |
| 26| I felt down-hearted and blue                                      | 0 | 1 | 2 | 3 |
| 27| I found that I was very irritable                                 | 0 | 1 | 2 | 3 |
| 28| I felt I was close to panic                                       | 0 | 1 | 2 | 3 |
| 29| I found it hard to calm down after something upset me             | 0 | 1 | 2 | 3 |
| 30| I feared that I would be "thrown" by some trivial but              | 0 | 1 | 2 | 3 |
|   | unfamiliar task                                                   |     |     |     |     |
| 31| I was unable to become enthusiastic about anything                 | 0 | 1 | 2 | 3 |
| 32| I found it difficult to tolerate interruptions to what I was doing| 0 | 1 | 2 | 3 |
| 33| I was in a state of nervous tension                               | 0 | 1 | 2 | 3 |
| 34| I felt I was pretty worthless                                     | 0 | 1 | 2 | 3 |
| 35| I was intolerant of anything that kept me from getting on with    | 0 | 1 | 2 | 3 |
|   | what I was doing                                                  |     |     |     |     |
| 36| I felt terrified                                                  | 0 | 1 | 2 | 3 |
| 37| I could see nothing in the future to be hopeful about             | 0 | 1 | 2 | 3 |
| 38| I felt that life was meaningless                                   | 0 | 1 | 2 | 3 |
| 39| I found myself getting agitated                                   | 0 | 1 | 2 | 3 |
| 40| I was worried about situations in which I might panic and make a  | 0 | 1 | 2 | 3 |
|   | fool of myself                                                    |     |     |     |     |
| 41| I experienced trembling (eg. in the hands)                        | 0 | 1 | 2 | 3 |
| 42| I found it difficult to work up the initiative to do things       | 0 | 1 | 2 | 3 |
APPENDIX 6.7
DASS PROFILE SHEET

Name: __________________________ Date: __________________________

ID: __________________________ Age: ______ Sex: __________________________

<table>
<thead>
<tr>
<th>Z Score</th>
<th>Depression</th>
<th>Anxiety</th>
<th>Stress</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.0</td>
<td>35 42 34</td>
<td>25 42 24</td>
<td>41 42</td>
</tr>
<tr>
<td>3.0</td>
<td>33 32</td>
<td>23 22</td>
<td>39 38</td>
</tr>
<tr>
<td>2.0</td>
<td>31 30</td>
<td>21 20</td>
<td>37 36</td>
</tr>
<tr>
<td>1.0</td>
<td>29 28</td>
<td>27 26</td>
<td>35 34</td>
</tr>
<tr>
<td>0.0</td>
<td>27 26</td>
<td>19 18</td>
<td>33 32</td>
</tr>
<tr>
<td>-1.0</td>
<td>25 24</td>
<td>17 16</td>
<td>25 24</td>
</tr>
<tr>
<td></td>
<td>23 22</td>
<td>15 14</td>
<td>13 12</td>
</tr>
<tr>
<td></td>
<td>21 20</td>
<td>11 10</td>
<td>9 8</td>
</tr>
<tr>
<td></td>
<td>19 18</td>
<td>13 12</td>
<td>9 8</td>
</tr>
<tr>
<td></td>
<td>17 16</td>
<td>11 10</td>
<td>9 8</td>
</tr>
<tr>
<td></td>
<td>15 14</td>
<td>7 8</td>
<td>15 14</td>
</tr>
<tr>
<td></td>
<td>9 8</td>
<td>5 4</td>
<td>9 10</td>
</tr>
<tr>
<td></td>
<td>7 6</td>
<td>3 2</td>
<td>7 8</td>
</tr>
<tr>
<td></td>
<td>5 4</td>
<td>1 0</td>
<td>5 6</td>
</tr>
<tr>
<td></td>
<td>3 2</td>
<td>0 -3</td>
<td>4 4</td>
</tr>
<tr>
<td></td>
<td>1 0</td>
<td></td>
<td>0 0</td>
</tr>
</tbody>
</table>

For each scale, draw a horizontal line through the score obtained for the scale, and fill in the dotted lines below to form a bar graph. The heights of the bars are in Z score units and may be compared with each other and with the severity labels. Note that conversion to percentiles on the right hand axis is approximate only.
## THE GENERAL HEALTH QUESTIONNAIRE

### GHQ28

David Goldberg

(Copyright: see [http://www.qp-training.net/protocol/docs/ghq.doc](http://www.qp-training.net/protocol/docs/ghq.doc))

Please read this carefully.

We should like to know if you have had any medical complaints and how your health has been in general, over the past few weeks. Please answer ALL the questions on the following pages simply by underlining the answer which you think most nearly applies to you. Remember that we want to know about present and recent complaints, not those that you had in the past.

It is important that you try to answer ALL the questions.

Thank you very much for your co-operation.

### Have you recently

<table>
<thead>
<tr>
<th>Question</th>
<th>Better than usual</th>
<th>Same as usual</th>
<th>Worse than usual</th>
<th>Much worse than usual</th>
</tr>
</thead>
<tbody>
<tr>
<td>A1 been feeling perfectly well and in good health?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A2 been feeling in need of a good tonic?</td>
<td>Not at all</td>
<td>No more than usual</td>
<td>Rather more than usual</td>
<td>Much more than usual</td>
</tr>
<tr>
<td>A3 been feeling run down and out of sorts?</td>
<td>Not at all</td>
<td>No more than usual</td>
<td>Rather more than usual</td>
<td>Much more than usual</td>
</tr>
<tr>
<td>A4 felt that you are ill?</td>
<td>Not at all</td>
<td>No more than usual</td>
<td>Rather more than usual</td>
<td>Much more than usual</td>
</tr>
<tr>
<td>A5 been getting any pains in your head?</td>
<td>Not at all</td>
<td>No more than usual</td>
<td>Rather more than usual</td>
<td>Much more than usual</td>
</tr>
<tr>
<td>A6 been getting a feeling of tightness or pressure in your head?</td>
<td>Not at all</td>
<td>No more than usual</td>
<td>Rather more than usual</td>
<td>Much more than usual</td>
</tr>
<tr>
<td>A7 been having hot or cold spells?</td>
<td>Not at all</td>
<td>No more than usual</td>
<td>Rather more than usual</td>
<td>Much more than usual</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Question</th>
<th>Not at all</th>
<th>No more than usual</th>
<th>Rather more than usual</th>
<th>Much more than usual</th>
</tr>
</thead>
<tbody>
<tr>
<td>B1 lost much sleep over worry?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>B2 had difficulty in staying asleep once you are off?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>B3 felt constantly under strain?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>B4 been getting edgy and bad-tempered?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>B5 been getting scared or panicky for no good reason?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>B6 found everything getting on top of you?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>B7 been feeling nervous and strung-up all the time?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Please turn over
<table>
<thead>
<tr>
<th>Have you recently</th>
<th>More so than usual</th>
<th>Same as usual</th>
<th>Rather less than usual</th>
<th>Much less than usual</th>
</tr>
</thead>
<tbody>
<tr>
<td>C1 been managing to keep yourself busy and occupied?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>C2 been taking longer over the things you do?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>C3 felt on the whole you were doing things well?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>C4 been satisfied with the way you've carried out your task?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>C5 felt that you are playing a useful part in things?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>C6 felt capable of making decisions about things?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>C7 been able to enjoy your normal day-to-day activities?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>D1 been thinking of yourself as a worthless person?</td>
<td>Not at all</td>
<td>No more than usual</td>
<td>Rather more than usual</td>
<td>Much more than usual</td>
</tr>
<tr>
<td>D2 felt that life is entirely hopeless?</td>
<td>Not at all</td>
<td>No more than usual</td>
<td>Rather more than usual</td>
<td>Much more than usual</td>
</tr>
<tr>
<td>D3 felt that life isn't worth living?</td>
<td>Not at all</td>
<td>No more than usual</td>
<td>Rather more than usual</td>
<td>Much more than usual</td>
</tr>
<tr>
<td>D4 thought of the possibility that you might make away with yourself?</td>
<td>Definitely not think so</td>
<td>Has crossed my mind</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D5 found at times you couldn't do anything because your nerves were too bad?</td>
<td>Not at all</td>
<td>No more than usual</td>
<td>Rather more than usual</td>
<td>Much more than usual</td>
</tr>
<tr>
<td>D6 found yourself wishing you were dead and away from it all?</td>
<td>Not at all</td>
<td>No more than usual</td>
<td>Rather more than usual</td>
<td>Much more than usual</td>
</tr>
<tr>
<td>D7 found that the idea of taking your own life kept coming into your mind?</td>
<td>Definitely not think so</td>
<td>Has crossed my mind</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
**APPENDIX 6.9**

**GENERAL WELL BEING INDEX**

**PLEASE READ THIS CAREFULLY**

On the following pages you will find some questions asking about how you have been feeling in yourself *during the past two weeks*. Please answer these questions as honestly as you can.

Do not ask anyone else about your answer - just say what you think best applies to you.

The questions below refer to how you have been feeling in the past two weeks.

Just put a tick in the brackets [ ] which is the closest to how you have been feeling.

<table>
<thead>
<tr>
<th>Question</th>
<th>Options</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. During the past two weeks</td>
<td>How have you been feeling in general?</td>
</tr>
<tr>
<td>In very good spirits [ ]</td>
<td>In good spirits mostly [ ]</td>
</tr>
<tr>
<td>I've been up and down a lot [ ]</td>
<td>In low spirits mostly [ ]</td>
</tr>
<tr>
<td>In very low spirits [ ]</td>
<td></td>
</tr>
<tr>
<td>2. During the past two weeks</td>
<td>Have you been bothered by your nerves?</td>
</tr>
<tr>
<td>Very much so [ ]</td>
<td>Quite a bit [ ]</td>
</tr>
<tr>
<td>Sometimes [ ]</td>
<td>A little [ ]</td>
</tr>
<tr>
<td>Not at all [ ]</td>
<td></td>
</tr>
<tr>
<td>3. During the past two weeks</td>
<td>Have you felt in firm control of your actions, thoughts or feelings?</td>
</tr>
<tr>
<td>Yes, definitely [ ]</td>
<td>Yes, mostly [ ]</td>
</tr>
<tr>
<td>Not too well [ ]</td>
<td>No, hardly at [ ]</td>
</tr>
<tr>
<td>Not at all [ ]</td>
<td></td>
</tr>
<tr>
<td>4. During the past two weeks</td>
<td>Have you felt sad, discouraged or hopeless, so much that you wondered if life was worthwhile?</td>
</tr>
<tr>
<td>Very much so [ ]</td>
<td>Quite a bit [ ]</td>
</tr>
<tr>
<td>Sometimes, enough to bother me [ ]</td>
<td>A little bit [ ]</td>
</tr>
<tr>
<td>Not at all [ ]</td>
<td></td>
</tr>
<tr>
<td>5. During the past two weeks</td>
<td>Have you been under any stress or pressure?</td>
</tr>
<tr>
<td>Yes, almost more than I could bare [ ]</td>
<td>Yes, more than usual [ ]</td>
</tr>
<tr>
<td>Yes, about the same as usual [ ]</td>
<td>Yes, a little [ ]</td>
</tr>
<tr>
<td>No, not at all [ ]</td>
<td></td>
</tr>
<tr>
<td>6. During the past two weeks</td>
<td>How happy, pleased or satisfied have you been?</td>
</tr>
<tr>
<td>Very satisfied [ ]</td>
<td>Fairly satisfied [ ]</td>
</tr>
<tr>
<td>Satisfied on the whole [ ]</td>
<td>Rather dissatisfied [ ]</td>
</tr>
<tr>
<td>Very dissatisfied [ ]</td>
<td></td>
</tr>
<tr>
<td>7. During the past two weeks</td>
<td>Have you seriously thought you might be losing control over your thoughts and actions?</td>
</tr>
<tr>
<td>Not at all [ ]</td>
<td>Only a little [ ]</td>
</tr>
<tr>
<td>Not enough to worry about [ ]</td>
<td></td>
</tr>
<tr>
<td>Yes, quite often [ ]</td>
<td>Yes, very often [ ]</td>
</tr>
<tr>
<td>8. During the past two weeks</td>
<td>Have you been anxious, worried or upset?</td>
</tr>
<tr>
<td>Very much so [ ]</td>
<td>Quite a lot [ ]</td>
</tr>
<tr>
<td>Sometimes enough to bother me [ ]</td>
<td>A little bit [ ]</td>
</tr>
<tr>
<td>Not at all [ ]</td>
<td></td>
</tr>
<tr>
<td>9. During the past two weeks</td>
<td>Have you been waking up feeling fresh and rested?</td>
</tr>
<tr>
<td>Every day [ ]</td>
<td>Most days [ ]</td>
</tr>
<tr>
<td>Less than half the time [ ]</td>
<td>Not often [ ]</td>
</tr>
<tr>
<td>Not at all [ ]</td>
<td></td>
</tr>
<tr>
<td>10. During the past two weeks</td>
<td>Have you been bothered by any illness, pains or fears about your health?</td>
</tr>
<tr>
<td>All the time [ ]</td>
<td>A lot of the time [ ]</td>
</tr>
<tr>
<td>Some of the time [ ]</td>
<td>A little bit [ ]</td>
</tr>
<tr>
<td>Not at all [ ]</td>
<td></td>
</tr>
</tbody>
</table>
11. During the past two weeks
Has your daily life been filled with things that interest you?

<table>
<thead>
<tr>
<th>All the time [ ]</th>
</tr>
</thead>
<tbody>
<tr>
<td>Most of the time [ ]</td>
</tr>
<tr>
<td>Some of the time [ ]</td>
</tr>
<tr>
<td>A little [ ]</td>
</tr>
<tr>
<td>Not at all [ ]</td>
</tr>
</tbody>
</table>

12. During the past two weeks
Have you felt disheartened and sad?

<table>
<thead>
<tr>
<th>All of the time [ ]</th>
</tr>
</thead>
<tbody>
<tr>
<td>Most of the time [ ]</td>
</tr>
<tr>
<td>From time to time [ ]</td>
</tr>
<tr>
<td>Very occasionally [ ]</td>
</tr>
<tr>
<td>Not at all [ ]</td>
</tr>
</tbody>
</table>

13. During the past two weeks
Have you felt stable and sure of yourself?

<table>
<thead>
<tr>
<th>All of the time [ ]</th>
</tr>
</thead>
<tbody>
<tr>
<td>Most of the time [ ]</td>
</tr>
<tr>
<td>Some of the time [ ]</td>
</tr>
<tr>
<td>Now and then [ ]</td>
</tr>
<tr>
<td>Not at all [ ]</td>
</tr>
</tbody>
</table>

14. During the past two weeks
Have you felt tired, worn out or exhausted?

<table>
<thead>
<tr>
<th>All of the time [ ]</th>
</tr>
</thead>
<tbody>
<tr>
<td>Most of the time [ ]</td>
</tr>
<tr>
<td>Some of the time [ ]</td>
</tr>
<tr>
<td>Now and then [ ]</td>
</tr>
<tr>
<td>Not at all [ ]</td>
</tr>
</tbody>
</table>

15. During the past two weeks
Did you feel depressed?

<table>
<thead>
<tr>
<th>Yes, very much so [ ]</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes, quite a bit [ ]</td>
</tr>
<tr>
<td>Sometimes, enough to bother me [ ]</td>
</tr>
<tr>
<td>A little depressed now and then [ ]</td>
</tr>
<tr>
<td>No, not at all [ ]</td>
</tr>
</tbody>
</table>

16. During the past two weeks
How tense have you been?

<table>
<thead>
<tr>
<th>Extremely tense all the time [ ]</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very tense most of the time [ ]</td>
</tr>
<tr>
<td>A little tense sometimes [ ]</td>
</tr>
<tr>
<td>Rarely tense [ ]</td>
</tr>
<tr>
<td>Not tense at all [ ]</td>
</tr>
</tbody>
</table>

17. During the past two weeks
Did you feel well enough to do the things you like to do or had to do?

<table>
<thead>
<tr>
<th>Yes, definitely [ ]</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes, for the most part [ ]</td>
</tr>
<tr>
<td>About half the time [ ]</td>
</tr>
<tr>
<td>No, not often [ ]</td>
</tr>
<tr>
<td>No, not at all [ ]</td>
</tr>
</tbody>
</table>

18. During the past two weeks
How much energy or vitality did you have?

<table>
<thead>
<tr>
<th>Lots of energy [ ]</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fairly energetic most of the time [ ]</td>
</tr>
<tr>
<td>Energy varied quite a bit [ ]</td>
</tr>
<tr>
<td>Low in energy mostly [ ]</td>
</tr>
<tr>
<td>No energy at all [ ]</td>
</tr>
</tbody>
</table>

19. During the past two weeks
Have you had any worries or fear about your health?

<table>
<thead>
<tr>
<th>Yes, all the time [ ]</th>
</tr>
</thead>
<tbody>
<tr>
<td>Most of the time [ ]</td>
</tr>
<tr>
<td>From time to time [ ]</td>
</tr>
<tr>
<td>Not a lot [ ]</td>
</tr>
<tr>
<td>Not at all [ ]</td>
</tr>
</tbody>
</table>

20. During the past two weeks
How active and vigorous have you felt?

<table>
<thead>
<tr>
<th>Very active every day [ ]</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mostly active [ ]</td>
</tr>
<tr>
<td>Fairly active [ ]</td>
</tr>
<tr>
<td>Seldom active [ ]</td>
</tr>
<tr>
<td>Not at all active [ ]</td>
</tr>
</tbody>
</table>

21. During the past two weeks
How cheerful have you been?

<table>
<thead>
<tr>
<th>Not cheerful at all [ ]</th>
</tr>
</thead>
<tbody>
<tr>
<td>A little cheerful now and then [ ]</td>
</tr>
<tr>
<td>Cheerful about half the time [ ]</td>
</tr>
<tr>
<td>Mostly quite cheerful [ ]</td>
</tr>
<tr>
<td>Very cheerful all the time [ ]</td>
</tr>
</tbody>
</table>

22. During the past two weeks
How relaxed have you felt?

<table>
<thead>
<tr>
<th>Very relaxed all the time [ ]</th>
</tr>
</thead>
<tbody>
<tr>
<td>Most relaxed [ ]</td>
</tr>
<tr>
<td>Relaxed about half the time [ ]</td>
</tr>
<tr>
<td>Rarely felt relaxed [ ]</td>
</tr>
<tr>
<td>Not at all relaxed [ ]</td>
</tr>
</tbody>
</table>

Thank you for taking the trouble to fill in this questionnaire.
Please go back to the beginning and make sure that you have answered every question on each page.
APPENDIX 6.10

PROBLEMS to GOALS SHEET

a) Write a brief description of what you feel your central problems are at present:-

b) List any activities or situations which you find difficult to tackle or anxiety provoking or that you avoid:-

c) List if possible the aims or goals towards which you wish to work in therapy (e.g. what you would like to be able to do which at present you can’t). Also list short term, medium term and long term goals for the future:
APPENDIX 6.11

a) Patient No. 1:

DASS Pre Score:  D: 11, A: 12, S: 11.

(See DASS Profile Sheet below)

PRE:

Central Problems:
Wants to overcome excessive worrying/checking; putting off doing things; fear of doing wrong (eg paperwork or daily chores); lack of confidence and/or getting things right; being confident at work; also how to deal with family issues.

Specific Difficulties:
Paperwork, working, certain people, family, daily ordinary things/routines.

Goals:
To be able to: have an effective method to address everyday and "out of the blue" situations; not to procrastinate, feel more confident to eliminate over-checking or to return to work feeling more independent; allow myself to make mistakes and take risks; to learn how to deal effectively with family and not be too sensitive.

POST-TREATMENT:

Things that Have Changed: (written comments)
I feel more confident and in control; doing things that I have been putting off; more motivated and energetic; feeling more relaxed as a result of doing relaxation; I’m sorting things out: clearing out documents and “clearing the decks”; able to detach more from the family; realise that I can have fun and don’t need to feel miserable; there’s now part of me that’s able to observe when I’m feeling bad and am able to do something about it; I haven’t had a headache or backache (which she used to); I’m thinking much more positively, am listening to music very much more; have a new and different relationship with my mother and sister; I feel like I’m “winding back” and reclaiming my life; doing what I wish I’d done 20 years ago! I feel like there’s more out there and it’s time to get on.

PATIENT 1: DASS PROFILE SHEET


<table>
<thead>
<tr>
<th>Z Score</th>
<th>4.0</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th>Percentile</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>35</td>
<td>42</td>
<td>34</td>
<td>25</td>
<td>42</td>
<td>41</td>
<td>42</td>
<td>99.5</td>
<td>Extremely</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>33</td>
<td>32</td>
<td>31</td>
<td>23</td>
<td>22</td>
<td>39</td>
<td>40</td>
<td>99</td>
<td>Severe</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>30</td>
<td>29</td>
<td>28</td>
<td>21</td>
<td>20</td>
<td>37</td>
<td>36</td>
<td>98</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>27</td>
<td>26</td>
<td>19</td>
<td>18</td>
<td>33</td>
<td>31</td>
<td>32</td>
<td>95</td>
<td>Moderate</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>25</td>
<td>24</td>
<td>17</td>
<td>16</td>
<td>29</td>
<td>28</td>
<td>27</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>23</td>
<td>22</td>
<td>21</td>
<td>15</td>
<td>25</td>
<td>23</td>
<td>24</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>19</td>
<td>18</td>
<td>13</td>
<td>14</td>
<td>21</td>
<td>22</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>17</td>
<td>16</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
b) Patient No. 2:

(see DASS profile sheet No. 2)

Central Problems: Feels tired and anxious all the time. Finds it very difficult to get up in the mornings, knows how life wants to be but not how to achieve that life. Tired of all the selfishness in the world and does not know what his/her place is within such a society. Is resentful of everything that she does and just wants some peace and happiness.

Specific Difficulties: Work, confronting people, functioning generally and relating to people (other than friends and family)

Goals: To get out of the cycle that she keeps finding themselves in. Wants to find the balance between looking after themselves without being selfish. Wants to stop feeling so sad and crying all the time. Wants to live a worthwhile and fulfilling life and help people while not losing themselves in the process. Wants to stop feeling responsible for everything and everyone without feeling like they are letting people down.

Things that Have Changed: (written comments)
I feel just amazing. I feel much freer and lighter now. The more I put myself out there the more fulfilled I feel. I'm being much more proactive, I'm now getting good feedback from people. I now feel much more valued at work, I've got really interesting plans and I'm carrying them out. Something has happened in me to trigger thinking differently and creatively. I now have so much more freedom and feel much more positive and free with the family. I'm doing things on my terms now and things have just opened up "out of nowhere."

PATIENT 2: DASS PROFILE SHEET
For each scale, draw a horizontal line through the score obtained for the scale, and fill in the dotted lines below to form a bar graph. The heights of the bars are in Z score units and may be compared with each other and with the severity labels. Note that conversion to percentiles on the right hand axis is approximate only.
APPENDIX 6.12

PATIENT SATISFACTION SURVEY

The purpose of this survey is to enable us to improve the quality of the services we offer. All information on this form is entirely confidential and any statistics developed from this information will not be identifiable.

Please circle the response that is closest from 1 (strongly agree) to 5 (strongly disagree)

<table>
<thead>
<tr>
<th></th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Neutral</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. I was pleased my Doctor referred me to a Clinical Psychologist</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>2. The opportunity to see a Clinical Psychologist in my Doctor’s practice was a helpful experience</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>3. Seeing the Clinical Psychologist helped to relieve my symptom(s) or problem(s)</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>4. I felt listened to and understood by the Clinical Psychologist</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>5. I felt involved in my assessment and treatment</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>6. I feel I received the right treatment for my presenting problem</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>7. The Clinical Psychologist gave me some explanation and understanding of my condition</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>8. Because of therapy I am now able to deal more effectively with my problem(s)</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>9. I would recommend this therapist to others</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>10. I felt more comfortable seeing a Clinical Psychologist in the Doctor’s practice rather than being referred to another place</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>11. I would have sought treatment from a Psychologist even if the Doctor had not referred me</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>12. The Doctor attended part of my first session</td>
<td>YES</td>
<td>NO</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
13. If yes, was this helpful? YES / NO

14. In what way was it helpful? ____________________________________________________________

15. Had you received counselling or other treatment elsewhere for the same problems? YES / NO

16. If so was this provided by:
(tick)
- [ ] Counsellor
- [ ] Psychologist
- [ ] GP
- [ ] Psychiatrist
- [ ] Other

17. Compared to this earlier treatment was the previous treatment:
   a) More helpful
   b) about the same
   c) Less helpful

Why? ____________________________________________________________

18. The typical fee for Clinical Psychology services is normally around $100 per session. Would you seek the services of a Clinical Psychologist in a similar setting if there were such a fee involved? YES / NO

Would such a fee be a problem? YES / NO

19. How would you describe your sessions with the Clinical Psychologist? ____________________________________________________________

20. Please list any changes/improvements you have noted as a result of your sessions with the Clinical Psychologist, i.e. ways do you think you are better? (please be as specific as possible):

21. Any other comments?

Thank you for filling out and returning this survey.

Name and address (optional): ____________________________________________________________

311
Dear Doctor,

We are currently undertaking a study funded by the Commonwealth Department of Health and Aged Care entitled “Clinical Psychology in Rural General Practice”. Specifically, the aim of the study is to assess the potential role of Clinical Psychologists in General Practice in facilitating the treatment of stress, anxiety and depression. We are working in collaboration with the NSW Central West Division of General Practice.

As part of this study we are assessing General Practitioners’ attitudes to the treatment of mental health and whether collaborative treatment options such as the one outlined above could be of use in your practice. We would be grateful if you could fill out the questionnaire below and return it in the stamped addressed envelope.

Thank you for your assistance. If you have any questions about the study please contact us on (02) 6338 4694.

Robyn F. Vines
Senior Clinical Psychologist
Charles Sturt University

Professor Don Thomson
Professor of Psychology
Charles Sturt University

---

1. How long have you been a GP? 
   .........(Years)

2. How long have you been working in your current practice? 
   .........(Years)

3. What percentage of your patients do you estimate have mental health problems/difficulties as a significant component of their overall health? (please tick a box)
   <10% □  10-30% □  30-50% □  50-70% □  70+% □

4. Do you feel your formal training adequately prepares you for dealing with mental health problems? (please tick a box)
   a. Not at all... □.
   b. Not very.... □
   c. Somewhat.... □
   d. Very.... □

5. How comfortable are you in dealing with mental health problems? (please tick a box)
   a. Not at all.... □
   b. Not very.... □
   c. Somewhat.... □
   d. Very.... □

6. Do you feel you have adequate time to see patients with mental health difficulties? (please tick a box)
   a. Yes... □
   b. No... □

7. Would you like to become more involved in the treatment of mental health problems? (please tick a box)
   a. Yes... □
   b. No... □

8. For what proportion of patients with a mental health problem do you estimate you prescribe medication as treatment? (please tick a box)
   <10% □  10-30% □  30-50% □  50-70% □  70+% □
9. Do you most frequently prescribe medication for mental health problems...?
   (Please tick a box)
   a. as the sole treatment...☐
   b. in conjunction with...☐
      counselling provided by yourself
   c. in conjunction with treatment...☐
      provided by another mental health professional

10. Please Rank in order to whom you most frequently refer to for mental health issues
    (1 most frequent; 5 least frequent)
    a. Counsellor.........☐
    d. Psychiatrist.........☐
    b. Psychologist.........☐
    e. Other .................
    c. Clinical Psychologist....☐

11. Do you know the difference between a Psychologist and Clinical Psychologist? (please tick a box)
    a. Yes....☐
    b. No....☐

    Please elaborate: ........................................................................................................................................................................

12. Please Rank in order which of the following you would prefer to refer to (putting aside cost,
    service availability, etc..) (1 most frequent; 5 least frequent)
    a. Counsellor.........☐
    d. Psychiatrist.........☐
    b. Psychologist.........☐
    e. Other .................
    c. Clinical Psychologist....☐

    Comments: ........................................................................................................................................................................

13. Please Rank in order the main reasons why you may not have referred patients with mental health issues to a clinical psychologist (1 most frequent; 5 least frequent)
    a. I can treat patient's psychological problems myself...................☐
    b. I have no clear idea of what a clinical psychologist can provide...☐
    c. There are no clinical psychologists available..........................☐
    d. Patients want drug treatment for psychological problems...........☐
    e. patients reject referral....☐
       to any mental health specialist
    f. patients can't afford....☐
       treatment fees
    d. Other......................

14. How useful would it be to have a clinical psychologist as a part of a multidisciplinary team in your practice? (please tick a box)
    a. Not at all...☐
    b. Not very...☐
    c. Somewhat...☐
    d. Very...☐

15. Other Comments: ........................................................................................................................................................................

...................................................................................................................................................................

Name: .................................................................  Practice: .................................................................

Thank you
Clinical Psychologists in General Practice Survey

Dear Doctor,

We are currently undertaking a study funded by the Commonwealth Department of Health and Aged Care entitled “Clinical Psychology in Rural General Practice”. Specifically, the aim of the study is to assess the potential role of Clinical Psychologists in General Practice in facilitating the treatment of stress, anxiety and depression. We are working in collaboration with the NSW Central West Division of General Practice.

As part of this study we are assessing General Practitioners’ attitudes to the treatment of mental health and whether collaborative treatment options such as the one outlined above could be of use in your practice. We would be grateful if you could fill out the questionnaire below and return it in the stamped addressed envelope.

Thank you for your assistance. If you have any questions about the study please contact us on (02) 6338 4694.

Robyn F. Vines
Senior Clinical Psychologist
Charles Sturt University

Professor Don Thomson
Professor of Psychology
Charles Sturt University

1. How long have you been a GP? ............(Years)

2. How long have you been working in your current practice? .........(Years)

3. G) What percentage of your patients do you estimate have mental health problems/difficulties as a significant component of their overall health? (please tick a box)

   <10% □  10-30% □  30-50% □  50-70% □  70+% □

4. Do you feel your formal training adequately prepares you for dealing with mental health problems? (please tick a box)

   a. Not at all...□  b. Not very...□  c. Somewhat...□  d. Very...□

5. How comfortable are you in dealing with mental health problems? (please tick a box)

   a. Not at all...□  b. Not very...□  c. Somewhat...□  d. Very...□

6. Do you feel you have adequate time to see patients with mental health difficulties? (please tick a box)

   a. Yes...□  b. No...□

7. Would you like to become more involved in the treatment of mental health problems? (please tick a box)

   a. Yes...□  b. No...□
8. For what proportion of patients with a mental health problem do you estimate you prescribe medication as treatment? (please tick a box)

- [ ] <10%
- [ ] 10-30%
- [ ] 30-50%
- [ ] 50-70%
- [ ] 70+

9. Do you most frequently prescribe medication for mental health problems...
(Please tick a box)

- [ ] a. as the sole treatment...
- [ ] b. in conjunction with...
- [ ] c. in conjunction with treatment...
  counselling provided by yourself
  provided by another mental health professional

10. PLEASE RANK IN ORDER TO WHOM YOU MOST FREQUENTLY REFER TO FOR MENTAL HEALTH ISSUES
(1 most frequent, 5 least frequent)

- [ ] a. Counsellor
- [ ] b. Psychologist
- [ ] c. Clinical Psychologist
- [ ] d. Psychiatrist
- [ ] e. Other

- Comments

11. Do you know the difference between a Psychologist and Clinical Psychologist? (please tick a box)

- [ ] a. Yes
- [ ] b. No

Please elaborate:

__________________________________________________________________________

12. Please Rank in order which of the following you would prefer to refer to (putting aside cost, service availability, etc.) (1 most frequent, 5 least frequent)

- [ ] a. Counsellor
- [ ] b. Psychologist
- [ ] c. Clinical Psychologist
- [ ] d. Psychiatrist
- [ ] e. Other

- Comments

13. Please Rank in order the main reasons why you may not have referred patients with mental health issues to a clinical psychologist (1 most frequent; 5 least frequent)

- [ ] a. I can treat patient’s psychological problems myself
- [ ] b. I have no clear idea of what a clinical psychologist can provide...
- [ ] c. There are no clinical psychologists available...
- [ ] d. Patients want drug treatment for psychological problems...
- [ ] e. patients reject referral... to any mental health specialist
- [ ] f. patients can’t afford treatment fees
- [ ] g. Other...

14. How useful would it be to have a clinical psychologist as a part of a multidisciplinary team in your practice? (please tick a box)

- [ ] a. Not at all
- [ ] b. Not very
- [ ] c. Somewhat
- [ ] d. Very

15. Other Comments

__________________________________________________________________________

Name: ____________________________  Practice: ____________________________

Thank you

315
APPENDIX 6.15

CLINICAL PSYCHOLOGY FORM

TREATMENT PLAN AND DISCHARGE SUMMARY

Date: 

Client Name: 

Clinical Psychologist: Referral by: 

Dates seen: 

Date of initial session: Date last seen: 

Psychotropic Medication: Duration: 

Presenting Problem: 

Formulation: 

Treatment Plan: 

Related Physical Health/Psychosocial Factors: 

Other Services/Professionals Involved: 

Outcome Measures:

<table>
<thead>
<tr>
<th>Outcome Measure</th>
<th>Pre (Date: / / )</th>
<th>Post (Date: / / )</th>
<th>Follow Up (Date: / / )</th>
</tr>
</thead>
<tbody>
<tr>
<td>DASS - Depression</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>DASS - Anxiety</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>DASS - Stress</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>DASS - Total</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>GHQ - Total</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>GWB - Total</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Outcome Rating

☐ Worse
☐ No Change
☐ Slight Improvement
☐ Moderate Improvement
☐ Much Improvement

Termination

☐ Left treatment without consultation
☐ Patient terminated against advice from therapist
☐ Mutually agreed termination
☐ Referred on (Give details):

General Outcome:

Risk Assessment:

Further management plans:
APPENDIX 6.16

DOCTOR OR MASTER OF PSYCHOLOGY (Clinical or Forensic)

EVALUATION OF PLACEMENT EXPERIENCE (EPE)

[STUDENT'S RATING FORM] Placement [PSY ]

Student: ________________________________ Date: _________________________

Field Supervisor(s): _______________________________________________________

Placement Setting: _______________________________________________________

PLEASE CIRCLE THE RATINGS WHICH APPLY TO EACH ASPECT OF THE PLACEMENT EXPERIENCE. SOME VARIABLES TO CONSIDER WHEN MAKING EACH RATING ARE PROVIDED.

N/A = not applicable
1 = extremely unsatisfactory
2 = poor
3 = satisfactory
4 = good
5 = very good

1. PROFESSIONAL/MANAGERIAL ASPECTS

a) Induction (meeting people, understanding the work, the organisation and its context).

N/A 1 2 3 4 5

b) Provision of Information (regarding the organisation, local procedures, local networks and referral systems, etc.)

N/A 1 2 3 4 5

c) Physical Setting (rooms, desk space, access to tests, equipment, and facilities)

N/A 1 2 3 4 5

d) Contract (present/absent, negotiated, thorough/sparse goals and expectations clear/unclear)

N/A 1 2 3 4 5

e) Organisation/Planning (of tasks and activities)

N/A 1 2 3 4 5

f) Mid-Placement Review (present/absent, prepared for/not prepared for)

N/A 1 2 3 4 5
g) Ending (sufficient help, feedback, ending marked)

N/A 1 2 3 4 5

2. SUPERVISION

a) Access and Arrangements (amount, reliability, availability, and approachability)

N/A 1 2 3 4 5

317
b) Theory/Practice Links (directed to appropriate reading, models made explicit)
N/A 1 2 3 4 5

c) Nature of Clinical Advice (appropriate to level, flexible, alternative approaches)
N/A 1 2 3 4 5

d) Guidance Given (on treatment techniques, case management, test administration, interpretation, report writing, etc.)
N/A 1 2 3 4 5

e) Methods of Teaching (variety, including didactic, mutual observation, joint work)
N/A 1 2 3 4 5

f) Provision of Feedback on Performance (constructive or not, sufficient or insufficient amount, overly positive or overly negative, both unprompted and on request)
N/A 1 2 3 4 5

3. RELATIONSHIP ISSUES

a) Support (with difficult cases, with colleagues, with own feelings)
N/A 1 2 3 4 5

b) Mutuality (sharing ideas, encouraging expression of ideas)
N/A 1 2 3 4 5

c) Encouragement (adapted to trainee level, moves toward autonomy facilitated, positive aspects noted)
N/A 1 2 3 4 5

4. EXPERIENCE PROVIDED

a) Case Work (under/over demanding, range, depth, choice)
N/A 1 2 3 4 5

Comment to clarify rating: ___________________________________________

b) Work Load (too much/too little, balance, choice)
N/A 1 2 3 4 5

Comment to clarify rating: ___________________________________________
c) **Liaison with Other Professionals** (opportunity, nature of, relationships with other disciplines clarified or not)

N/A 1 2 3 4 5

d) **Non-clinical work** (e.g., teaching roles, administration, liaison with other staff, research)

N/A 1 2 3 4 5

5. **OVERALL RATING**

Please provide an overall rating of the placement experience by ticking the most appropriate statement given below.

- [ ] an excellent placement experience
- [ ] a very good placement experience
- [ ] a satisfactory placement experience
- [ ] a disappointing placement experience
- [ ] an unpleasant/negative placement experience

6. **GENERAL COMMENTS OF THE STUDENT:**

a) What aspects of the placement were particularly beneficial to your learning experience?

b) What would you consider to be the particular strengths of the placement?

c) What aspects of the placement and/or supervision would you like to see improved?

7. **GENERAL COMMENTS OF THE FIELD SUPERVISOR:**

Student's Signature: ___________________________ Date: ___________

Field Supervisor's Signature: _______ Date

319
APPENDIX 6.17

CLINICAL PSYCHOLOGY IN GENERAL PRACTICE
REGISTRAR PLACEMENT QUESTIONNAIRE

Dear Clinical Psychologist/Clinical Psychology Registrar,

We are writing to ask you to fill out the following questionnaire about your Clinical Placement through the Clinical Psychology in General Practice Project. We would like to hear about your experience of the internship, as part of an evaluation of Clinical Psychology Registrarships and their effectiveness in training people to work collaboratively with GPs in the Primary Care setting. We also want to gain feedback from those who have worked within the new model of collaborative care for patients with common mental disorders in General Practice.

If you could return the completed questionnaire to Michelle Kluin via e-mail (mkluin@csu.edu.au) or fax (02) 6338 4966 by Thursday 8th July we would be most grateful.

Thank you for help with the evaluation. If you have any queries about the questionnaire please contact us on (02) 6338 4858.

Robyn F. Vines
Senior Research Fellow
Charles Sturt University

Professor Don Thomson
Professor of Psychology
Charles Sturt University

1. Which placement did you undertake?
   a) MPsy  o  Full-time  o  Part-time  o
   b) DPsych  o  Full-time  o  Part-time  o

2. What year of your degree were you in whilst on placement on the Project?

3. Were you a Registered Psychologist at the time of your placement?  Yes  o  No  o

4. Location of your Placement:

5. Placement Goals:
   (Please indicate the importance of the following goals (Yes/No) next to each goal below and fill out additional ones that were crucial in your placement):

   i) to observe, participate and develop confidence in fulfilling a Clinical Psychologist’s role in the General Practice setting;  Yes/No
   ii) to enhance clinical skills in assessment, diagnosis and treatment of a variety of disorders, particularly the high prevalence disorders of depression and anxiety;  Yes/No
   iii) to develop a collaborative professional relationship with primary care practitioners (ie. GPs);  Yes/No
   iv) to develop skills relevant to the promotion of Clinical Psychology within the public-health field;  Yes/No
   v) to develop the capacity to perform as a “scientist practitioner” in the Primary Care setting.  Yes/No
   vi) Other (please elaborate): .................................................................

6. PLACEMENT ORIENTATION.  Please rank the following (1= poor, 5 = Excellent)

   a) Information provided (about model of collaborative mental health service delivery, the Division of GPs, General Practices and Practitioners, etc.)

       1  2  3  4  5

   b) Organisation and Planning (of placement, procedures, networks, referral systems, etc.)

       1  2  3  4  5

   Comments:

7. SUPERVISION.  Please rank the following (1= poor, 5 = excellent)

   a) Supervision (amount, reliability, availability, and approachability of supervisor)
b) Theory/Practice (collaborative model made explicit, appropriate input for patients seen, directed to appropriate reading, etc)

c) Nature of Clinical Advice (appropriate, flexible, alternative approaches)

d) Guidance Given (treatment techniques, case management, interpretation and report writing)

e) Methods of Teaching (variety: including didactic, observation)

f) Provision of Feedback (constructive, sufficient, positive)

Comments:

8. CLINICAL EXPERIENCE

a) Was your Placement experience: (1 = poor, 5 = excellent)

Please elaborate:

b) Work Load

Too demanding o Adequate o Under demanding o

c) Compared to other Clinical Placements experiences, how does this one rank
(from 1 = poorest placement to 5 = the best placement undertaken during clinical training)

Comments:

9. WORKING IN THE GENERAL PRACTICE SETTING

a) Do you think that the provision of psychological services within the General Practice setting improves mental health service delivery for patients?

Please elaborate:

b) Did you find working with the General Practitioner beneficial to your professional practice?

Please elaborate:

c) Comments from patients about this psychological service within the General Practice setting was generally:

Very positive o Positive o Neutral o Negative o Very Negative o

Please elaborate:
d) What aspects of the placement were particularly beneficial in your learning?


e) What would you consider to be the particular strengths of the placement?


f) What aspects of the placement and/or supervision would you like to see improved?


g) Did you achieve the required goals and objectives during the placement? (please refer to the Placement Goals listed above under 5)

i) Confidence as a primary care psychologist: Yes o No o

ii) Enhanced clinical skills: Yes o No o

iii) Collaborative professional relationships: Yes o No o

iv) Promotional skills for the profession: Yes o No o

v) Capacity to be a “scientist-practitioner” Yes o No o

vi) Other: Yes o No o

Please elaborate:


h) Are you, as a consequence of this Placement, now working in the primary care setting? Yes o No o

i) If yes, in which geographic setting?

   Metropolitan o Rural o Regional o

j) If No, are you planning/hoping to work in the Primary Care setting in the future? Yes o No o

k) If yes, in which geographic setting?

   Metropolitan o Rural o Regional o

10. ANY OTHER GENERAL COMMENTS:


Age: ___________________________ Gender: Male o Female o

Name (optional): ___________________________ Date: ___________________________

THANK YOU FOR FILLING OUT THIS QUESTIONNAIRE.
APPENDIX 6.18

CLIENT CASE REGISTER

Name of consulting health professional

<table>
<thead>
<tr>
<th>No</th>
<th>Name</th>
<th>Address/Phone Number</th>
<th>Age/d.o.b</th>
<th>M/F</th>
<th>Referring GP</th>
<th>Referral Date</th>
<th>Referring problem</th>
<th>Meds</th>
<th>Dates Seen</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

From: Robyn Vines: "Clinical Psychology in General Practice Project"
Australian Government Department of Health and Ageing
GP PATIENT REFERRAL FORM

Name of Patient/Client: .................................................................

Telephone No. : ......................... Age: ......................... Male / Female

Reason for Referral/Referring Problem: ......................................................

........................................................................................................

Provisional Diagnosis (?): ......................................................................

Clinical Psychologist to whom Patient is Referred: ...................................

Date of Referral: .................................................................

Referring Doctor: ........................................................................

........................................................................................................

--------------------------------------------------------------------------

GP PATIENT REFERRAL FORM

Name of Patient/Client: ...........................................................................

Telephone No. : ......................... Age: ......................... Male / Female

Reason for Referral/Referring Problem: ......................................................

........................................................................................................

Provisional Diagnosis (?): ......................................................................

Clinical Psychologist to whom Patient is Referred: ...................................

Date of Referral: .................................................................

Referring Doctor: ........................................................................

........................................................................................................
APPENDIX D
CHAPTER 7: RESULTS

7.1 Early analysis by gender of Bathurst treatment and control patients’ mean pre-test scores.

7.2 Results in relation to medication as a factor:

7.2a: Medication: Mean scores on pre-test measures for control and treatment group members by whether or not they were taking medication

7.2b: Mean Difference Scores for Treatment and Control Group Patients by Use of Medication

7.2c: T-test of difference scores (pre-test minus post-test) for control group Bathurst patients with both pre-Test and post-test scores

7.2d: T-test of difference scores (pre-test minus post-test) for treatment group Bathurst patients with both pre-test and post-test scores

7.3 Analysis of variance (ANOVAS):

7.3a: Pre-test scores by three factors: Condition (1,2 ie. treatment vs. control); Location (1,2,3) and Gender (1,2)

7.3b: Difference scores between pre- and post-test scores by three factors: Condition (1,2), Location (1,2,3) and Gender (1,2)
### Appendix 7.1: Early analysis by gender of Bathurst treatment and control patients’ mean pre-test scores

<table>
<thead>
<tr>
<th>Group</th>
<th>Patient sex</th>
<th>Anxiety</th>
<th>Depression</th>
<th>Stress</th>
<th>Composite</th>
<th>General</th>
<th>GHQ Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Control</td>
<td>Male</td>
<td>Mean</td>
<td>9.1</td>
<td>11.0</td>
<td>15.3</td>
<td>35.4</td>
<td>52.7</td>
</tr>
<tr>
<td></td>
<td></td>
<td>N</td>
<td>27</td>
<td>27</td>
<td>27</td>
<td>27</td>
<td>30</td>
</tr>
<tr>
<td></td>
<td>Female</td>
<td>Mean</td>
<td>6.1</td>
<td>6.8</td>
<td>11.0</td>
<td>23.9</td>
<td>56.1</td>
</tr>
<tr>
<td></td>
<td></td>
<td>N</td>
<td>72</td>
<td>72</td>
<td>72</td>
<td>72</td>
<td>73</td>
</tr>
<tr>
<td>Treatment</td>
<td>Male</td>
<td>Mean</td>
<td>13.0</td>
<td>17.1</td>
<td>17.6</td>
<td>47.6</td>
<td>38.2</td>
</tr>
<tr>
<td></td>
<td></td>
<td>N</td>
<td>23</td>
<td>23</td>
<td>23</td>
<td>23</td>
<td>21</td>
</tr>
<tr>
<td></td>
<td>Female</td>
<td>Mean</td>
<td>15.3</td>
<td>20.9</td>
<td>22.9</td>
<td>59.3</td>
<td>36.6</td>
</tr>
<tr>
<td></td>
<td></td>
<td>N</td>
<td>90</td>
<td>90</td>
<td>89</td>
<td>89</td>
<td>87</td>
</tr>
</tbody>
</table>
### APPENDIX 7.2

**RESULTS IN RELATION TO MEDICATION AS A FACTOR**

Appendix 7.2a): Mean scores on pre-test measures for Control and Treatment Group members by Whether or Not They Took Medication for the Treatment of Psychological Conditions

<table>
<thead>
<tr>
<th>Group</th>
<th>Any medication for psych treatment?</th>
<th>DASS Anxiety</th>
<th>DASS Depression</th>
<th>DASS Stress</th>
<th>GWBI</th>
<th>GHQ Total</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Control</strong></td>
<td>Not known, because patient name not provided</td>
<td>Mean 5.00</td>
<td>5.50</td>
<td>11.00</td>
<td>53.00</td>
<td>21.50</td>
</tr>
<tr>
<td></td>
<td>N 2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Took medication</td>
<td>Mean 11.39</td>
<td>12.83</td>
<td>17.35</td>
<td>46.83</td>
<td>31.95</td>
<td></td>
</tr>
<tr>
<td></td>
<td>N 23</td>
<td>23</td>
<td>23</td>
<td>23</td>
<td>22</td>
<td></td>
</tr>
<tr>
<td>Did not take medication</td>
<td>Mean 5.25</td>
<td>6.56</td>
<td>10.72</td>
<td>56.34</td>
<td>20.84</td>
<td></td>
</tr>
<tr>
<td></td>
<td>N 61</td>
<td>61</td>
<td>61</td>
<td>65</td>
<td>64</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Std. Deviation 6.911</td>
<td>7.788</td>
<td>7.944</td>
<td>16.244</td>
<td>11.588</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>Mean 6.88</td>
<td>8.21</td>
<td>12.50</td>
<td>53.83</td>
<td>23.64</td>
<td></td>
</tr>
<tr>
<td></td>
<td>N 86</td>
<td>86</td>
<td>86</td>
<td>90</td>
<td>88</td>
<td></td>
</tr>
<tr>
<td><strong>Treatment</strong></td>
<td>Not known, because patient name not provided</td>
<td>Mean 16.90</td>
<td>20.60</td>
<td>23.05</td>
<td>35.80</td>
<td>42.50</td>
</tr>
<tr>
<td></td>
<td>N 20</td>
<td>20</td>
<td>20</td>
<td>20</td>
<td>20</td>
<td></td>
</tr>
<tr>
<td>Took medication</td>
<td>Mean 17.41</td>
<td>23.09</td>
<td>23.07</td>
<td>34.37</td>
<td>40.77</td>
<td></td>
</tr>
<tr>
<td></td>
<td>N 55</td>
<td>55</td>
<td>53</td>
<td>52</td>
<td>53</td>
<td></td>
</tr>
<tr>
<td>Did not take medication</td>
<td>Mean 14.72</td>
<td>20.87</td>
<td>22.62</td>
<td>35.60</td>
<td>41.10</td>
<td></td>
</tr>
<tr>
<td></td>
<td>N 60</td>
<td>60</td>
<td>60</td>
<td>55</td>
<td>58</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Std. Deviation 10.268</td>
<td>11.588</td>
<td>10.415</td>
<td>14.897</td>
<td>15.102</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>Mean 16.14</td>
<td>21.73</td>
<td>22.86</td>
<td>35.13</td>
<td>41.18</td>
<td></td>
</tr>
<tr>
<td></td>
<td>N 135</td>
<td>135</td>
<td>133</td>
<td>127</td>
<td>131</td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>Not known, because patient name not provided</td>
<td>Mean 15.82</td>
<td>19.23</td>
<td>21.95</td>
<td>37.36</td>
<td>40.59</td>
</tr>
<tr>
<td></td>
<td>N 22</td>
<td>22</td>
<td>22</td>
<td>22</td>
<td>22</td>
<td></td>
</tr>
<tr>
<td>Took medication</td>
<td>Mean 15.64</td>
<td>20.06</td>
<td>21.34</td>
<td>38.19</td>
<td>38.19</td>
<td></td>
</tr>
<tr>
<td></td>
<td>N 78</td>
<td>78</td>
<td>76</td>
<td>75</td>
<td>75</td>
<td></td>
</tr>
<tr>
<td>Did not take medication</td>
<td>Mean 9.94</td>
<td>13.65</td>
<td>16.62</td>
<td>48.83</td>
<td>30.48</td>
<td></td>
</tr>
<tr>
<td></td>
<td>N 121</td>
<td>121</td>
<td>121</td>
<td>120</td>
<td>122</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Std. Deviation 9.874</td>
<td>12.311</td>
<td>11.025</td>
<td>18.112</td>
<td>16.056</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>Mean 12.54</td>
<td>16.47</td>
<td>18.79</td>
<td>42.89</td>
<td>34.13</td>
<td></td>
</tr>
<tr>
<td></td>
<td>N 221</td>
<td>221</td>
<td>219</td>
<td>217</td>
<td>219</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Std. Deviation 10.857</td>
<td>12.941</td>
<td>11.315</td>
<td>18.847</td>
<td>18.026</td>
<td></td>
</tr>
</tbody>
</table>

**MEANS:** TABLES=dskdf ddfdf dsdfs dfdf df dglf ghdfgh dhfghf BY group BY anyamed CELLS MEAN COUNT STDDEV .
## Appendix 7.2b: Mean Difference Scores for Treatment and Control Group Patients, by Use of Medication

<table>
<thead>
<tr>
<th>Group</th>
<th>Any medication for psych treatment?</th>
<th>dadif</th>
<th>ddif</th>
<th>dsdiff</th>
<th>gwbdiff</th>
<th>ghqdf</th>
</tr>
</thead>
<tbody>
<tr>
<td>Control</td>
<td>Not known, because patient name not provided</td>
<td>Mean</td>
<td>6.00</td>
<td>0.00</td>
<td>4.00</td>
<td>-18.00</td>
</tr>
<tr>
<td></td>
<td></td>
<td>N</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Std. Deviation</td>
<td>.</td>
<td>.</td>
<td>.</td>
<td>.</td>
</tr>
<tr>
<td>Took medication</td>
<td>Mean</td>
<td>36</td>
<td>1.00</td>
<td>1.00</td>
<td>-3.38</td>
<td>2.62</td>
</tr>
<tr>
<td></td>
<td>N</td>
<td>14</td>
<td>14</td>
<td>14</td>
<td>13</td>
<td>13</td>
</tr>
<tr>
<td>Did not take medication</td>
<td>Mean</td>
<td>2.65</td>
<td>2.04</td>
<td>1.52</td>
<td>-2.13</td>
<td>.70</td>
</tr>
<tr>
<td></td>
<td>N</td>
<td>23</td>
<td>23</td>
<td>23</td>
<td>23</td>
<td>23</td>
</tr>
<tr>
<td></td>
<td>Std. Deviation</td>
<td>6.450</td>
<td>6.977</td>
<td>5.984</td>
<td>12.263</td>
<td>17.065</td>
</tr>
<tr>
<td>Total</td>
<td>Mean</td>
<td>1.89</td>
<td>1.76</td>
<td>1.39</td>
<td>-3.00</td>
<td>1.86</td>
</tr>
<tr>
<td></td>
<td>N</td>
<td>38</td>
<td>38</td>
<td>38</td>
<td>37</td>
<td>37</td>
</tr>
<tr>
<td>Treatment</td>
<td>Not known, because patient name not provided</td>
<td>Mean</td>
<td>11.07</td>
<td>14.33</td>
<td>15.20</td>
<td>-26.13</td>
</tr>
<tr>
<td></td>
<td></td>
<td>N</td>
<td>15</td>
<td>15</td>
<td>15</td>
<td>14</td>
</tr>
<tr>
<td></td>
<td>Std. Deviation</td>
<td>7.611</td>
<td>11.412</td>
<td>10.248</td>
<td>18.578</td>
<td>19.975</td>
</tr>
<tr>
<td>Took medication</td>
<td>Mean</td>
<td>8.22</td>
<td>11.40</td>
<td>8.77</td>
<td>-23.25</td>
<td>18.77</td>
</tr>
<tr>
<td></td>
<td>N</td>
<td>26</td>
<td>26</td>
<td>24</td>
<td>24</td>
<td>26</td>
</tr>
<tr>
<td>Did not take medication</td>
<td>Mean</td>
<td>9.71</td>
<td>15.91</td>
<td>13.29</td>
<td>-28.15</td>
<td>27.23</td>
</tr>
<tr>
<td></td>
<td>N</td>
<td>24</td>
<td>23</td>
<td>24</td>
<td>20</td>
<td>22</td>
</tr>
<tr>
<td>Total</td>
<td>Mean</td>
<td>9.43</td>
<td>13.71</td>
<td>12.02</td>
<td>-25.64</td>
<td>22.79</td>
</tr>
<tr>
<td></td>
<td>N</td>
<td>65</td>
<td>64</td>
<td>63</td>
<td>59</td>
<td>62</td>
</tr>
<tr>
<td></td>
<td>Std. Deviation</td>
<td>10.529</td>
<td>11.022</td>
<td>9.953</td>
<td>16.565</td>
<td>17.496</td>
</tr>
<tr>
<td>Total</td>
<td>Not known, because patient name not provided</td>
<td>Mean</td>
<td>10.75</td>
<td>13.81</td>
<td>14.50</td>
<td>-25.63</td>
</tr>
<tr>
<td></td>
<td></td>
<td>N</td>
<td>16</td>
<td>16</td>
<td>16</td>
<td>16</td>
</tr>
<tr>
<td></td>
<td>Std. Deviation</td>
<td>7.461</td>
<td>11.220</td>
<td>10.289</td>
<td>18.062</td>
<td>19.280</td>
</tr>
<tr>
<td>Took medication</td>
<td>Mean</td>
<td>5.47</td>
<td>7.76</td>
<td>5.91</td>
<td>-16.27</td>
<td>13.38</td>
</tr>
<tr>
<td></td>
<td>N</td>
<td>40</td>
<td>40</td>
<td>38</td>
<td>37</td>
<td>39</td>
</tr>
<tr>
<td>Did not take medication</td>
<td>Mean</td>
<td>6.26</td>
<td>8.98</td>
<td>7.53</td>
<td>-14.23</td>
<td>13.67</td>
</tr>
<tr>
<td></td>
<td>N</td>
<td>47</td>
<td>46</td>
<td>47</td>
<td>43</td>
<td>45</td>
</tr>
<tr>
<td>Total</td>
<td>Mean</td>
<td>6.65</td>
<td>9.28</td>
<td>8.02</td>
<td>-16.92</td>
<td>14.97</td>
</tr>
<tr>
<td></td>
<td>N</td>
<td>103</td>
<td>102</td>
<td>101</td>
<td>96</td>
<td>99</td>
</tr>
</tbody>
</table>

**MEANS**

`TABLES=dadif ddif dsdiff gwbdiff ghqdf BY group BY anymed`  
`CELLS MEAN COUNT STDEV`.
### Appendix 7.2c: T-test of difference scores (pre-test minus post-test) for control group Bathurst patients with both pre-test and post-test scores

<table>
<thead>
<tr>
<th>Any medication for psych treatment?</th>
<th>N</th>
<th>Mean</th>
<th>Difference in Means</th>
<th>t</th>
<th>Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>DASS Anxiety DIFF</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Took medication</td>
<td>14</td>
<td>.36</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Did not take medication</td>
<td>23</td>
<td>2.65</td>
<td>-2.29</td>
<td>-1.027</td>
<td>0.311</td>
</tr>
<tr>
<td>DASS Depression DIFF</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Took medication</td>
<td>14</td>
<td>1.00</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Did not take medication</td>
<td>23</td>
<td>2.04</td>
<td>-1.04</td>
<td>-0.480</td>
<td>0.648</td>
</tr>
<tr>
<td>DASS Stress DIFF</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Took medication</td>
<td>14</td>
<td>1.00</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Did not take medication</td>
<td>23</td>
<td>1.52</td>
<td>-0.522</td>
<td>-0.237</td>
<td>0.814</td>
</tr>
<tr>
<td>GWBI DIFF</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Took medication</td>
<td>13</td>
<td>3.38</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Did not take medication</td>
<td>23</td>
<td>-2.13</td>
<td>-1.25</td>
<td>-0.274</td>
<td>0.786</td>
</tr>
<tr>
<td>GHQ DIFF</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Took medication</td>
<td>13</td>
<td>2.62</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Did not take medication</td>
<td>23</td>
<td>.70</td>
<td>1.92</td>
<td>0.297</td>
<td>0.788</td>
</tr>
</tbody>
</table>

USE ALL.
COMPUTE filter_5=(dualf(== missing(dualf)) and group=1).
VARIABLE LABELS filter_5 'dualf --- missing(dualf) and group=1' (FILTER).
VALUE LABELS filter_5 0 'Not Selected' 1 'Selected'.
FORMAT filter_5 (f1.0).
FILTER BY filter_5.
EXECUTE.

### Appendix 7.2d: T-test of difference scores (pre-test minus post-test) for treatment group Bathurst patients with both pre-test and post-test scores

<table>
<thead>
<tr>
<th>Any medication for psych treatment?</th>
<th>N</th>
<th>Mean</th>
<th>Difference in Means</th>
<th>t</th>
<th>Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>DASS Anxiety DIFF</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Took medication</td>
<td>26</td>
<td>8.22</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Did not take medication</td>
<td>24</td>
<td>9.71</td>
<td>-1.49</td>
<td>-0.463</td>
<td>0.645</td>
</tr>
<tr>
<td>DASS Depression DIFF</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Took medication</td>
<td>28</td>
<td>11.40</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Did not take medication</td>
<td>23</td>
<td>15.91</td>
<td>-4.52</td>
<td>-1.449</td>
<td>0.154</td>
</tr>
<tr>
<td>DASS Stress DIFF</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Took medication</td>
<td>24</td>
<td>8.77</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Did not take medication</td>
<td>24</td>
<td>13.29</td>
<td>-4.52</td>
<td>-1.634</td>
<td>0.109</td>
</tr>
<tr>
<td>GWBI DIFF</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Took medication</td>
<td>24</td>
<td>-23.25</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Did not take medication</td>
<td>2</td>
<td>-28.15</td>
<td>4.90</td>
<td>1.007</td>
<td>0.320</td>
</tr>
<tr>
<td>GHQ DIFF</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Took medication</td>
<td>26</td>
<td>18.77</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Did not take medication</td>
<td>22</td>
<td>27.23</td>
<td>-8.46</td>
<td>1.762</td>
<td>0.085</td>
</tr>
</tbody>
</table>

FILTER OFF.
USE ALL.
EXECUTE.

T-TEST
GROUPS = anymed(1,2)
/MISSING = ANALYSIS
/VARIABLES = dualf dualf dualf dualf dualf dualf dualf dualf dualf
/CRITERIA = CI(95).

T-TEST
GROUPS = anymed(1,2)
/MISSING = ANALYSIS
/VARIABLES = dualf dualf dualf dualf dualf dualf dualf dualf dualf
/CRITERIA = CI(95).

329
APPENDIX 7.3: ANALYSIS OF VARIANCE (ANOVAS):

7.3a) Pre-test scores by three factors: Condition (1,2 ie. treatment vs. control); Location (1,2,3) and Gender (1,2)
7.3b) Difference scores between pre- and post-test scores by three factors: Condition (1,2), Location (1,2,3) and Gender (1,2).

<table>
<thead>
<tr>
<th>Appendix 7.3a)</th>
<th></th>
<th>Sum of Squares</th>
<th>df</th>
<th>Mean Square</th>
<th>F</th>
<th>Sig.</th>
</tr>
</thead>
<tbody>
<tr>
<td>DASS Depression</td>
<td>Main Effects</td>
<td>(Combined)</td>
<td>12066.875</td>
<td>4</td>
<td>3018.719</td>
<td>23.075</td>
</tr>
<tr>
<td></td>
<td>Condition</td>
<td></td>
<td>5086.297</td>
<td>1</td>
<td>5086.297</td>
<td>38.905</td>
</tr>
<tr>
<td></td>
<td>Research Centre</td>
<td></td>
<td>347.558</td>
<td>2</td>
<td>173.779</td>
<td>1.329</td>
</tr>
<tr>
<td></td>
<td>gender</td>
<td></td>
<td>145.374</td>
<td>1</td>
<td>145.374</td>
<td>1.112</td>
</tr>
<tr>
<td></td>
<td>2-Way Interactions</td>
<td>(Combined)</td>
<td>716.105</td>
<td>5</td>
<td>143.221</td>
<td>1.096</td>
</tr>
<tr>
<td></td>
<td>Condition * Research Centre</td>
<td></td>
<td>462.433</td>
<td>2</td>
<td>231.216</td>
<td>1.769</td>
</tr>
<tr>
<td></td>
<td>Condition * gender</td>
<td></td>
<td>222.803</td>
<td>1</td>
<td>222.803</td>
<td>1.704</td>
</tr>
<tr>
<td></td>
<td>Research Centre * gender</td>
<td></td>
<td>98.537</td>
<td>2</td>
<td>49.269</td>
<td>.377</td>
</tr>
<tr>
<td></td>
<td>Model</td>
<td></td>
<td>19869.679</td>
<td>9</td>
<td>2185.520</td>
<td>16.717</td>
</tr>
<tr>
<td></td>
<td>Residual</td>
<td></td>
<td>59615.436</td>
<td>456</td>
<td>130.738</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td></td>
<td>79285.114</td>
<td>465</td>
<td>170.506</td>
<td></td>
</tr>
<tr>
<td>DASS Anxiety</td>
<td>Main Effects</td>
<td>(Combined)</td>
<td>5561.568</td>
<td>4</td>
<td>1390.392</td>
<td>13.828</td>
</tr>
<tr>
<td></td>
<td>Condition</td>
<td></td>
<td>2037.468</td>
<td>1</td>
<td>2037.468</td>
<td>19.970</td>
</tr>
<tr>
<td></td>
<td>Research Centre</td>
<td></td>
<td>309.207</td>
<td>2</td>
<td>154.604</td>
<td>1.515</td>
</tr>
<tr>
<td></td>
<td>gender</td>
<td></td>
<td>192.803</td>
<td>1</td>
<td>192.803</td>
<td>1.890</td>
</tr>
<tr>
<td></td>
<td>2-Way Interactions</td>
<td>(Combined)</td>
<td>1256.431</td>
<td>5</td>
<td>251.286</td>
<td>2.463</td>
</tr>
<tr>
<td></td>
<td>Condition * Research Centre</td>
<td></td>
<td>1017.432</td>
<td>2</td>
<td>508.716</td>
<td>4.986</td>
</tr>
<tr>
<td></td>
<td>Condition * gender</td>
<td></td>
<td>184.202</td>
<td>1</td>
<td>184.202</td>
<td>1.805</td>
</tr>
<tr>
<td></td>
<td>Research Centre * gender</td>
<td></td>
<td>231.011</td>
<td>2</td>
<td>115.506</td>
<td>1.132</td>
</tr>
<tr>
<td></td>
<td>Model</td>
<td></td>
<td>10445.735</td>
<td>9</td>
<td>1160.637</td>
<td>11.376</td>
</tr>
<tr>
<td></td>
<td>Residual</td>
<td></td>
<td>46523.655</td>
<td>456</td>
<td>102.026</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td></td>
<td>56669.390</td>
<td>465</td>
<td>122.515</td>
<td></td>
</tr>
<tr>
<td>DASS Stress</td>
<td>Main Effects</td>
<td>(Combined)</td>
<td>9725.289</td>
<td>4</td>
<td>2431.322</td>
<td>23.043</td>
</tr>
<tr>
<td></td>
<td>Condition</td>
<td></td>
<td>4723.439</td>
<td>1</td>
<td>4723.439</td>
<td>44.757</td>
</tr>
<tr>
<td></td>
<td>Research Centre</td>
<td></td>
<td>150.393</td>
<td>2</td>
<td>75.197</td>
<td>.713</td>
</tr>
<tr>
<td></td>
<td>gender</td>
<td></td>
<td>95.788</td>
<td>1</td>
<td>95.788</td>
<td>.908</td>
</tr>
<tr>
<td></td>
<td>2-Way Interactions</td>
<td>(Combined)</td>
<td>1415.486</td>
<td>5</td>
<td>283.097</td>
<td>2.683</td>
</tr>
<tr>
<td></td>
<td>Condition * Research Centre</td>
<td></td>
<td>1185.358</td>
<td>2</td>
<td>592.679</td>
<td>5.617</td>
</tr>
<tr>
<td></td>
<td>Condition * gender</td>
<td></td>
<td>236.333</td>
<td>1</td>
<td>236.333</td>
<td>2.240</td>
</tr>
<tr>
<td>General Well Being</td>
<td>Research Centre * gender</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>-------------------</td>
<td>--------------------------</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td></td>
</tr>
<tr>
<td>Model</td>
<td>17373.974</td>
<td>9</td>
<td>1930.442</td>
<td>18.296</td>
<td>.000</td>
<td></td>
</tr>
<tr>
<td>Residual</td>
<td>48113.192</td>
<td>456</td>
<td>105.511</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>65487.166</td>
<td>465</td>
<td>140.833</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Main Effects</td>
<td>(Combined)</td>
<td>4</td>
<td>7282.724</td>
<td>26.753</td>
<td>.000</td>
<td></td>
</tr>
<tr>
<td>Condition</td>
<td>12176.269</td>
<td>1</td>
<td>12176.269</td>
<td>44.729</td>
<td>.000</td>
<td></td>
</tr>
<tr>
<td>Research Centre</td>
<td>748.167</td>
<td>2</td>
<td>374.084</td>
<td>1.374</td>
<td>.254</td>
<td></td>
</tr>
<tr>
<td>gender</td>
<td>225.590</td>
<td>1</td>
<td>225.590</td>
<td>.829</td>
<td>.363</td>
<td></td>
</tr>
<tr>
<td>Interactions</td>
<td>(Combined)</td>
<td>5</td>
<td>540.432</td>
<td>1.985</td>
<td>.080</td>
<td></td>
</tr>
<tr>
<td>Condition *</td>
<td>2574.042</td>
<td>2</td>
<td>1287.021</td>
<td>4.728</td>
<td>.009</td>
<td></td>
</tr>
<tr>
<td>Research Centre</td>
<td>83.079</td>
<td>2</td>
<td>41.539</td>
<td>.153</td>
<td>.859</td>
<td></td>
</tr>
<tr>
<td>Condition * gender</td>
<td>83.079</td>
<td>1</td>
<td>83.079</td>
<td>.003</td>
<td>.956</td>
<td></td>
</tr>
<tr>
<td>Research Centre * gender</td>
<td>83.079</td>
<td>2</td>
<td>41.539</td>
<td>.153</td>
<td>.859</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>GHQ total</th>
<th>Research Centre * gender</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Model</td>
<td>46907.783</td>
<td>9</td>
<td>5211.976</td>
<td>19.146</td>
<td>.000</td>
</tr>
<tr>
<td>Residual</td>
<td>124133.22</td>
<td>456</td>
<td>272.222</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>171041.01</td>
<td>465</td>
<td>367.830</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Main Effects</td>
<td>(Combined)</td>
<td>4</td>
<td>4751.534</td>
<td>18.738</td>
<td>.000</td>
</tr>
<tr>
<td>Condition</td>
<td>10268.008</td>
<td>1</td>
<td>10268.008</td>
<td>40.493</td>
<td>.000</td>
</tr>
<tr>
<td>Research Centre</td>
<td>197.514</td>
<td>2</td>
<td>98.757</td>
<td>.389</td>
<td>.678</td>
</tr>
<tr>
<td>gender</td>
<td>144.088</td>
<td>1</td>
<td>144.088</td>
<td>.568</td>
<td>.451</td>
</tr>
<tr>
<td>Interactions</td>
<td>(Combined)</td>
<td>5</td>
<td>104.641</td>
<td>.413</td>
<td>.840</td>
</tr>
<tr>
<td>Condition *</td>
<td>218.401</td>
<td>2</td>
<td>109.200</td>
<td>.431</td>
<td>.650</td>
</tr>
<tr>
<td>Research Centre</td>
<td>139.739</td>
<td>1</td>
<td>139.739</td>
<td>.551</td>
<td>.458</td>
</tr>
<tr>
<td>Condition * gender</td>
<td>258.188</td>
<td>2</td>
<td>129.094</td>
<td>.509</td>
<td>.601</td>
</tr>
<tr>
<td>Research Centre * gender</td>
<td>139.739</td>
<td>1</td>
<td>139.739</td>
<td>.551</td>
<td>.458</td>
</tr>
</tbody>
</table>

ANOVA(a,b)

- DASS Depression, DASS Anxiety, DASS Stress, General Well Being, GHQ total by Condition, Research Centre, gender
- All effects entered simultaneously

FILTER OFF.
USE ALL.
EXECUTE.

*Perform Analysis of Variance on Original file with pre-test scores to determine effects of group, location and gender.

ANOVA VARIABLES = DASSDEP DASSANX DASSSTR GWB GHQTOTAL by GROUP(1,2) AREA(1,3) GENDER (1,2)/ MAXORDERS=2/STATISTICS=MEAN.

331
<table>
<thead>
<tr>
<th>Appendix 7.3b)</th>
<th>Sum of Squares</th>
<th>df</th>
<th>Mean Square</th>
<th>F</th>
<th>Sig</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>DASS Depression</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Main Effects (Combined)</td>
<td>12056.875</td>
<td>4</td>
<td>3016.719</td>
<td>23.075</td>
<td>.000</td>
</tr>
<tr>
<td>Condition</td>
<td>5086.297</td>
<td>1</td>
<td>5086.297</td>
<td>38.905</td>
<td>.000</td>
</tr>
<tr>
<td>Research Centre gender</td>
<td>347.558</td>
<td>2</td>
<td>173.779</td>
<td>1.329</td>
<td>.266</td>
</tr>
<tr>
<td>145.374</td>
<td>1</td>
<td>145.374</td>
<td>1.112</td>
<td>.292</td>
<td></td>
</tr>
<tr>
<td>(Combined)</td>
<td>716.105</td>
<td>5</td>
<td>143.221</td>
<td>1.096</td>
<td>.362</td>
</tr>
<tr>
<td>2-Way Interactions</td>
<td>462.433</td>
<td>2</td>
<td>231.216</td>
<td>1.769</td>
<td>.172</td>
</tr>
<tr>
<td>Condition * Research Centre</td>
<td>222.803</td>
<td>1</td>
<td>222.803</td>
<td>1.704</td>
<td>.192</td>
</tr>
<tr>
<td>Condition * Research Centre gender</td>
<td>98.537</td>
<td>2</td>
<td>49.269</td>
<td>.377</td>
<td>.686</td>
</tr>
<tr>
<td>Model</td>
<td>19869.679</td>
<td>9</td>
<td>2185.520</td>
<td>16.717</td>
<td>.000</td>
</tr>
<tr>
<td>Residual</td>
<td>59615.436</td>
<td>456</td>
<td>130.736</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>79285.114</td>
<td>455</td>
<td>170.506</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>DASS Anxiety</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Main Effects (Combined)</td>
<td>5551.568</td>
<td>4</td>
<td>1390.392</td>
<td>13.628</td>
<td>.000</td>
</tr>
<tr>
<td>Condition</td>
<td>2037.468</td>
<td>1</td>
<td>2037.468</td>
<td>19.970</td>
<td>.000</td>
</tr>
<tr>
<td>Research Centre gender</td>
<td>309.207</td>
<td>2</td>
<td>154.604</td>
<td>1.515</td>
<td>.221</td>
</tr>
<tr>
<td>192.803</td>
<td>1</td>
<td>192.803</td>
<td>1.890</td>
<td>.170</td>
<td></td>
</tr>
<tr>
<td>(Combined)</td>
<td>1256.431</td>
<td>5</td>
<td>251.286</td>
<td>2.463</td>
<td>.032</td>
</tr>
<tr>
<td>2-Way Interactions</td>
<td>1017.432</td>
<td>2</td>
<td>508.716</td>
<td>4.986</td>
<td>.007</td>
</tr>
<tr>
<td>Condition * Research Centre</td>
<td>184.202</td>
<td>1</td>
<td>184.202</td>
<td>1.805</td>
<td>.180</td>
</tr>
<tr>
<td>Condition * Research Centre gender</td>
<td>231.011</td>
<td>2</td>
<td>115.506</td>
<td>1.132</td>
<td>.323</td>
</tr>
<tr>
<td>Model</td>
<td>10445.735</td>
<td>9</td>
<td>1160.637</td>
<td>11.376</td>
<td>.000</td>
</tr>
<tr>
<td>Residual</td>
<td>46523.655</td>
<td>456</td>
<td>102.026</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>56969.390</td>
<td>465</td>
<td>122.515</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>DASS Stress</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Main Effects (Combined)</td>
<td>9725.289</td>
<td>4</td>
<td>2431.322</td>
<td>23.043</td>
<td>.000</td>
</tr>
<tr>
<td>Condition</td>
<td>4723.439</td>
<td>1</td>
<td>4723.439</td>
<td>44.767</td>
<td>.000</td>
</tr>
<tr>
<td>Research Centre gender</td>
<td>150.393</td>
<td>2</td>
<td>75.197</td>
<td>.713</td>
<td>.491</td>
</tr>
<tr>
<td>95.788</td>
<td>1</td>
<td>95.788</td>
<td>.906</td>
<td>.341</td>
<td></td>
</tr>
<tr>
<td>(Combined)</td>
<td>1415.486</td>
<td>5</td>
<td>283.097</td>
<td>2.683</td>
<td>.021</td>
</tr>
<tr>
<td>2-Way Interactions</td>
<td>1185.355</td>
<td>2</td>
<td>592.679</td>
<td>5.617</td>
<td>.004</td>
</tr>
<tr>
<td>Condition * Research Centre</td>
<td>236.333</td>
<td>1</td>
<td>236.333</td>
<td>2.240</td>
<td>.135</td>
</tr>
<tr>
<td>Condition * Research Centre gender</td>
<td>31.026</td>
<td>2</td>
<td>15.513</td>
<td>.147</td>
<td>.863</td>
</tr>
<tr>
<td>Model</td>
<td>17373.974</td>
<td>9</td>
<td>1930.442</td>
<td>18.296</td>
<td>.000</td>
</tr>
<tr>
<td>General Well Being</td>
<td>Residual</td>
<td>Total</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>-------------------</td>
<td>----------</td>
<td>-------</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>46113.192</td>
<td>455</td>
<td>105.511</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>65487.168</td>
<td>465</td>
<td>140.833</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Main Effects (Combined)</th>
<th>Condition</th>
<th>Research Centre</th>
<th>Gender</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>29130.896</td>
<td>12176.269</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>748.167</td>
<td>2347.084</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>225.590</td>
<td>225.590</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>2702.162</td>
<td>540.432</td>
<td>5</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>2-Way Interactions (Combined)</th>
<th>Condition * Research Centre</th>
<th>Condition * Gender</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2574.042</td>
<td>1287.021</td>
</tr>
<tr>
<td></td>
<td>839</td>
<td>839</td>
</tr>
<tr>
<td></td>
<td>83.073</td>
<td>83.073</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>GHQ total</th>
<th>Model Residual</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>46907.783</td>
<td>5211.976</td>
</tr>
<tr>
<td></td>
<td>124133.229</td>
<td>272.222</td>
</tr>
<tr>
<td></td>
<td>171041.012</td>
<td>367.580</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Main Effects (Combined)</th>
<th>Condition</th>
<th>Research Centre</th>
<th>Gender</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>19006.134</td>
<td>4751.534</td>
<td>18.738</td>
</tr>
<tr>
<td></td>
<td>10268.008</td>
<td>10268.008</td>
<td>40.493</td>
</tr>
<tr>
<td></td>
<td>197.514</td>
<td>96.757</td>
<td>0.389</td>
</tr>
<tr>
<td></td>
<td>144.088</td>
<td>144.088</td>
<td>0.568</td>
</tr>
<tr>
<td></td>
<td>523.204</td>
<td>104.641</td>
<td>0.413</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>2-Way Interactions (Combined)</th>
<th>Condition * Research Centre</th>
<th>Condition * Gender</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>218.401</td>
<td>109.200</td>
</tr>
<tr>
<td></td>
<td>139.739</td>
<td>139.739</td>
</tr>
<tr>
<td></td>
<td>258.188</td>
<td>129.094</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Model Residual</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>31166.007</td>
<td>3462.890</td>
</tr>
<tr>
<td>115630.356</td>
<td>253.575</td>
</tr>
<tr>
<td>146796.363</td>
<td>315.691</td>
</tr>
</tbody>
</table>

7.3b) Difference scores between pre- and post-test scores by three factors: Condition (1,2), Location (1,2,3) and Gender (1,2).

a DASS Depression, DASS Anxiety, DASS Stress, General Well Being, GHQ total by Condition, Research Centre, gender.
b All effects entered simultaneously.

```
DATASET ACTIVATE Dataset1.
FILTER OFF.
USE ALL.
EXECUTE.
*Perform Analysis of Variance of file with both pre-test and post-test scores to
determine effects of group, location and gender.
*The dependent variables are the difference scores between pre-test and
post-test.

  t on each measure.
ANOV A VARIABLES = DADiff DDDIF DSDIF GWBDIF GHQDiff BY GROUP(1,2)
AREA(1,2) GENDER
(1,2)/
MAXORDERS=2/STATISTICS=MEAN.
```
APPENDIX E

CHAPTER 9: FURTHER DEVELOPMENTS

9.1 Number of services and FTE for allied health professionals engaged by Divisions and funded through MAHS in 2005-2006.

Reports:

9.2 "Clinical Psychology in Rural General Practice" Reports
Commonwealth Department of Health and Ageing – see Disk 2 appended to the thesis.

- June 30, 2001
- December 31, 2001
- June 30, 2002
- October 31, 2002
- December 31, 2002
- December 31, 2003
- March 31, 2004
- August 31, 2004

Policy Submissions:

9.3 Submission to The Hon. Tony Abbott, Minister for Health, 20 November 2003: "Clinical Psychology in Primary Care: An Early Intervention and Prevention Approach to Common Mental Disorders in General Practice" (Evidence-Based Best Practice in Mental Health Service Delivery):

a) Submission
b) GP Support letters

c) Opinion/editorial in the Australian: 8 February 2006
d) Articles in New Matilda
e) Follow-up letters to the Prime Minister
f) Response letters

9.4 Submission to Council of Australian Governments, 23 January 2006:

a) Letter to the Prime Minister: "Early Intervention for Mental Illness: Primary Care Psychological Services"
b) Summary submission
c) Opinion/editorial in the Australian: 8 February 2006
d) Articles in New Matilda
e) Follow-up letters to the Prime Minister
f) Response letters

c) Response letters

9.5 Submission to the Federal Health Minister, the Hon. Nicola Roxon, 31 March, 2008: "Collaborative Primary Mental Health Care"

a) Letter to Nicola Roxon with appendix (re: press articles)
b) Cover email to Bob Debus
c) Response letters

c) Response letters

9.6 20/20 Submission
APPENDIX 9.1:

Number of services and FTE for allied health professionals engaged by Divisions and funded through MAHS in 2005-06

<table>
<thead>
<tr>
<th>MAHS Services</th>
<th>Number of Divisions (unknown)*</th>
<th>Number of Services</th>
<th>Number of Divisions (unknown)*</th>
<th>MAHS FTE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychologists</td>
<td>41 (3)</td>
<td>22135</td>
<td>42 (2)</td>
<td>45.8</td>
</tr>
<tr>
<td>Social workers</td>
<td>12 (1)</td>
<td>4199</td>
<td>12 (1)</td>
<td>10.9</td>
</tr>
<tr>
<td>RN - Mental health nurses</td>
<td>7 (1)</td>
<td>2658</td>
<td>8</td>
<td>6.2</td>
</tr>
<tr>
<td>Occupational therapists</td>
<td>11 (3)</td>
<td>3440</td>
<td>14</td>
<td>4.6</td>
</tr>
<tr>
<td>ATSI mental health workers</td>
<td>1 (2)</td>
<td>70</td>
<td>2 (1)</td>
<td>6.1</td>
</tr>
<tr>
<td>RN - Diabetes educators</td>
<td>27 (3)</td>
<td>14045</td>
<td>30</td>
<td>21.1</td>
</tr>
<tr>
<td>Dietician/nutritionists</td>
<td>29 (1)</td>
<td>14249</td>
<td>30</td>
<td>19.4</td>
</tr>
<tr>
<td>Counsellors</td>
<td>18 (3)</td>
<td>10056</td>
<td>20 (1)</td>
<td>18.8</td>
</tr>
<tr>
<td>ATSI health workers</td>
<td>4 (4)</td>
<td>236</td>
<td>7 (1)</td>
<td>13.8</td>
</tr>
<tr>
<td>Podiatrists</td>
<td>27 (2)</td>
<td>13161</td>
<td>28 (1)</td>
<td>9.5</td>
</tr>
<tr>
<td>RN - Asthma educators</td>
<td>8 (2)</td>
<td>2803</td>
<td>10</td>
<td>6.0</td>
</tr>
<tr>
<td>Physiotherapists</td>
<td>15 (2)</td>
<td>6053</td>
<td>16 (1)</td>
<td>4.4</td>
</tr>
<tr>
<td>RN - General</td>
<td>3</td>
<td>1270</td>
<td>3</td>
<td>2.7</td>
</tr>
<tr>
<td>Speech pathologists</td>
<td>4 (1)</td>
<td>1121</td>
<td>5</td>
<td>1.7</td>
</tr>
<tr>
<td>Practice nurses</td>
<td>3 (1)</td>
<td>250</td>
<td>3 (1)</td>
<td>1.5</td>
</tr>
<tr>
<td>Audiologists</td>
<td>3 (1)</td>
<td>243</td>
<td>4</td>
<td>0.4</td>
</tr>
<tr>
<td>Chiropractors</td>
<td>0 (1)</td>
<td>0</td>
<td>0 (1)</td>
<td>0.0</td>
</tr>
<tr>
<td>Other type of AHP</td>
<td>66</td>
<td>1276</td>
<td>66</td>
<td>5.9</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>53 (13)</strong></td>
<td><strong>97264</strong></td>
<td><strong>61 (5)</strong></td>
<td><strong>178.7</strong></td>
</tr>
</tbody>
</table>

*Only 61 Divisions provided information. 5 Divisions did not provide data to the Annual Survey of Divisions. Source: Commonwealth Department of Health and Aged Care. (2007). More Allied Health Services (MAHS) Program
Thursday 20\textsuperscript{th} November, 2003

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

Dear Minister,

**MENTAL HEALTH NEEDS TO BE AUSTRALIA'S "NUMBER 1" HEALTH PRIORITY
can you as health minister make a difference?**

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

There is an urgent requirement to address the mental health needs of the people of Australia:
- The burden of disease due to mental disorders/mental health problems is high and rising;
- The escalating cost of pharmaceutical benefits in treating mental disorders is unsustainable.

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

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

Since early 1998, with Commonwealth Government support from January 2001, we have trialled the provision of psychological services in Primary Care for high prevalence anxiety and depressive disorders (see Appendix for a summary of the early intervention model and relevant research). Using a six session treatment framework, the approach to intervention is evidence-based, time-limited, accountable and short. Patients, many of whom have been on medication for years and frequently disempowered by the “medicalisation of their unhappiness”, have responded extremely positively to treatment. Psychological intervention has entailed the development of new strategies in patients (cognitive, behavioural and interpersonal) to cope with and change their current, often exceedingly complex life situations and ways of responding to them (of which illness can be an expression).
Early intervention objectives include autonomy/resilience-building and, importantly, prevention/diminution of dependency on the health system. Mental health sequelae/parallels of chronic illnesses such as cardiovascular disease, arthritis, Parkinson's disease, diabetes etc are also addressed using psychological treatments which enhance patients’ self-management strategies.

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

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

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

Research evidence suggests that huge cost savings:

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

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

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

We believe that, for a fraction of the amount currently allocated to: the training of General Practitioners in Australia; Medicare expenditure on psychiatrists (a similar sized profession of approximately 2000 FTEs) and PBS costs on antidepressant medication alone, a new and innovative framework for:
- national psychological service delivery providing equitably available, early intervention and prevention for patients with Common Mental Disorders in Primary Care;
- collaborative service delivery between GPs and psychologists with appropriate clinical skills;
- specialist mental health workforce training and development, similar to that provided in Britain;
- support and up-skilling of GPs in relation to mental disorders;

could be implemented.

Cost savings resulting from being adequately prepared for the escalating prevalence/envisaged epidemic of depression and other Common Mental Disorders, by having appropriate training and early intervention frameworks in place, would more than pay for the proactive investment in this new, best practice collaborative approach. Early intervention and prevention is critical when we look at the increasing burden of disease clearly
emerging in the mental health area. Australians need to be empowered rather than rendered dependent (and frequently demoralised) by their treatment. We believe the model we are advocating meets these objectives.

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

Yours sincerely,

Robyn F. Vines  
MSc, FAPS  
Clinical Psychologist  
Director, Clinical Psychology in General Practice Project/ 
Senior Research Fellow  
Charles Sturt University/  
Conjoint Senior Lecturer, Centre for Rural and Remote Mental Health, University of Newcastle

Professor Don Thomson  
PhD, FAPS  
Professor of Psychology  
Charles Sturt University/  
Co-Chief Investigator  
Clinical Psychology in General Practice Project

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

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

OVERVIEW

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

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

Patterns of Care:
Approximately 95% of people with mental illness are now being cared for in the community. As is well known, General Practitioners bear the brunt of the treatment load, having emerged as the key primary care service providers and the gatekeepers to secondary care. Recent findings indicate that 85% of the Australian population visit a GP at least once in any year and 90% in any two year period. Of those presenting in the General Practice setting, conservative estimates suggest that somewhere between 19% and 40% of patients have mental health disorders. Estimates are higher if comorbidities with physiological conditions are taken into account.

Approximately 30-50% of these patients manifest sufficient psychological distress to warrant further assessment and treatment. In relation to depression: the National Survey suggested that at least 40% of people suffering with depression consult with a GP within the first year of onset of the condition. Of these, only 6.2% are referred on to and see a psychologist, only 8.4% a psychiatrist. The remainder are managed purely in the primary care setting, often not receiving recommended best practice treatment (see below).

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

- common comorbidity with (and disguise by) physiological conditions such as hypertension, back complaints, diabetes, sleep disturbance, etc which then become the focus of consultation and treatment;
- patients’ perception of the GP’s role as focusing on physiological conditions; and
- GPs’ attitudes to mental illness and reluctance to diagnose appropriately due to perceived:
  - possible stigma associated with labelling;
  -minimal likelihood of appropriate treatment being available due to lack of appropriate treatment resources. Some findings suggest that GPs therefore focus on more “treatable conditions”.
Current Primary Care Practice: The single greatest increase in public health expenditure over the last ten years has been under the Pharmaceutical Benefits Scheme. In the area of mental health, use of antidepressant medication alone has sky rocketed - doubling between 1994 and 2000 and continuing to rise. Government statistics on anti-depressant prescriptions showed a 40 per cent increase between 1998 and 2000, with 7.4 million scripts being written in the year to 2000 - up from 5.2 million two years earlier. At an average cost to government of about $50 per script, this implies an annual national antidepressant bill of $400million. The figures show that most of the increase in the use of newer drugs (such as Aropax, Zoloft and Prozac) is for new patients, in contrast to the widely held view that they are and should be replacing the older tricyclic antidepressants (the “TCA’s”) which have more serious side-effects. Health Insurance Commission statistics indicate that use of these older drugs has in fact remained static, declining by only 2 per cent during the two years studied, to 2.25 million scripts.

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

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

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

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

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

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

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

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

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

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

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

**Rurality and Equity: A Snapshot of Some Rural Mental Health Issues:**

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

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

**Particular risk factors and needs of rural people:** People living in regional communities have particular risk factors and mental health needs associated with isolation and exposure to environmental hazards such as drought, flood and fire. The impact of drought alone has been found to lead to anxiety, depression, family breakdown, grief and anger. In addition, rural environments are often characterised by distance, specific occupational hazards, sparse infrastructure (including lack of health services) and risk-taking attitudes to health, illness and behaviour. These factors are associated with lower socio-economic status, hardship and risk exposure in early life, high levels of stress and job insecurity, low social support, ill health, addictive behaviours,
unhealthy food choices and other risky behaviours (e.g., dangerous driving practices). On average, Australian rural people are poorer and attain lower levels of education than people in urban areas. 56% of rural households fall into the two lower income quintiles, compared to 36% of capital city households and 43% of "other urban" households. In rural and remote communities, the cost of basic food is frequently up to 10% higher than in metropolitan and regional centres, giving a "double deprivation": lower levels of income combined with higher basic costs. Lower levels of education and higher levels of poverty are reflected in both physical and mental health status. Research findings suggest that rural and remote women are more exposed to violence in personal relationships than urban women; many are isolated without public transport. Physical and sexual violence against women are well documented as determinants of poor mental health. Compared to metro, rural/remote area males and females aged 20-29 are twice as likely to consume alcohol in hazardous or harmful quantities. Alcohol has been implicated in up to 50% of all suicides in Australia. There is also a high level of gun ownership in rural areas. The factors outlined above combine to create what is termed 'Social Exclusion' within a community, a shorthand term to describe what can happen when people or areas suffer from a combination of linked problems such as unemployment, poor skills, low incomes, poor housing, high crime, bad health and family breakdown. Social Exclusion disadvantages communities in many ways and rural communities are considered to be the most socially disadvantaged in relation to this global index. Equity of access to services: As is well known, recruitment to and retention of health professionals in small communities in regional, rural and remote Australia is a major challenge. Access to appropriate specialist mental health professionals is extremely limited once one moves beyond the main metropolitan centres. The establishment of a network of University Departments of Rural Health as well as Rural Clinical Schools across Australia has been one of a number of initiatives to assist the remedying of this imbalance. However, on the ground, availability of appropriately qualified and skilled personnel and services remains woefully inadequate.

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

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

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

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

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

c) General Practice: In real terms, Community Mental Health Teams and GPs receive the brunt of formal mental health presentations in rural areas. However, waiting lists are long and costs for patients can be prohibitive as many GPs in rural areas do not bulk bill. Approximately 20% of GPs practice and live in rural areas. However, when one considers that, in rural NSW for example, there are 1.9 persons per sq. km. compared
to the NSW urban average of 96.1 persons per sq. km., service delivery issues and equity of access remain clearly unaddressed, despite the relative representation of GPs. Further, referral criteria for mental health interventions often focus on more acute and extreme mental health conditions leaving people with high prevalence disorders of depression, anxiety, stress and substance use frequently slipping through the net, their needs remaining unmet. (The latter issue is not unique to rural areas alone).

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

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

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

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

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

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

PROPOSAL FRAMEWORK:

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

343
(Costs are done on a per annum basis. It is suggested, to ensure service continuity at Primary Care level, that the funding framework initially be for a five year period (renewable if evaluation indicates positive health outcomes are achieved, as in line with current research).

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

a) Training and Registrar Service Delivery Framework

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

- 30 training University provide post-graduate training in Clinical Psychology (MPSych/DPsych) with (on average) 10-15 students per annum graduating per University (total enrolled students = 620);
- 6 stipended internships for Clinical Psychology Registrars would be provided (via fund holding in local Divisions of General Practice) per University (ie total of 180);
- Number of patients treated per placement: 20 (MPSych) – 30 (DPsych); using the 6 (plus 6 if needed) session treatment framework (total no. of patients treated = 3600);
- Stipends are currently funded at $150 per day: ie $3,250 per 7 week (full-time) placement (Internships can also be done part-time over 12 or 15 weeks);
- Provision of incentives for rural primary care placements are required (eg. $7,000 per placement);
- Assume 30% of placements;

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

b) Supervision Framework:

- Supervision payment (via fund holding at Divisions of GPs) = $34,500 per University to cover the 50 hours face to face supervision for each of the 6 stipend students required by APS College of Clinical Psychologists Supervision Guidelines (ie 300 hours face to face, plus large administrative component in getting placement arrangements underway)
- Total cost = $1,035,000
- This will be an interim cost for the first two years whilst workforce development initiatives are implemented (see below).
- Adjusted cost per patient = $79.50 (including supervision costs) – again for the six (plus six if needed) session treatment framework.

Supervision will eventually be undertaken by psychologists with appropriate clinical skills employed in Divisions of General Practice to work clinically in Primary Care and to coordinate training and service delivery at Division level (see Section 3: Workforce Development Model). Hence cost savings on supervision will be factored in after the first two years.

NB. Uptake at Universities may be “staggered” (ie it is unlikely that all 30 training institutions will “come on board” by the first year).

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

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

CHARLES STURT UNIVERSITY

(similar to that provided by GPET for GPs)

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

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

**Total Cost = $ per annum**

**Staff:**

Director $130,554
Professoral Consultant re: research & model $52,221.60
development
Senior Lecturer (Training/Module Development) $97,055
Senior Lecturer (Research) $97,055
Research Assistant/Data Analyst $66,869
Administrative Assistant $59,989
(All salary costs inclusive of 25.8% "on costs")

**Total:** $503,743.60

**Consultancy Fees:**

Health Economist $30,000
International Experts $25,000

**Total:** $55,000

**Administrative:**

Accommodation/rental: $30,000
Travel: $85,000
(to cover training in DGPs across the country)
Administrative Expenses: $51,500
Promotion/PR/Printing: $23,000

**Total:** $189,500

University Infrastructure Levy $112,236.54

**TOTAL:** $860,480.14

3) **WORK FORCE DEVELOPMENT MODEL**

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

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

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

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

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

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

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

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

---

R. F. Vines  
D. M. Thomson  
(20th November, 2003)
REFERENCES:


Australian Psychological Society Papers*.
- AMWAC General Practice Workforce Review: APS Submission, 2003
- “Cost-effective, Evidence-based Psychological/Behavioural Interventions and Medicare: A Proposal”: Submission to the Senate Select Committee on Medicare, 2003
- “The Role of Psychological Treatments in Managing High Prevalence Mental Health Disorders” (Lavender Tip Sheet: APS Ltd: 2000)


Party Line. Working for Good Health and Well Being in Rural and Remote Australia”, Newsletter of the National Rural Health Alliance, September, 2003

Robotham, Julie: “Big business, bad medicine cloud our epidemic of the blues”: Sydney Morning Herald, April 3 2002


**We are exceedingly grateful to the Australian Psychological Society for their generous permission to quote and paraphrase a number of recent APS documents on mental health service delivery in Australia. Particular thanks are due to Dr. Lyn Littlefield, Chief Executive Officer and Mr. David Stokes, Manager, Professional Practice for their assistance.
Wednesday 10th December, 2003

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

Dear Minister,

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

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

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

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

We believe that our collaborative approach to the provision of mental health service has been highly successful. Empirically, we have shown that the collaborative model of care has a significant and positive impact on patients’ mental health and well-being (Vines, Thomson, Richards, Brechman-Toussaint, & Vessely, 2003). GPs report that the model of intervention has helped them move forward with many of their
most difficult clients and develop a collaborative team approach (sometimes including the patient) in doing so. We have attached a letter that was written to the Department of Health and Ageing by one of our Central West GPs (Dr Coral Morris) in response to the reduced funding of the AAHS pilot projects in the second and third year of the programs. The letter typifies the sort of “working day” experienced by many rural GPs, and no doubt many urban GPs, who struggle with the enormous mental health demands that present to their practice. As Dr Morris points out:

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

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

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

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

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

Yours sincerely,

Dr Louise Roufeil PhD, MAPS
Program Director

Ms Sandra Christensen
CEO

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

349
Dr Coral Morris,
Bowenfells Medical Practice,
7 Colonel Drew Drive,
Lithgow, 2790,
N.S.W.
14th October, 2003.

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

Dear Dr Castle,

re: Availability of Psychological Support Services in Central West NSW

I am a rural GP registrar. My husband has urged me to write this letter to you. I had thought when I planned to write a submission to you, that I would have all my usual passion and energy for this subject that is so close to my heart, but instead I find myself flat and dejected. I feel that the subject is so enormous that I don’t know where to start describing the problem.

I have very recently found out that the funding for the Central West Division of General Practice pilot scheme for the 3 step mental health process has been drastically reduced because money could not be ‘rolled over’ from one financial year to the next. Consequently we are going from five psychologists to whom we could refer patients over several days a week, to one psychologist one day a week. I am told that she will be able to see a maximum of 5 clients a day.

On Monday I saw 10 patients. Seven of them were mental health patients with whom I spent 40 minutes or more each. Here are the profiles of these patients:

- One seriously stressed and out of control father.
- His very depressed and angry son followed.
- One raped, and possibly psychotic, 16 year old girl.
- One victim of serious physical, mental and emotional domestic violence with social phobia and depression.
- One depressed and hopeless young woman about to enter a marriage she doesn’t want, to have children she is not ready for, because her self esteem is so low that she doesn’t see any alternatives for herself.
- One case of depression and obsessive-compulsive disorder who is about to walk out on her husband and family, and is contemplating ending her life.

Clearly many of these problems require urgent and ongoing attention.

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

I spent the last 2 hours of my working day writing 5 referrals to a paediatrician for the five children in a family with severe behavioural problems, which include ADHD, oppositional-defiant disorder and depression. Their mother has depression, anxiety and post-traumatic stress disorder, and problems with control of impulsivity and anger. Their father has recently declared himself to be homosexual, and after a brief stint away from home, is now back with his family and trying to find a way to cope with it all.

This is the psychological coastline of Lithgow. How does the withdrawal of psychological services affect our patients? Even with 5 psychologists available, patients were reporting a wait of several weeks before getting an appointment.

However, the good news is that the system really works.

- Take the widow of a volunteer bush fireman, her soul-mate, killed in last year’s fires, who has received regular counseling and support, and who rates it as the most valuable factor in helping her to cope with her grief at the same time as continuing to raise her now fatherless baby.
- Then there is the 18 year old with depression and self-harming behaviour, who managed to get her HSC, and with improved self-esteem via cognitive behavioural therapy was able to obtain work in a solicitor’s office where she is a great success and will shortly be promoted.
- How about the young husband with anti-social personality disorder and un-diagnosed ADHD who is now learning how to communicate with his wife other than by beating her. They have been back together 5 months with none of the weekly beatings she received prior to psychological intervention. He has also managed to get a job and hold it.
- Or the depressed, socially-phobic woman who has gone back to work for the first time in years.
- The young woman with a history of depression and childhood sexual abuse who has started a car-detailing business.
The intervention and support we were able to offer our patients were immeasurably valuable to both the patients and society - so clearly the fence at the top of the cliff.

How has the reduced funding affected me as a rural GP?

I feel abandoned. In good faith, with the understanding that there would be psychologist back-up, I undertook the necessary training to be able to diagnose and treat psycho-social problems. I have been overwhelmed by referrals from my GP colleagues, allied health workers, and from patients who have heard on the grapevine that I’m one to see for psychological and emotional problems.

I recently formed an arrangement with a local primary school headmaster, to assess problem children threatened with expulsion following multiple suspensions, with their parents consent, so that they can be referred for paediatric, psychiatric and psychological intervention. This would clearly be extremely useful in attempting to avert disaster for the children, their families and society. But there are many children in this situation, and too few psychologists employed by the Department of Education to deal with these numbers. I enclose a letter from one 8 year old who we were able to offer intervention to, who was about to be expelled. This would have meant leaving the safety of his grandparents home, to return to live with his violent, personality-disordered father. With support and psychological strategies, he is attempting to change his behaviour.

Sometimes I long for a working day of coughs, tummy pains, ankle sprains and vaccinations, but here’s how it is: An urgent appointment request - this lady has been losing hair for a couple of months. A careful examination – no obvious abnormality, reassurance follows – “This is probably a simple, self-resolving case of telogen effluvium” I say.

“Or perhaps it’s just the stress,” says the patient.

Response 1) “Could be stress,” says I.

“Come back in 6 weeks if the hair is still falling.”

Response 2) “Tell me about the stress..........”

Anyway, back to the coalface, I’ve just checked my appointments for tomorrow:

9.00 Anxiety disorder
9.10 Depression and panic attacks
9.30 Relationship problems
10.00 Childhood sexual abuse/alcoholic father
10.10 Anorexia, depression, PTSD
10.40 ??????????? A sore throat??????????
11.10 Depressed child
11.20 Ovarian cancer counseling
11.40 Bipolar disorder, PTSD, childhood sexual abuse
12.10 Depressed mother of the 5 behaviourally challenged children previously mentioned.

12.30 Depressed, chronic pain, childhood sexual abuse..............

I’m a female GP, I’m needed in the country, but if I’m not to turn into a sort of pseudo-psychologist, and if I am to be able to exercise my GENERAL medical skills, then I need adequate [as I define it] back up, because I’ll never be able to NOT ask the question “Tell me about the stress.....”

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

Thankyou for reading and considering my submission.

Yours sincerely,

Dr Coral Morris
MB ChB, DRACOG

Copies: Louise Roufeil, Central West Division of General Practice, NSW
11 December 2003

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

Dear Minister

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

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

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

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

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

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

Yours sincerely

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

Dr Debbie McClure  
Senior Partner  
George Street Medical Practice
5th December 2003

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

Dear Sir,

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

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

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

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

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

Yours faithfully,

Dr Colin Jamieson
5th December 2003

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

Dear Sir,

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

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

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

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

Over the last few years, encouraged by the Federal Government, we have undertaken further training in the Mental Health area so that we can access the Psychology in General Practice services. Since 1998 this has been provided by the Clinical Psychology in General Practice Project and latterly under
the Better Outcomes in Mental Health Care Initiative. This has proved invaluable to our patients who are able to be identified early in the course of their “dysfunction”. They are managed with timely intervention through prompt referral to a psychologist for appropriate assessment and time-limited therapy. There is always the expectation of a return to an improved level of functioning in a specific given time, usually less than 3 months. The patient is managed in a respectful and confidential manner and feels a great sense of relief and optimism as he/she is supported by a “team” approach. The vast majority of patients are not in a socio-economic position to pay for these services themselves.

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

Yours faithfully

Dr Bernadette Droulers

Dr John Sandra

Dr Colin Jamieson

Dr Ian Thong

cc: The Honourable John Anderson MP
The Honourable Julia Gillard MP
The Honourable John Murphy MP
Mr Dermot Casey
APPENDIX 9.4a

Robyn Vines MSc, FAPS
Clinical Psychologist
P.O. Box 16062, Dubai
Email: rvines@emirates.net.ae
Tel.: (0011971) 50 872 7419

Monday 23rd January, 2006

The Honorable John Howard
Prime Minister
Parliament House
Canberra, ACT, 2600
Australia

Dear Prime Minister,

Early Intervention for Mental Illness:
Primary Care Psychological Services

I am writing, prior to the forthcoming COAG meeting in February, to request that consideration be
given to establishing a sustainable system of Primary Care Psychological Services across Australia.
Collaborative care between General Practitioners and appropriately trained psychologists for patients
with mental health conditions needs to be a key component of any solution envisaged for mental health
service delivery in Australia. Primary Care is the venue in which most patients first present,
particularly those with the high prevalence “common mental disorders” (ie. depression, anxiety and
comorbid conditions). In order to halt progression to more serious problems, accurate detection,
diagnosis and evidence-based treatment is required at this early point of contact.

and despair in mental health care in Australia” (17.10.05) and the Productivity Commission
Workforce document released last week both address the question: “What does it take to keep the
Australian population healthy, thereby keeping health costs to a minimum?” The MIICA Report has
been particularly productive in bringing mental health under scrutiny again, highlighting many people’s
plight and the issues to be addressed in the treatment of acute and chronic mental illness. It is now our
biggest social problem – statistically bigger than unemployment and poverty. Approximately one third
of the families in our country are affected by lack of access to appropriate treatments, despite effective
means of treatment being available. In particular, evidence based psychological therapies such as
Cognitive Behavioural Therapy (CBT), which are in heavy demand, are not equitably accessible under
the public health system.

A number of important gains initiated by your Government in mental health care (eg. the Better
Outcomes in Mental Health Care Access to Allied Health Initiative: BOMHC AAHI, 2001- ; and the
closely-aligned trials of Clinical Psychology in General Practice: 2001-6) have not yet been articulated
into widely available and sustainable frameworks across the country. Most people with mental health
conditions still do not receive appropriate, evidence-based treatment at the optimal time (ie
early!).

BOMHC AAHI has in many respects been highly successful, with 104 (out of 121) Divisions of
General Practice now running Allied Health projects (90% of which are comprised of service delivery
by psychologists). However, these are all still at “repeat trial” stage four-five years later with little
certainty or continuity of adequate funding. Three Divisions of GPs in NSW have ceased to take
referrals to psychologists as funding has run out; several more Divisions are likely to follow suit
shortly due to funding short-falls. At current levels of support the services are obviously in great
demand both by patients and GPs but are unable to meet need. There is further a clear requirement for
standardization and quality control of procedures under BOMHCl and, additionally, considerable
expansion to ensure that all GPs are able to refer to psychologists (not just the BOMHC-trained
minority of GPs who are frequently the most interested in/able to deal with MHI issues). Sustainable
frameworks and certainty & expansion of funding is required. Present funding levels do not even allow
current BOMHC-registered GPs to refer at level of need. If all GPs became accredited (as DoHA indicate they want), there would be enough money to fund only a handful of referrals per GP per year! There is a lot to be done to ensure that the gains made under your Government in mental health service delivery and GP support are retained and consolidated.

What is required is a sustainable (ie. permanent) model of Primary Care Psychological Services that:

a) normalizes help-seeking for mental illness and psychological problems (ie. prevents stigma. General Practice is a “socially acceptable” setting in which treatments of all kinds are provided);
b) enables early intervention and prevention (thereby minimizing damage and misery to individual sufferers, families and the broader community);
c) provides predictable and universal “pathways to care”;
d) supports GPs, the key primary care providers, with their onerous mental health work load;
e) is evidence-based (i.e. provides intervention techniques that have been proved to work);
f) is “accountable” (i.e. provides effective short-term treatment - six sessions, with a further six if needed for complex conditions);
g) averts the current “medicalisation of unhappiness” which frequently renders patients dependent and demoralised rather than responsible, autonomous and resilient.

Primary Care Psychological Services are required as a permanent part of primary care - ie. not as a continuing series of “trials”/“projects”/“initiatives” which require time-(&-service-delivery-dollar)-consuming annual applications from within Divisions of General Practice for precarious repeat funding (currently the case). The model would significantly diminish present inequities in publicly-funded specialist mental health services (see below). However, it requires strong political support to ensure that it become a sustainable part of the public health framework within Australia.

The Clinical Psychology in General Practice Project (launched by The Hon. John Anderson in 1999 and funded by your Government, 2001-6) found that collaborative care was highly effective, and led to a 2004 Health Budget Submission (attached) which included the following ideas:

a) salaried appointment of clinical psychologists in Divisions of GPs to provide evidence-based outreach services to General Practices within each region;
b) limited inclusion under Medicare for appropriately trained psychologists - similar to the funding of psychiatrists but time-limited and accountable - for clinicians in private practice working closely with GPs to meet patient need;
c) a training model for clinical psychology registrars (under supervision with salaried clin. psychs.) to address the current shortage in specialist mental health professionals, predicted to grow progressively worse, particularly in rural areas.

Present funding allocations to psychiatry (both through Medicare and salaried positions) and government subsidies to pharmaceuticals (estimated, for anti-depressant medications alone, to be $400million per year prior to over-the-counter-costs to patients themselves) are astronomically higher than those currently provided for psychological interventions. The first round of Allied Health Funding under BOMHC was $22.7million over four years. Currently, medical funding continues to expand despite:

a) the expressed preference of many patients not to take medication;
b) perhaps more crucially, the research evidence which indicates that:
   • focused psychological interventions are more effective, especially in the longer term, than these other modes of treatment;
   • pharmacological treatments are best combined with psychological help as improvements made on medication are frequently not sustainable if the patient/client is not assisted to change the factors that generated the condition in the first place.

Current inequities in mental health service delivery in Australia: Analysis of postcodes of psychiatrists practicing under Medicare (University of Adelaide study, 2003) found that (approx.) only 7% of psychiatrists practice in rural areas. The majority of the remaining 93% were found to practice in the upper-middle class suburbs of Melbourne, Adelaide and Sydney (from billing postcodes of practices). Analysis of patient postcodes also indicated that the majority of patients seeing psychiatrists under Medicare come from similar locations and socioeconomic levels (i.e. middle/upper-middle class) and are sometimes seen weekly for years. These research findings are of great concern since psychiatry is the only consistently publicly-funded mental health specialty in Australia. The
proposed model of public-sector Primary Care Psychological Services would address some of this inequity - statistics indicate that psychologists are spread pretty much like the rest of the population with approx. 20-30% in the country/rural areas.

**Treatment for all**
The collaborative model of care in General Practice goes some way towards the provision of treatment for all in the health system (including the group commonly referred to as the “neglected majority”). It complements the focus of “pointy end” psychiatry on the important minority of patients with psychotic illnesses, and the need for assisted housing for the chronically ill when earlier patterns of care have not worked effectively. The suggested framework provides a solid cornerstone of the system of solutions required, and is an effective way of helping the majority of those with high prevalence depression, anxiety and comorbid conditions (estimated to be approximately 20% of the population annually compared to 0.5% for schizophrenia.) The model is also easily accessible and preventative, diminishing the need for (expensive) hospitalization of this group of people who often get worse if not treated effectively. Crucially, it provides much-needed support for GPs who are currently expected to treat complex mental health presentations as part of an already huge workload.

**Primary Care Psychology specialties** are well-established in the US and Britain. In Australia, under your Government, clinical psychologists have made significant gains in collaborating with GPs and Divisions of GPs to establish services which work for the majority of presenting mental health conditions.

**Conclusion**
There is a form of illness in Australia which is largely untreated and imposes severe burden on the economy and the fabric of our society. We possess effective treatments, especially evidence-based psychological therapies such as CBT, which are in heavy demand but with little public availability. Treatment outcome studies and practice guidelines (NICE) demonstrate that CBT is as effective if not more effective than medication and in economic terms such treatments pay for themselves.

Unlike health professions with workforce shortages, the clinical psychology profession has both the numbers and the expertise in psychological treatment to provide effective early interventions and build community capacity for better mental health. Fledgling initiatives from your government have begun to match this pool of professional expertise with the people needing the treatments. Expansion of such initiatives into sustainable frameworks under the Public Health System makes good economic sense.

Yours sincerely,

---

Robyn Vines  MSc, FAPS  
Clinical Psychologist  
Hon. Senior Research Fellow  
Department of General Practice  
Faculty of Nursing, Medicine and Health Sciences  
Monash University  
(PO Box 16062, Dubai, UAE)  
Email: rvines@emirates.net.ae  
Tel:  (0011971) 04 3431227  
(0011971) 50 872 7419 (mobile)

Cc.
- Premiers  
- Ministers of Health

**Attachments:**
- a) 2003/4 Submission to the Honourable Tony Abbott, Federal Minister for Health  
- b) Letters endorsing the Model from General Practitioners who have participated in empirical trials of its effectiveness  
- c) Articles outlining results from research trials
Background:
Just to briefly outline why I am writing in relation to mental health service delivery: I trained and worked as a clinical psychologist in the UK where clinical psychology services have been available in primary care since the mid-'70s (when the Trentham Report endorsed clinical psychology as a permanent part of the publicly-funded mental health framework under the NHS). At the beginning of my career I worked for six years as a Basic Grade (Fyrs.) and Sr. (4yrs.) Clinical Psychologist at University College Hospital in London, becoming convinced of the necessity for early intervention for those suffering from mental health conditions. Following a number of sr. clinical and management positions in Australia in the '80s and '90s, I headed a team of researchers running Australian Government-funded trials of collaborative care between clns. psychs. and GPs in the primary care setting (Jan. 2001-Aug. 2004). The 'Clinical Psychology in General Practice Project' started in Bathurst in 1998, was formally launched by John Anderson in 1999 and involved the development and trial (in Bathurst, Armadale, Ballarat and other rural locations) of a clinically- and cost-effective model of mental health service delivery for high prevalence/common mental disorders. As a consequence, a training and workforce development model was developed - to be provided through Divisions of General Practice - which our research and service delivery experience indicated was an optimal way of providing these treatment services in the community (see 2004 Health Budget Submission). At the beginning of Phase 2 (August 2004), the Project was transferred with Commonwealth approval to the Department of General Practice at Monash University where a "best practice manual" for the training of clinical psychology registrars is currently being developed. I have temporarily moved overseas for family reasons, but remain committed - as an Australian citizen, mental health practitioner & researcher - to ensuring that mental health service delivery in Australia becomes increasingly effective and more reliably available to those in need.

Robyn Vines
(23rd January, 2006)
PROPOSAL: Primary Care Psychological Services: Early Intervention for Mental Illness

INTRODUCTION:
Collaborative care between General Practitioners and appropriately trained psychologists for patients with mental health conditions needs to be a key component of any solution envisaged for mental health service delivery in Australia. A high quality, sustainable system of Primary Care Psychological Services needs to be endorsed and established across the country.

Mental illness is now our biggest social problem – statistically bigger than unemployment and poverty. The current high prevalence of common mental disorders (estimated to be more than 20% of the population, compared to 0.5% for schizophrenia) and, in addition, the WHO prediction that depression will be the largest “burden of disease” world-wide by 2020 - need to be proactively addressed. Current services are inadequate. Most people with mental health conditions still do not receive appropriate, evidence-based treatment at the optimal time; many do not receive any treatment at all. Most of these conditions remain largely unaddressed and impose a severe burden on the economy and the fabric of our society.

Key questions in addressing these needs are: “What does it take to keep the Australian population healthy? to genuinely reduce numbers of people with mental illness? and to ensure quality outcomes? (ie. genuine demand reduction) - thereby keeping health costs to a minimum?” We do possess effective treatments (eg. evidence-based psychological therapies such as CBT) which are in heavy demand but with little public availability (ie. they are not equitably accessible under the Public Health System). Treatment outcome studies and practice guidelines demonstrate that focused psychological interventions are as effective, if not more effective, than medication - certainly in the longer term maintenance of treatment gains. In economic terms such treatments pay for themselves, and expansion of such initiatives into sustainable frameworks under the Public Health System makes good economic sense. Genuine demand reduction requires investment in high quality and safe treatments, with “bottom-line calculations” taking into account not just the overall cost of these treatments but also the cost of untreated conditions if these interventions are not put into place (for example, research indicates that early and competent treatment of depression associated with heart disease, improves overall health outcomes).

Primary Care is the venue in which most patients first come for help. GPs are the main providers of mental health care (10 million mental health consultations in General Practice, compared to just under 5 million visits in community mental health care services and public hospital outpatient clinics – AIHW, 2005). The majority of consultations are for patients with high prevalence depression, anxiety and co-morbid conditions. In order to halt progression of these conditions, accurate detection, diagnosis and evidence-based treatment is required at this early point of contact.

What is required?
A long-term developmental vision is required of what it would mean to put in place an appropriately trained psychology workforce, well prior to 2020 when the envisaged epidemic of depression is predicted by the WHO to surpass other major burdens of disease (eg. cardiovascular disease and cancer). This would require immediate articulation of a properly-trained clinical psychology workforce across the country to provide treatment of patients (& their families) and support for GPs, whilst also supervising and training the next generation to work effectively in primary care. We need to create an immediate as well as growing capacity to meet mental health needs quickly and relatively cheaply (ie. using an accountable treatment framework in which short-term & effective/evidence-based interventions are used).

What is required is a sustainable (ie. permanent) model of Primary Care Psychological Services that: normalises help-seeking for mental illness (ie. prevents stigma and is “socially acceptable” as in the case in General Practice); enables early intervention and prevention; provides predictable and universal “pathways to care”; supports GPs - the key primary care providers, with their onerous mental health work load; is evidence-based and “accountable” (ie. short-term and effective), and prevents the current “medicalisation of unhappiness” which frequently renders patients dependent and demoralised rather than responsible and autonomous. These services need to be available to all GPs (rather than the minority who are currently able access them under the BOMHHC framework) and their patients.
THE PROPOSAL:

Primary Care Psychological Services as a permanent part of Primary Care.

Their provision would entail:

a) salaried appointment of clinical psychologists in Divisions of GPs across Australia to provide evidence-based outreach services to General Practices within each region (one full-time in all Divisions of General Practice across the country; two full-time in the larger Divisions). These practitioners would provide General Practice-based treatment in each region; supervision of clinical psychology registrars (who would increase the treatment capacity of each Divisional area); delivery of psycho-educational & skills training programs within the community, etc.

Estimated cost: $18,603,000 per annum.

b) limited inclusion under Medicare for appropriately trained psychologists - similar to the funding of psychiatrists but time-limited and accountable - for clinicians in private practice working closely with GPs to meet patient need. Estimated cost: approx. $100 million per annum (see article exploring this funding option and quantum by Prof. Stephen Leeder, Director, Australian Health Policy Institute: www.newmatilda.com)

c) stipended primary care internships for clinical psychology registrars in General Practice, under supervision with salaried clinical psychologists (in addition to the already promised 200 University training places).

Estimated cost: $2,085,000 per annum.

d) coordinating infrastructure via the 121 local Divisions of GPs: including Clinical Program Managers (in addition to clinicians mentioned above) to coordinate the framework and provide services such as data collection, liaison with GPs and General Practice Managers, running of the service delivery framework etc. - this cannot be done by busy clinicians.

Estimated cost: $9,000,000 per annum. (approx. $74,000 per Division: personnel and costs)

e) a centralised quality control and Psychology Workforce Development & Training Centre similar to GPET. Estimated cost: $560,500 per annum

COSTS: Total estimated cost: $130,548,500 per annum

Five year estimate: $652,742,500 (ie. $653 million)

Differences from ADGP Submission:

- A five year time frame (rather than four) is being applied for, to establish continuity of services for GPs. (Problems with BOMHC have included: annual funding (and hence service) shortfalls; the necessity to reapply for funding every year; consequent uncertainty and consumption of service-delivery-dollar and time in writing applications).

- Medicare funding for private practitioners is not included in the the ADGP submission.

Present funding allocations to psychiatry (both through Medicare and salaried positions) and government subsidies to pharmaceuticals (estimated, for anti-depressant medications alone, to be $400 million per year - ie. $2 billion over five years - prior to over-the-counter-costs to patients themselves) are considerably higher than those currently provided for psychological interventions, and remain much higher than the amount proposed above.

Currently, medical funding continues to expand despite:

a) the expressed preference of many patients not to take medication;

b) more crucially, the research evidence which indicates that:

- focused psychological interventions are more effective, especially in the longer term, than these other modes of treatment;

- pharmacological treatments are best combined with psychological help as treatment gains on medication alone are frequently not sustainable once medication is withdrawn.

Treatment for all

The collaborative model of care involving psychologists working in General Practice goes some way towards the provision of treatment for all in the health system (including the group commonly referred to as the "neglected majority" - ie. with high prevalence conditions). It complements the crucial focus of psychiatry on the important minority of patients with psychotic illnesses; in addition to the need for assisted housing for the chronically ill. The proposed model is easily accessible and preventative, diminishing the need for expensive hospitalization which frequently occurs if early prevention is not available.

Robyn F. Vines  (20.4.06)
OPINION

Stephen Leeder: Medicare should fund general practice psychologists
There's a simple way to meet the challenge of community mental health care.

February 08, 2006

THIS Friday's meeting of the Council of Australian Governments will have health care high on its agenda. The NSW and Victorian governments will take a $500 million healthcare reform package to the meeting in Canberra. The way we care for patients with serious and continuing chronic disorders needs to change and this package may help.

Like parents of children in a blended family, COAG members will seek ways to harmonise care that comes from different origins - hospitals, both private and public, community-based services including general practice, multiple professions, non-hospital specialty services and pharmaceutical benefits.

This is especially critical for the care of people with mental illness.

The new patterns of care demand flexibility and tolerance from COAG. They will require generosity of spirit among health professionals expressed as a willingness to work more closely together across professions.

On the COAG table will also be the report of the Productivity Commission on the health workforce. The report is critical of the tight preserve many health professions exercise over their territory. It acknowledges the value of maintaining clear professions that complement each other and does not advocate training generalists who have no professional heritage. But with too few people to do the work, it needs to be shared among professions better than at present.

For decades publicly funded aged care in Australia has demonstrated how health professionals of different persuasions - doctors, nurses, occupational therapists and physiotherapists - can work effectively together.
in teams.

But in the private sector, of which general practice is the largest component, collaboration is not so easily achieved unless paid for by the patient and their health fund.

But there are encouraging signs of change. Treatment studies in several hundred general practices have shown how mental health care can be shared between professions to good effect. Since 2001 federally funded treatment trials of collaborative care between general practitioners and primary care psychologists with certified skills have helped patients with common disorders including depression and anxiety.

More than 25,000 patients have received publicly funded treatment with success rates about 90 per cent. Treatment is short-term - up to six sessions, with six more if needed. The average treatment consists of four visits at a cost of $400.

Helen, a 37-year-old teacher and mother of two children, was referred by her GP to the local primary care psychologist for a severe panic disorder. Her first attack came out of the blue at a family party and led to her admission to hospital. She experienced severe palpitations, causing concern about a heart condition, but tests were negative.

While on extended sick leave from work, her GP referred her for four sessions of treatment from a clinical psychologist. She gained an understanding of the symptoms of panic and learned to recognise and counteract the signs of stress contributing to her attacks.

A long lead-up of cumulative distress and tension, including bereavement and financial pressures, had led to her condition, and this was explored. She was taught techniques to manage stress more effectively, to balance commitments and to set limits on demands. She had planned to quit her job but she returned to work within weeks. She received four treatments over two months and had two follow-up sessions.

The GPs involved in the collaborations seem to be generally well satisfied with the system and do not see it as stealing their income. Nevertheless, continued funding is far from secure.

At present only a minority of GPs can access these services. Detailed costing has not been done, and should be, but those responsible for Medicare may wish to check it out as an example that health service providers other than doctors can be reimbursed for care without cost blowouts and with good clinical results.
Beyond concerns with money, the trials also address a health workforce problem. Psychiatrists are a scarce commodity in unrelenting demand. Rural patients find it difficult to access psychiatric services located primarily in urban areas. Psychologists are more widely dispersed and numerous. There are at least 5000 psychologists in Australia with sufficient clinical expertise to function as mental health specialists and who could provide the style of non-pharmacological interventions that many persons with less severe disorders both need and seek.

The debate about the extension of Medicare to other health professionals is one that must be joined. In the US and Britain, primary care psychology is established as a mental health specialty in which clinical and health psychologists provide collaborative care with GPs and physicians.

The trials of similar services in Australian general practice described here suggest that this model might well be developed across Australia to good effect.

For patients with other serious and continuing illness such as heart failure, these trials give hope that better care can be provided to people in need without the different health professions sharpening their swords and going into battle over turf.

Stephen Leeder is director of the Australian Health Policy Institute and Menzies Centre for Health Policy at the University of Sydney.
Mental health and the federal budget

*Wednesday, May 03, 2006*

*Robyn Vines*

After decades of neglect, mental health is on the national agenda. Australia is currently faced with an historic opportunity for meaningful and lasting change in mental health service delivery. We last had such an opportunity in 1993 with the Burdekin Royal Commission.

Three recent major reports will influence the May federal budget. All call for increased clinical and health services in the community, with new team work arrangements proposed for GPs, psychiatrists, psychologists and mental health nurses. In addition, new non-clinical and respite services for people suffering mental illness, their families and carers, an increase in the mental health workforce and new programs for community awareness are likely to be funded. The reports are:


- The Productivity Commission Health Workforce Study report: *‘Australia’s Health Workforce’* (released 19th January, 2006) saw mental health as a major aspect of a more general problem in the health system. It was critical of the tight preserve many health professions exercise over their territory, particularly in the area of mental health where there are too few people to do the work. It did not advocate the training of generalists, who have no professional heritage. Instead, it acknowledged the value of maintaining clear professions with unique competencies that complement each other, whilst sharing the work more effectively than at present.

- The long-awaited Senate Select Committee into Mental Health: *“A National Approach to Mental Health: from Crisis to Community”* (released: 28th April, 2006) claims (as do the above reports) that “there is not enough emphasis on prevention and early intervention. There are too many people ending up in acute care, and not enough is being done to manage their illness in the community... because early intervention and community-based care would deliver savings in the long term”. It advocates substantially increasing the funding for mental health services to “between 9 and 12 percent of the total health budget.” A key recommendation of the Report is a “Better Mental Health in the Community” program to be rolled out over 4-5 years, including “the establishment of 300-400 community-based mental health centres for primary health care, staffed by teams of psychiatrists, clinical psychologists, psych nurses, GPs and social workers, funded by Medicare for salaries or contracts, not fee for
service". Others, including the Australian Divisions of General Practice (ADGP), support the alternative model of making the Federally-based Divisions of General Practice responsible for providing services to the key front primary care providers – namely the thousands of GPs in general practice across the community.

"Not for Service" elevated mental health to a prominent position on the agenda of the Council of Australian Governments (COAG) meeting on the 10th February this year. The meeting, troubled by the implications of an ageing population and already committed to considering health as part of a new drive to create a larger, fitter workforce, established the COAG Health Working Group to report in June. It has received submissions (from the ADGPs, the APS, etc) that highlight successful recent trials and service delivery options in the community.

Thanks to Bill Leak.

The Prime Minister has announced, well prior to final reporting deadlines, (specifically on 22.3.06 and 5.4.06) that $1.8 billion - increasing to $500million in the fifth year and ongoing - will be made available for mental health. He has suggested that these funds be matched by the states and territories and that they concentrate on the supported accommodation needs of the mentally ill, improvements in emergency and crisis services, and hospital and prison care. The challenge of providing humane and effective employment options for people who have had severe mental illness and now wish to work does not yet figure in the proposed arrangements.

The Federal Budget to be tabled on May 9th will finalise these allocations at federal level before the COAG Health Working Group completes its report. It is hoped that State allocations will complement, rather than overlap or clash with, federal funding priorities.
Because of the common emphasis among the reports on the provision of care in the community, especially for people in the early stages of mental illness, it is worth establishing a check-list of features that this care should satisfy.

1. It should be in a form that normalises the process of seeking help for mental illness, preventing stigma and providing services in a socially acceptable environment where patients are not reluctant to access them.
2. It should enable, if possible, effective early intervention and prevention of more serious conditions.
3. It should be equitably available across the country providing clear and universal pathways to care.
4. It should support GPs, the key primary care providers, and be located close to them.
5. It should be built on evidence of effectiveness and so avoid the medicalisation of unhappiness which can make patients demoralized and dependent on inappropriately prescribed medications.
6. It should not duplicate expensive health infrastructure.

Since 2001 the Commonwealth Government has funded clinical trials of shared care between GPs and appropriately trained psychologists. These trials have shown that collaborative care - involving short-term, evidence-based, focused psychological interventions – can be highly successful for patients suffering from the common mental disorders (i.e. depression, anxiety and some co-morbid conditions) which are estimated to affect more than 20% of the population every year. The trials demonstrated strong patient satisfaction and high rates of treatment success (including for those in the severe range). GPs expressed a strong desire for this practice-based specialist mental health support to continue - indicating the need for it to be available to all GPs, not just the minority accessing services under the trial arrangements. Medicare-funded psychiatric services are primarily located in more privileged urban areas, whereas the distribution of psychologists more evenly matches that of the Australian population as a whole.

The model of primary care psychological services which provide treatment for the "neglected majority" would complement care for the minority of patients with psychotic and other severe illnesses; assisted housing for the chronically ill; multi-disciplinary centres and multi-systemic therapy for the acutely disturbed. None of these services, however, would solve the challenge of providing humane support for people who have had severe mental illness and now wish to work. The new ‘work instead of welfare’ arrangements starting on July 1 will not assist those who require gradual and assisted reentry to the workforce. Appropriate resources for this particular group of people will also need to be found.

About the Author
Robyn Vines MSc, FAPS is a clinical psychologist and Honorary Senior Research Fellow at the Monash University Faculty of Medicine, Nursing and Health Sciences.

She is currently based in Dubai (rvines@emirates.net.ae)
The Federal Budget and Mental Health

Wednesday, May 17, 2006

Robyn Vines

The 2006-7 Federal Budget is large on promise but slim in detail in its increased funding to mental health care – an area deemed by many, including the Prime Minister, to be in need of radical reform. Of note is the increased support for general practitioners - the front-line providers of most primary mental health care services – and the first ever allocation of Medicare rebates to clinical psychologists. These developments are to be highly commended.

What are the key allocations?

A major funding boost of $1.9 billion over five years has been provided to address the currently estimated shortfall of 50% of mental illness in the community remaining untreated. This includes:

- $538 million to improve access to GPs, psychiatrists and clinical psychologists under Medicare (of which $381.8 million over five years will be spent on rebates to improve availability of potentially life-saving treatments);

- $191.6 million over five years for private psychiatrists and GPs to hire mental health nurses to coordinate patient care, provide home visits and monitor patient medication;

- $284.8 million over five years for 900 personal "helpers and mentors" to ensure mentally ill patients get appropriate treatment, income support payments, accommodation services and other benefits they are entitled to;

- $73.9 million over five years for non-government organisations to train drug and alcohol workers to detect signs of mental illness in people battling drug and alcohol problems;

- $51.7 million to improve access to mental health services for people in rural and remote Australia;

- an extra $62.4 million over five years for suicide prevention programs;

- $103.5 million to provide training places for 420 mental health nurses and 200 clinical psychologists;

- $46 million for 7000 extra places for the mentally ill in programs designed to help with cooking, shopping and social outings;
- $1 million over five years for the Mental Health Council of Australia.

The government estimates that in the fifth year the initiative is likely to result in:

- an extra 35,000 people being able to see a psychiatrist;

- about 400,000 Medicare-funded services being provided by clinical psychologists.

There are a number of anomalies in the overall design of the allocations.

Firstly, if the extra 35,000 patients are provided with current psychiatric rebates and average number of sessions per patient, the allocation to psychiatry increases considerably beyond the current funding base, estimated in 2001-2 to be approximately $196 million per annum. This is despite recent research evidence indicating a mal-distribution of these services with fewer than 7% of psychiatrists practicing in rural areas. The majority are located in the affluent “leafy” suburbs of Melbourne, Adelaide and Sydney.

Second, if 400,000 rebated sessions are provided for patients with clinical psychologists at $100 per session - (one of the unanswered questions in the new package remains how much Medicare will pay out on these new rebates) - a total allocation of $40 million for 66,700 patients (ie. an average of 6 sessions per patient) will be provided. If these patients are to be referred by the 8,000 treating GPs who have undertaken mental health training and are currently eligible to access psychologists for their patients, the doctors can refer an average total of 8.3 patients per year. Given that a conservative estimate of prevalence of psychological disorder in GP patients is 20-40%, and GPs often see more than 30 patients per day, this would seem slightly inadequate.

Thirdly, an allocation of $191.6 million over five years for GPs and psychiatrists to employ mental health nurses flies in the face of the findings of the Access to Allied Health primary care trials (undertaken since 2001 under the Better Outcomes in Mental Health Care Initiative). In 90% of these trials, general practitioners chose psychologists as their key collaborative allied health service providers, resulting in the program being renamed “Access to Psychological Services” (ATAPS). In addition, research indicates that focused psychological interventions are the treatment of choice for most high prevalence mental health conditions, as well as most chronic conditions (in combination with pharmacotherapy). It would therefore be more productive for GPs themselves to have the ultimate choice as to which mental health practitioners they employ with the additional $191.6 million to be provided to assist them.

Finally, missing in all of this is a clear allocation for people who have had severe mental illness and now wish to work, many of whom require gradual and assisted reentry to the workforce. Relevant
support services need to be included.

Recent estimates from Commonwealth surveys indicate that more than 20% of the population has some form of mental illness in any one year. Most have the high prevalence disorders (e.g. depression and anxiety) and are referred to as the “neglected majority”. These conditions frequently result in demoralization, de-motivation, diminished creativity and productivity. (In Britain, for example, ½ million people are absent from work each day as a consequence of depression alone). Apart from the sheer misery for the person, the flow-on effects are simply terrible – catastrophic both for the Australian economy and the country as a whole if they remain un- or ineffectively treated.

This is the first time since the Burdekin Royal Commission in 1993 that the political spotlight has been turned “full-wattage” on the parlous state of mental health service delivery in Australia. The budget allocations show that it is a high priority. However, the rationale for the current distribution of these much-needed resources remains unclear. Access to psychological services, in which pathways to care are clear and universally accessible, are a crucial part of the equation. It is important that we get it right this time and systematically and effectively resource them.

(Thanks to The Australian health editor Adam Cresswell for the figures. See Medicare yet to win over psychiatrists, Weekend Australian, p.31, 08.04.06)

About the Author

Robyn Vines MSc, FAPS is a clinical psychologist and Honorary Senior Research Fellow at the Monash University Faculty of Medicine, Nursing and Health Sciences.

She is currently based in Dubai (rvines@emirates.net.ae)
Mental Health Reform: will we realise this opportunity?

Friday, 22 September 2006
Robyn Vines

Negotiating the Australian mental health system in search of suitable treatment is enough to drive anyone nuts. For someone experiencing a significant mental health problem, it can be a total nightmare. Pathways to care are unpredictable and highly variable and access to treatment is inadequately funded, ensuring that the “well heeled” are frequently the only ones able to afford appropriate interventions. In rural areas, even this is problematic.

Over the past twelve months a number of enquiries and reports have once again highlighted the parlous state of our mental health services and have resulted in making the issue a high political priority - perhaps for the first time since the Burdekin Royal Commission in 1993. Amongst these have been the Senate Select Enquiry into the nation’s mental health system; the Productivity Commission Report on the Australian Health Workforce and, perhaps most effectively, the Mental Health Council of Australia’s Not for Service Report. Launched in October last year, the Not for Service Report was responsible for putting mental health on the agenda of the Council of Australian Governments’ (COAG) meeting early this year. Extremely positive signs emerged from this February meeting. In early April the Prime Minister pledged to spend an additional $1.8 billion on mental health services, with an implied expectation for State Governments to match this spending on a “pro rata” basis. In May the Federal Budget consolidated the Commonwealth Government’s commitment and outlined a number of key funding targets:

- increased access to GPs, psychiatrists, clinical psychologists, mental health nurses, helpers and mentors;
- further training of drug and alcohol workers;
- extra training places for 420 mental health nurses and 200 clinical psychologists;
- improved access to services for people living in rural and remote areas;
- suicide prevention programs;
- 7000 extra places for the mentally ill in programs designed to help with cooking, shopping and social outings;

(c)2006 New Matilda Pty Ltd
All Rights Reserved
www.newmatilda.com
• a new network of community-based mental health care made up of GPs and community health workers to help people live active lives and to prevent illnesses escalating to the point where patients need hospitalisation;

• 24-hour mental health care hotlines staffed by medical experts;

• $1 million over five years for the Mental Health Council of Australia.

Some of these targets were based on emerging State-based promises, others were pure Federal initiatives.

But after the initial euphoria of both consumer and professional groups in the face of this political will and the promise of effective change, doubts have begun to surface. Not only is it clear that the State Governments are not meeting expectations on their side of the funding bargain, but the translation of policy into action in time for the November launch of the new reforms has remained a well kept secret. Adam Cresswell's excellent article in The Australian: 'COAG mental health plan — on the rocks' (5.8.06) highlights the State-by-State funding shortfalls compared to pro rata estimates of what they should be contributing. His earlier article: 'Mental health push falters' also emphasises the lack of an appropriate 'road map' for the reforms, quoting the follow-up Mental Health Council of Australia Report: Time for Service, which was launched the same week.

Few people have any idea what the framework to be unveiled in November will look like. It is not at all clear why it has taken so long for something of substance to emerge nor why, after so many years of research and enquiry into the area, the outcomes seem to be a lot of good ideas cobbled together in a please-all package which everyone hopes will work. What is missing is a unified, evidence-based, coherent model of service delivery which provides universal pathways to effective treatment. Whatever the final amount of funding provided, a rational and systematic approach is needed to ensure that all new services are accessible, accountable and provide early intervention for those who need them. There is no point in perpetuating and replicating, albeit on a larger and more expensive scale, the mish-mash of pathways to care and service options currently in operation. Many of these lack an evidence base and create an enormous amount of confusion. They also waste time and money. What is needed is a coherent framework providing patterns of care that make sense to those who use them, particularly patients themselves and their referring doctors.

An integrated proposal of this kind was put to the Federal Health Minister in November 2003 following a series of successful control trials of collaborative care between GPs and appropriately trained psychologists in a number of locations across Australia. It is well known that General Practice is the first port of call for the majority of people suffering from mental health conditions. These early intervention trials, supported by the Access to Allied Psychological Services framework under the
Commonwealth Better Outcomes in Mental Health Care initiative (2001-2006), clearly indicated that primary care psychological services were a highly effective model of care. The proposed training and workforce development proposal, which was put to COAG again in January 2006 involves both salaried public-health psychologists and clinical psychology registrars working in Divisions of General Practice across the country who would be complemented by privately practicing, Medicare-funded clinicians (equivalent to current privately practicing psychiatrists) in each community. The aim of having salaried psychologists located in local Divisions is to provide appropriate coordination of clinical services available to referring GPs and their patients in each region. This removes the autonomy and fragmentation inherent in the current situation where private practices operate independently under Medicare.

The emerging COAG framework (where details of it can be detected) suggests that Medicare-based psychological services are being favoured as an alternative to salaried coordinating positions. There are hints that the fledgling GP Division-based services which have emerged under ATAPS may be dismantled, possibly to release funds for the promised Medicare rebate on psychological treatment. If these services were to be cut, this would belie the promise that the new developments under COAG will represent a real increase in, rather than a shifting of, resources.

If we are truly serious about reforming the plight of those suffering from mental health conditions instead of just creating vote-winning political window-dressing, then adequate provision must be made for well-structured, universally available and evidence-based early intervention. Such an early intervention program must be easily accessible for patients without the additional burden of the stigma associated with many current service delivery options. Primary care psychological services provide such a model of care. They need to be adequately resourced as a core part of the COAG framework. Funding projections indicate that a fully-coordinated network of psychological services across the country involving both salaried public-health positions and Medicare-funded practitioners would cost a fraction of current expenditure under Medicare alone for psychiatry. There is ample room for both if the political will is there.

We have a huge and rare opportunity to take a gigantic leap forward in reforming the terrible state of our mental health services. It would be to Australia’s detriment to let this opportunity pass to resolve or at the very least considerably improve the public mental health service delivery framework through high quality, equitable early intervention. Estimates from Commonwealth surveys indicate that more than 20% of the population has some form of mental illness in any one year, resulting in demoralisation, de-motivation, diminished creativity and productivity. Apart from the sheer misery of it all, the magnitude of the problem and its flow-on effects are simply terrible – catastrophic both for the economy and our country. We’ve got to be smarter than that – even if doing so is not an immediate vote-winner.

However, with public concern about the state of mental health care on the rise, political leaders may
well find themselves rewarded for doing the right thing.

About the author

Robyn Vines is a Clinical Psychologist, Honorary Senior Research Fellow in the Department of General Practice at Monash University and Adjunct Senior Lecturer in the Department of Medical Practice and Population Health at Newcastle University. She was Principal Investigator on the Commonwealth-funded 'Clinical Psychology in General Practice Project' (2001-5) which trialled collaborative mental health service delivery between GPs and psychologists in a number of regional and rural locations. She is currently based in Dubai. She can be contacted at rvines@emirates.net.au
FUNDING FOR PRIMARY CARE PSYCHOLOGICAL SERVICES:

Time for Permanent Resourcing Under the Public Health System

Since 2001, the Commonwealth Government has funded two successful mental health initiatives involving shared care between GPs and psychologists. The first of these, the Clinical Psychology in General Practice Project, which began in 1998, was launched in 1999 by the then Minister for Transport and Regional Services, the Hon. John Anderson, and was formally funded by the Department of Health and Ageing as a service delivery trial from 2001. The research entailed comparison of "collaborative care" involving both GPs and clinical psychologists (and clinical psychology registrars undertaking a final year primary care internship), with "GP treatment as usual" for patients with common mental disorders - currently estimated to affect more than 20% of the Australian population.

In the collaborative treatment, six sessions of evidence-based focused psychological interventions were provided for patients referred by GPs for treatment of depression and anxiety (ranging from mild to very severe). Comparison with a control group of patients receiving GP treatment alone (of whom those in the severe-and-above ranges were transferred to the treatment group for ethical reasons) indicated significantly greater treatment gains amongst those receiving collaborative care compared to those receiving treatment from GPs alone. Patient satisfaction with treatment was high (including those in the severe range) and GPs involved in the three regional locations where the trials took place expressed strong preference for continuation of practice-based mental health specialist support.

As a consequence, a primary care training manual is currently being developed by DoHA to ensure clinical psychology registrars are trained in this specialist area of care as part of their post-graduate training. A workforce development model has also been proposed as a consequence of the trials, as a means of providing and ensuring early specialist intervention and prevention by clinical psychologists in the primary care setting.

In parallel, the Better Outcomes in Mental Health Care Access to Allied Health Initiative (BOMHC AAHI) was funded in 2001 as a service delivery framework involving provision of mental health care by allied health professionals. Starting with 16 initial projects coordinated by local Divisions of GPs, the initiative grew to 108 Division-based projects by 2005. Since approximately 90% of the projects employed psychologists as the preferred key service providers under BOMHC, the initiative is now referred to as ATAPS (Access to Allied Psychological Services).

Whilst some Divisions have currently stopped referrals due to gross funding shortfalls and there have been reports of varying GP access, service provider pay, qualification levels and quality control of service delivery and patient outcomes, the initiative has been deemed successful and worthy of continuation. The Australian Divisions of General Practice have therefore applied for $220 million over four years to continue and expand the level of service provision under ATAPS whilst addressing some of the issues outlined.
above. This may entail a merging of the two initiatives, providing both a sustainable service delivery framework and quality control of both providers and patient outcomes.

**The Climate is Right**

Since the publication of the Mental Health Council of Australia’s scathing report in October 2005 on the state of mental health service delivery in Australia, and the Council of Australian Government’s endorsement of the need for reform in February 2006, an historic opportunity has arisen to transform the sector. Given the success of the two initiatives described above, both of which have laid the groundwork for the development of an early intervention model of collaborative care with GPs, it is time to ‘bite the bullet’ and invest permanently in sustainable, publicly-funded psychological services in primary care. John Mendoza, CEO of the MHCA indicates that Australia currently spends only about half the OECD average in the mental health sector. There is certainly room for more to be appropriately spent on early intervention and prevention. Most patients access their GP as the first port of call for help. If effective specialist care is available at this early stage, considerable misery on the part of patients and their families, as well as cost to the economy, can be avoided.

Robyn Vines  MSc, FAPS  
Clinical Psychologist/  
Honorary Senior Research Fellow  
Department of General Practice  
Faculty of Medicine, Nursing and Health Sciences  
Monash University  
(PO Box 16062, Dubai, UAE)  
Email: rvines@emirates.net.ae

Published in the Newsletter of the Public Health Association of Australia  
“Intouch”, Volume 23, No. 3, April 2006  
http://www.phaa.net.au/intouch/April06.pdf
APPENDIX 9.4e)

Robyn Vines MSc, FAPS
Clinical Psychologist
P.O. Box 16062, Dubai
Email: rvines@emirates.net.ae
Tel.: (0011971) 50 872 7419

Thursday 20th April, 2006

The Honorary John Howard
Prime Minister
Parliament House
Canberra, ACT, 2600
Australia

Dear Prime Minister,

Primary Care Psychological Services
Early Intervention for Mental Illness

Thank you for your reply to my letter of 23rd January. I am extremely heartened by your statements (both in your letter and in subsequent press releases) that an increasing role for publicly-funded psychologists is clearly envisaged as part of current plans for improved mental health service delivery across Australia. We look forward to appropriate inclusion and to contributing as part of the nation’s endeavour to deal with the escalating problem of mental disorders in our community.

Attached is a Summary Submission which suggests a potential funding framework for a coherent workforce development model, together with several relevant recent articles and earlier support letters from GPs.

There are a number of issues that need to be addressed to ensure that clinical psychology plays a key role in primary care mental health service delivery:

- Some have argued that it is better to hire cheaper services via other professional groups. In the longer term, however, it is expensive to provide cheap solutions. Investment in high quality early intervention pays off further down the track through both true demand reduction (people actually do get better with this form of skilled psychological help) and a considerable decrease in the “revolving door” phenomenon (which frequently results from incompetent treatment).
- Others have also argued, at the other end of the spectrum, that it would be better to increase funding to the existing medical mental health specialty of psychiatry via additional “incentive” payments of $500 and $1,000 to “service the under-serviced” - despite recent research indicating severe geographic and socio-economic limitations on the distribution of psychiatry (which incentives-per-session or per-patient are unlikely to alter). Such a proposal would seem an outrageous waste of money when these additional payments per patient could fund complete treatment of other patients via clinical psychologists - (whose distribution across Australia more evenly matches that of the population) - working closely with GPs.

A key question for us all to ask is: “where & to whom would one prefer to send one’s own child, or other close family member, if they were experiencing, for example, a
significant depressive episode?" It might be to a psychiatrist (particularly since cost is an issue for most people.). This would often entail a long wait - if accessible at all - by which time the critical need may have passed. If cost were not prohibitive (ie. exclusive of other options), many would prefer to send them to an appropriately trained psychologist working closely with their GP (the latter would know when to prescribe medication if needed). Many would also choose not to send their child to a mental health nurse as a primary therapist, but would welcome their involvement as part of a multi-disciplinary crisis team if required.

We already have much of the clinical psychology workforce required. It’s just that we’re not employing them. If we put into place the training and workforce development model/“vision” (outlined in the Submissions to your Government) and set up sustainable frameworks (that don’t end after two year research grants), we will get there. What we don’t need is a continuing mish-mash of competitive, half-baked alternatives that leave pathways-to-care unclear and varying levels of training and quality amongst primary care service providers. We need systematic, high quality psychological services that both patients and GPs can rely on.

Prime Minister, we are now faced with an historic opportunity for meaningful and lasting change in mental health service delivery in our community. We had an opportunity in 1993. It’s now 13 years later and we have another chance. It would be all too easy to let the positive promises “slip away” rather than doing what is required to establish sustainable (ie. permanent) models of psychological treatment that we know from recent trials funded by your Government - both small and large scale - are highly effective and address much of the current need (ie. the high-prevalence common mental disorders). It would be absolutely to Australia’s detriment to let this opportunity pass – ie. to not resolve or at the very least considerably improve part of the public mental health service delivery framework through high quality early intervention. Recent estimates from Commonwealth surveys indicate that more than 20% of the population has some form of mental illness in any one year, frequently resulting in demoralization, de-motivation, diminished creativity and productivity. Apart from the sheer misery of it all, the magnitude of the problem and its flow-on effects are simply terrible – catastrophic both for the economy and our wonderful country. We’ve GOT to be smarter than that.

Once again, thank you for your generous response to my letter and we look forward to positive and needed outcomes for the people of Australia.

All the very best,

Robyn Vines.

Robyn Vines  MSc, FAPS
Clinical Psychologist
Hon. Senior Research Fellow
Department of General Practice
Faculty of Nursing, Medicine and Health Sciences
Monash University
(PO Box 16062, Dubai, UAE)
Email: rvinde@emirates.net.ae
Tel: (0011971) 04 3431227; 50 872 7419 (M)
Cc. to:
- Council of Australian Governments
- COAG Health Working Group
- Federal and State Health Ministers
- Chair, Senate Select Committee on Mental Health
- The Opposition
Roobyn Vines MSc, FAPS
Clinical Psychologist

P. O. Box 16062, Dubai
United Arab Emirates
Email: rvines@emirates.net.ae
Tel.: (0011971) 50 872 7419

Tuesday 30th May, 2006

The Honourable John Howard
Prime Minister
Parliament House
Canberra, ACT, 2600

Dear Prime Minister,

Early Intervention for Mental Illness:
Primary Care Psychological Services

I am writing to thank and congratulate you on the contribution made by your government under the Federal Budget in altering the landscape of mental health service delivery in Australia. Of note is your increased support for general practitioners - the front-line providers of most mental health care services - and the first ever allocation of medicare rebates to appropriately trained psychologists. The additional allocation of 200 university places for clinical psychology training and scholarships for primary care internships for these students, indicates a clear intention for a significant role for the profession in meeting the nation’s mental health needs.

I am writing also in the lead-up to the COAG meeting in June, to follow-up on a number of key points. There are some anomalies in the current funding, particularly in the final allocations to psychiatry and clinical psychology under medicare. The Department of Health and Ageing estimates that in the fifth year of the new mental health initiative, the budget will result in:

- about 400,000 services/consults being provided by clinical psychologists under medicare, and
- an extra 35,000 people being able to see a psychiatrist.

These “drill down” figures raise a number of issues:

a) Clinical psychologists: 400,000 rebated sessions by the fifth year at $100 per session - (as a reasonable estimate - no rebate figure has been provided) result in a total allocation of $40 million per annum for 66,700 patients (see for an average of 6 sessions each, as is typical for effective clinical psychology treatment). This means that the approx. 8,000 GPs who have undertaken mental health training and are eligible to access psychologists (of the total 21,081 primary care clinicians - 2003 medical workforce figures) can refer approximately 8.3 patients per year. If however, all GPs can refer, as has been strongly recommended, a total of 3 patients per GP can be referred per annum.

Conservative estimates indicate that 20-40% of patients seen by GPs (often more than 30 patients per day) have psychological issues requiring help. The quantum of funding is therefore too small.

GPs and patients are now hugely relieved, as a consequence of the budget, at having the choice to refer/be referred to a specialist psychologist. However, most do not yet know that, at the culmination & peak of these new allocations, their annual allowance (3 - 8 referrals per annum) could run out on the first day of the year! It would be tragic if this much-needed initiative were inadvertently set up to fail through inadequate resourcing.

b) Psychiatrists: an extra 35,000 patients seen by psychiatrists by the fifth year indicates conservatively that an additional $101 million per annum will be allocated to psychiatry (based on the current psychiatric rebate of $145 for a modest 20 sessions per patient; 50 sessions are in fact allowed per annum).* The current allocation of more than $196 million per annum - (based on public 2001-2 figures; later allocations not available from HIC/Medicare/DoHA) - would therefore increase to approx. $300 million per annum, despite recent conclusive research indicating a gross mal-distribution of psychiatric services (fewer than 7% of psychiatrists are located in rural areas; the majority are in the “leafy” upper-middle class suburbs of Melbourne, Adelaide and Sydney.) Recent proposals suggest even further incentives to psychiatrists to overcome deficits in distribution and collaborative servicing
(eg. a proposed $360 rebate to see new patients, $170 for an initial 30 minute review; $500 for every fifth bulk-billed consultation; $1,000 for every fifth new non-metropolitan patient and $2,000 for every five case conferences held to discuss a patient care plan - see Hickie, The Australian, 8.4.06).

The increased budget allocation does not question current "anomalies" (eg. in servicing - see appendix) and essentially perpetuates and increases the government-subsidized monopoly by psychiatry of the mental health sector (to the tune of $300million per annum.) Patients who cannot afford alternative treatments have no other choice than to go to a psychiatrist (when/if available), despite frequently preferring to see a psychologist if they had the financial option. This compounds the existing subsidy for pharmacological treatments (eg. estimated to be at least $400million a year for anti-depressants alone). - Such "medicalisation of unhappiness" is to the real detriment of many Australian people and their families who require evidence-based psychological interventions to change their mental condition.

c) Mental Health Nursing: A third concern in the budget figures lies in tying an allocation of $191.6million over five years for GPs and psychiatrists to employ mental health nurses. It may be more productive for GPs themselves to have the ultimate choice as to which mental health practitioners they employ with the $191.6million, which is aimed at providing them with support for their onerous primary care mental health workload. (In more remote regions, this would enable the appropriate option of employing trained Aboriginal mental health workers to assist GPs with their work.)

The key thing in all of this is that Australia does not miss this extraordinary opportunity you have created to really address the needs of those suffering from mental illness in our community - more than 20% of our population per annum. We cannot afford the consequent demoralization, de-motivation, diminished creativity and productivity. (In Britain, for example, 1/2million people are absent from work each day as a consequence of depression alone). Apart from the sheer misery of it all, the flow-on effects are catastrophic for the Australian economy and the country as a whole. We need to get it right this time and systematically and effectively resource evidence-based early intervention in which pathways to care are clear and universally accessible. Primary care psychological services have been shown conclusively, both in Australia and elsewhere, to be highly effective in treating patients and meeting GP needs for support. They are not adequately catered for in the budget.

The attached proposal outlines a model of resourcing for primary care psychology both via salaried positions in Divisions of General Practice and medicare rebates for those practising independently - a total of $653million over 5 years. This falls well short of a quarter of the subsidy provided to pharmaceuticals and half of the medicare allocations (only) to psychiatry – the latter estimated at approximately $1.5billion over 5 years. (The additional Quantum spent on salaried psychiatry positions is not publicly available). This new allocation would be for the same sized workforce (more than doubling access by patients to specialist mental health services) with many more patients being effectively treated by psychologists than psychiatrists. Given current prevalence of mental disorders, there is ample room for both specialties. There is also ample money for both.

General Practice is primarily a Commonwealth responsibility. State allocations could well cover a number of the items provided for in the Federal Budget (eg. helpers and mentors; mental health nurses; etc). It would make good sense for allocations to be reshuffled to enable adequate resourcing of primary care psychological services, which successfully operate elsewhere eg. in the US and the UK. It would be tragic if the model of care was set up to fail through inadvertent funding shortfalls.

I will be in Australia from Dubai in mid-June (Canberra on June 22nd) and would be pleased to discuss the training and workforce development model of collaborative care between GPs and clinical psychologists outlined in the proposal. We request and need your advocacy for its implementation.

Yours sincerely,

Robyn Vines  MSc, FAPS
Clinical Psychologist
Hon. Senior Research Fellow
Department of General Practice
Faculty of Nursing, Medicine and Health Sciences
Monash University
Cc.

- The Minister for Health, The Hon. Tony Abbott
- The Council of Australian Governments (Premiers and State Health Ministers) & COAG Health Working Group
- Senator Lyn Allison & Senate Select Committee on Mental Health
- The Honourable John Anderson (who formally launched the original "Clinical Psychology in General Practice" project in 1999 and facilitated funding with the Hon. Michael Wooldridge – the then Minister for Health)
- The Opposition

* Any inaccuracy in estimates is due to the difficulty in obtaining figures on psychiatry - they are not in the public domain. Complete figures need to be publicly available. RV.
APPENDIX TO "Early Intervention for Mental Health"

a) Recent examples of psychiatric practice:

- Young man (16 yr. old): currently diagnosed as schizophrenic; unable to receive appropriate monitoring of his medication in the rural area he lives in; travels to Sydney (6 hour return journey, requiring meals and overnight accommodation) to see a well-known psychiatrist in Eastern suburbs for appropriate specialist intervention. Is seen for 20 minutes each month for medication review; charged $225 per consult. No evidence-based focused psychological interventions or strategies provided.

- Young man, aged 18 living in rural NSW: long history of behavioural and psychological problems as well as drug use (since age 14); referred by local GP to the only private psychiatrist in the region for assessment & management. Weekly visits were organised with payment to be made upfront at the time of session (gap after Medicare rebate: over $50 per session). Each session lasted, on average, 20 minutes. Only source of treatment offered was medication – no focused psychological interventions suggested or offered. Following request by the patient (a known extravenous amphetamine user), psychiatrist prescribed Ritalin (an amphetamine). Pt. overdosed on tablets, attempted to kill parents in a psychotic rage and was eventually scheduled.

- Young man (17-19): referred to a psychiatrist by GP for management of ADD (not addid) & D&A issues, was treated solely by medication; required to attend psychiatrist every 5 months for a 30 minute appointment at which the only issue discussed was medication. No focused psychological interventions were offered or suggested. Continued to see psychiatrist for over 3 years with no improvement. On three separate occasions during this time, the psychiatrist ‘forgot’ to obtain the required authorisation for the required script by the time of the appointment & no medication could be supplied to the pt. Pt was told to see their GP and obtain a sedative.

- There are many examples of patients being seen by psychiatrists for treatment of “common mental disorders” (eg. depression, anxiety, etc), kept on medication sometimes for years and/or advised that what they need is long term “analytic” (at least weekly) therapy. Little focus is provided on practical, confidence-building strategies for the specific issues they face in day-to-day life. Fees vary, often at the $200+ per session level (with a $50+ gap charged over the rebate).

b) Evidence-based, focused psychological interventions: When evidence-based techniques such as the cognitive behavioural therapy, dialectical behaviour therapy and other focused psychological interventions are used by psychiatrists (some of whom offer training programs to other professions in them), there is often lack of attribution to the research and practice of clinical psychology from which they arose. It is somewhat ironic that warnings have been issued by psychiatrists about the need to “control possible overservicing” if rebates are extended to clinical psychologists to provide these interventions.

c) Salary implications of Federal Budget Figures:

1) Psychiatrists: Estimates based on current fees (rebate + “gaps” of upwards of $50; ie $200 per hour) indicate approximately $160,000 per annum for a 20 hour week.

2) Psychologists: Assuming that initially 2,000 appropriately trained psychologists would be eligible to practice under medicare (about the same number as psychiatrists) the funding allocated under the budget in the fifth year would result in a gross income to each psychologist of approx. $20,000 per annum. If more are included, income levels would go down. This does not provide workable employment opportunities for the additional 200 students now offered places for specialist training in clinical psychology – with apparently nowhere to go afterwards. Training and (funded) workforce development models need to go in tandem. One doesn’t work without the other. If only the workforce development and no training, the eligible workforce dries up. If only training is facilitated, then trainees’ high expectations and commitment to the work have nowhere to go. The latter seems to be what would eventuate under the Federal Budget.

Robyn Vines (30.5.06)
Ms Robyn Vines  
PO Box 16062  
DUBAI  
UNITED ARAB EMIRATES  

15 FEB 2006

Dear Ms Vines,

Thank you for your correspondence of 25 January 2006 to the Prime Minister regarding COAG and Mental Health: Primary Care Psychological Services - An Early Intervention Approach. The Prime Minister has asked me to reply on his behalf.

As you are aware, the Council of Australian Governments (COAG) recognised at their 10 February 2006 meeting that mental health is a major problem for the Australian community. COAG acknowledged that governments have made significant recent investments in the area but also noted that additional resources will be required from all governments to address the issues.

The Australian Government will be working collaboratively with state and territory governments to prepare an action plan on mental health. This plan will be considered by the next COAG meeting around June 2006. COAG has asked that the following be included in the plan:

- a renewed focus on promotion, prevention and early detection and intervention - including reducing the impact on mental health of substance abuse, including illicit drugs (such as cannabis and amphetamine-type substances) and alcohol;
- getting the balance right between hospital care, community and primary care and the best type of accommodation for people who are unable to manage on their own;
- improving and integrating the care system to enable the right care to be accessed at the right time, including mental health services, primary care, general practice, private psychiatric services and emergency department services;
- improving participation in the community and employment, including greater use of non-government organisations and improved community-based and cross-sectoral supports for people with mental illness and their families such as supported accommodation, rehabilitation services and respite care;
- addressing structural issues such as workforce changes including the roles of different professions;
- increasing the role of psychologists and other health professionals in primary care; and
- increasing the health workforce available to address mental health issues.

COAG also agreed that the delivery of mental health services would be an integral element of the new National Health Call Centre Network.

I am sure that your submission will be of valuable assistance to COAG in their work on developing the plan and I will ensure that it is brought to their attention.

Thank you again for taking the time to write to the Prime Minister.

Yours sincerely

[Signature]

Perry Sperling
Senior Adviser
Ms Robyn Vines  
PO Box 16062  
Dubai  
UNITED ARAB EMIRATES

29 JUN 2006

Dear Ms Vines

Thank you for your correspondence of 30 May 2006 to the Prime Minister regarding mental health. The Prime Minister has asked me to reply on his behalf.

You raise a number of interesting issues in your letter on the mental health workforce and the funding of the Australian Government’s recent announcements in this area. I understand that you recently met with representatives from the Department of Health and Ageing to discuss your proposal for primary care psychological services and the new Australian Government initiatives. As discussed at this meeting, the Prime Minister’s announcement on 5 April 2006 of new funding for primary care services for people with a mental illness includes a range of initiatives, including services for people in rural and remote areas who currently do not always have access to psychiatrists and clinical psychologists.

I am sure that your proposal will be of valuable assistance to the Council of Australian Governments (COAG) in their work on developing the National Action Plan on Mental Health and I will ensure that it is brought to their attention.

Thank you again for bringing your views to the Prime Minister’s attention.

Yours sincerely

[Signature]

Perry Sperling  
Senior Adviser (Social Policy)
Ms Robyn Vines  
PO Box 16062  
DUBAI  
UNITED ARAB EMIRATES

Dear Ms Vines

Thank you for your letter of 23 January 2006 to the Prime Minister, the Hon John Howard MP, expressing your concerns regarding early intervention for mental illness and Primary Care Psychological Services in Australia. As this matter falls within the portfolio responsibilities of the Federal Minister of Health and Ageing, Hon Tony Abbott MP, your letter was forwarded for his reply. I am responding on his behalf. I do apologise for the delay in responding.

As you are aware on 10 February this year, the Australian Government and the State and Territory Governments on the Council of Australian Governments (COAG) committed to reforming the mental health system in Australia.

On 5 April 2006, the Prime Minister announced that the Australian Government will contribute $1.8 billion in new funds to reform the mental health system, with a commitment of around $500 million in the fifth year and ongoing, for the five-year action plan that is being developed.

The package is in response to many of the concerns raised by community and health professionals about the lack of services available for people with a mental illness, their families and carers. It addresses the key shortcomings in mental health services in those areas for which the Australian Government has responsibility, providing a major increase in clinical and health services available in the community and new team work arrangements for psychiatrists, general practitioners (GPs), psychologists and mental health nurses.

The Australian Government is funding a new team work approach to mental health services in the community, encouraging psychologists and mental health nurses to work alongside GPs and psychiatrists to offer more services to those with mental illness.

From 1 November 2006, the Medicare Benefits Scheme will be restructured so that GPs and psychiatrists can refer patients with a mental illness to psychologists, and these services will be eligible for a Medicare rebate. This means that appropriately trained psychologists will be able to play a much greater role in Australia’s mental health system.

In addition, the Australian Government will provide funding for over 200 additional clinical psychology places each year from January 2007.
The Australian Government will be consulting with key stakeholders during the development of these initiatives, and more information will be available after the Budget announcement on the 9 May 2006.

A full copy of the Prime Minister’s press release is available at the following web sites http://www.pm.gov.au/news/media_releases/media_Release1858.html

In your letter you raise issues regarding funding for the Access to Allied Psychological Services (ATAPS) component of the Better Outcomes in Mental Health Care Program. This Program will continue to 2008-09 and Divisions are not required to apply for funding each year, unless they are a new Division.

The ATAPS component has been successful beyond expectations. Increased awareness of the Program has added to increasing demand, still Divisions of General Practice as fundholders are required to manage the ATAPS within budget.

Thank you again for writing to the Prime Minister on this important issue and I would like to assure you that that Australian Government affirms it’s commitment to improving mental health outcomes through the primary health care system. I hope this information is of assistance to you.

Yours sincerely

David Dennis
Assistant Secretary
Mental Health and Suicide Prevention Branch
April 2006
10 FEB 2006

Ms Robyn Vines
Honorary Senior Research Fellow
Department of General Practice
Faculty of Medicine, Nursing and Health Sciences
Monash University
PO Box 16062
DUBAI
UNITED ARAB EMIRATES

Dear Ms Vines

Thank you for your email of 29 January 2006 concerning the Council of Australian Governments’ (COAG) consideration of mental health in February 2006.

I would like to thank you for taking the time to write to me enclosing information and research papers on a collaborative model of care between general practitioners (GPs) and psychologists to support early intervention in the primary care setting.

The Queensland Government recognises that it is time for reform of the mental health system, and that national commitment and coordinated effort across all jurisdictions is required to address the needs of people suffering mental illness. It is clear that we need to improve the mental health system to ensure that it is flexible and responsive enough to meet the needs of Australians with mental disorders, and I have noted your arguments for the increased use of GPs and appropriately trained psychologists in the primary care setting.

I am confident that at our February meeting, COAG will commit Senior Officials to develop proposals for collaborative reform of the mental health system for our consideration later in the year. Please be reassured that I will provide the Queensland officials participating in the COAG mental health reform process with a copy of your correspondence to inform their deliberations on this issue.

Yours sincerely

PETER BEATTIE MP
PREMIER OF QUEENSLAND
MI135137
MO: H/06/00755
1 MAR 2006

Ms Robyn Vines
Clinical Psychologist
PO Box 16062
DUBAI
UNITED ARAB EMIRATES

Dear Ms Vines

Thank you for your correspondence dated 29 January 2006, seeking the support and advocacy of the Queensland Government through the Coalition of Australian Government (COAG) mental health planning process for a sustainable model for Primary Care Psychological Services across Australia. I note that you have also written to the Prime Minister with copies to other State and Territory Premiers and Health Ministers. I also appreciate the extensive background correspondence you have provided dating back to 2003 when this topic was previously canvassed with the Federal Health Minister and Senior Commonwealth Public Servants in the Department of Health and Ageing.

I can assure you the Queensland Government is strongly committed to primary mental health care as an integral component of a comprehensive mental health care system. To this end, a number of Primary Mental Health Care initiatives have evolved over recent years in partnership with various key groups including the Queensland Division of General Practice (QDGP). Most recently Queensland Health has joined with the QDGP and the Queensland Office of the Department of Health & Ageing to fund the Partners in Mind project aimed at strengthening primary mental health care at the local level. The Better Outcomes in Mental Health Care Project to which you refer, has also been progressively implemented in Queensland. The QDGP advise me that all 18 Regional Divisions of General Practice are now engaged in the Better Outcomes in Mental Health Care Project with over 700 doctors undertaking the requisite training.

Queensland Health is currently developing the State Mental Health Services Plan 2006-2011 as part of the broader health services planning process underway within this State. Priority attention is being given to strategies and partnerships that strengthen and expand the quality, range and availability of primary mental health care options throughout this State. In addition to the important contribution of General Practitioners and Psychologists in provision of primary mental health care services, models that acknowledge the essential primary mental health care role played by a range of other health professionals, as well as cross sector agencies and workers, will also be pursued during this planning.
Please be assured that the Queensland Government's submissions to, and participation in the ongoing COAG mental health service planning will strongly advocate for the embedding of comprehensive and accessible primary mental health care models throughout Australian communities.

Should you have any queries regarding my advice to you, Ms Simone Caynes, Principal Policy Officer, Mental Health Branch, Queensland Health, will be pleased to assist you and can be contacted on telephone 61 7 3131 6911.

Yours sincerely

[Signature]

STEPHEN ROBERTSON MP
Ms Robyn Vines
Honorary Senior Research Fellow
Department of General Practice
Faculty of Medicine, Nursing and Health Sciences
Monash University
PO Box 16062
DUBAI
UNITED ARAB EMIRATES

Dear Ms Vines

Thank you for your further email of 1 June 2006 to the Premier concerning mental health services in Australia. I have been requested to reply to you on the Premier’s behalf.

The Premier notes your letter of 30 May 2006 to the Prime Minister and the attached information. As with your previous correspondence, I will provide the Queensland officials participating in the mental health working group with a copy of your letter to inform their deliberations on this issue.

Thank you for bringing your suggestions to the Premier’s attention.

Yours sincerely

Rob Whiddon
Chief of Staff
Ms Robyn Vines  
Clinical Psychologist  
Department of General Practice  
Faculty of Medicine, Nursing and Health Sciences  
Monash University  
PO Box 16062  
DUBAI  UAE

Dear Ms Vines

I refer to your email of 1 June 2006 addressed to Hon John Hill MP, Minister for Health concerning federal budget allocations to Mental Health. The Minister has noted your concerns.

I advise that this issue is the responsibility of the Minister for Mental Health and Substance Abuse. Accordingly, your correspondence has been forwarded to Hon Gail Gago MLC for her attention.

If you have any further enquiries regarding your correspondence, please contact Minister Gago’s Office on telephone 0061 88463 5680.

Yours sincerely

Carolyn Lee  
Office Manager to the  
Minister for Health

Date: 7-6-06
February 2006

Ms Robyn Vines  
Honorary Senior Research Fellow  
Faculty of Medicine, Nursing  
and Health Sciences  
Monash University  
PO Box 16062  
DUBAI UNITED ARAB EMIRATES

Dear Ms Vines,

I refer to your email of 29 January 2006 addressed to Hon John Hill MP, Minister for Health concerning the treatment of mental health patients. The Minister has noted your concerns.

I advise that this issue is the responsibility of the Minister for Mental Health and Substance Abuse. Accordingly, your correspondence has been forwarded to Hon Carmel Zollo MLC for her attention.

If you have any further enquiries regarding your correspondence, please contact Minister Zollo’s Office on telephone 61 8 8463 6611.

Yours sincerely

Carolyn Lee  
Office Manager to the  
Minister for Health
Dear Ms Vines,

Thank you for your recent emails to the Premier of South Australia, Hon Mike Rann MP and Hon John Hill MP, Minister for Health regarding early intervention models for psychological services. As this matter falls within my portfolio responsibilities, I am responding on behalf of the Government of South Australia. I apologise for the delay in this response.

The State Government welcomes input and advice on matters of public interest and I thank you for your suggestions.

Health and mental health in particular, is a top priority for this Government and the issues you have raised concerning early intervention and access to psychological therapies are being considered as part of ongoing COAG discussions on mental health reform.

The State Government is always interested in finding ways to improve services and your suggestions concerning ways to prevent increased acuity and subsequent acquisition of co-morbid disorders in clients will be considered along with other strategies during our planning processes. You may be interested to know that there has been some progress already in line with some of your suggestions and early intervention strategies involving the use of resources within the non-Government sector have already received support in South Australia.

In 2004-2005, $25 million in once off funding was allocated to boost primary mental health care services and community based recovery support services. As part of this funding, an allocation of $2.75 million was made to the South Australian Division of General Practice to improve shared care for clients with a mental illness and provide improved access to allied health professionals. We have also recently opened the Centre for Treatment of Anxiety and Depression in the western suburbs of Adelaide.
Further work is being undertaken as part of the current South Australian Mental Health Care Improvement Initiative, with emphasis on the area of short term intensive cognitive behavioural psychotherapy for clients presenting with anxiety and depression. This initiative brings together carers, consumers and frontline staff in the planning and implementation of care improvement activities via an evidence based action research methodology that will inform future service redesign.

Thank you for your interest in this matter.

Yours sincerely

HON GAIL GAGO MLC
26/4/2006
2 JUN 2006

Ms Robyn Vines
Honorary Senior Research Fellow
Department of General Practice
Faculty of Medicine, Nursing and Health Sciences
Monash University
PO BOX 16062
DUBAI
UNITED ARAB EMIRATES

Dear Robyn

Thank you for your email of 24 April 2006 following my previous letter to you of 10 February 2006 regarding mental health services in Australia.

I welcome your interest in improving mental health services. As you would be aware, the 10 February 2006 Council of Australian Governments (COAG) meeting achieved welcome progress on a number of health issues. Importantly, COAG noted that additional resources will be required from all governments to address mental health. COAG asked Senior Officials to prepare a mental health action plan to be brought forward for its consideration as soon as possible, no later than June 2006. You will be pleased to note that COAG specifically asked that the action plan include initiatives that align with some of your suggestions. In particular, it is to include:

- a renewed focus on promotion, prevention and early detection and intervention, including reducing the impact on mental health of substance abuse, including illicit drugs (such as cannabis and amphetamine-type substances) and alcohol;
- getting the balance right between hospital care, community and primary care, and the best type of accommodation for people who are unable to manage on their own;
- improving and integrating the care system to enable the right care to be accessed at the right time, including mental health services, primary care, general practice, private psychiatric services and emergency department services;
- improving participation in the community and employment, including greater use of non-government organisations and improved community based and cross-sectoral supports for people with mental illness and their families, such as supported accommodation, rehabilitation services and respite care; addressing structural issues such as workforce changes including the roles of different professions;
• increasing the role of psychologists and other health professionals in primary care; and
• increasing the health workforce available to address mental health issues.

In addition, COAG agreed that the delivery of mental health services would be an integral element of the new National Health Call Centre Network.

The Commonwealth and New South Wales are jointly chairing a national working group to take the action plan forward. Queensland is contributing to this process through an interdepartmental committee, which is examining the specific outcomes Queensland is seeking in mental health reform, as well as identifying possible initiatives for inclusion in the national reform package.

I note your concern about the level of funding that would be announced in the May Federal Budget. You would have seen by now that the Commonwealth announced $1.863 billion in new money over five years for the national action plan. My Government welcomes that announcement. In particular, the Commonwealth’s initiatives will help provide earlier and better treatment for mild and moderate cases of mental illness.

In October 2005, I announced a $201 million funding boost for mental health as part of Queensland’s Health Action Plan. That was on top of the $472 million already being spent in the health sector alone on mental health in 2005-06. Indeed, the National Mental Health Report 2005 showed that, between 1992 and 2003, Queensland increased its per capita gross recurrent expenditure on mental health by 74%. I can assure you that my Government will continue to work with the Commonwealth and all States and Territories to explore ways to improve Australia’s mental health system as we move forward with the national plan.

I will provide the Queensland officials participating in the interdepartmental committee with a copy of your correspondence to inform their deliberations on this issue.

Again, thank you for bringing your suggestions to my attention.

Yours sincerely

[Signature]

PETER BEATTIE MP
PREMIER OF QUEENSLAND
Ms R Vines  
Clinical Psychologist  
Honorary Research Fellow  
Department of General Practice  
Faculty of Medicine, Nursing and Health Sciences  
Monash University  
PO Box 16062  
Dubai  
United Arab Emirates

28 MAR 2006

Dear Ms Vines

I write in response to your emails concerning a model for the provision of psychological services in general practice settings.

I am advised by the NSW Department of Health that funding initiatives, such as the one you recommend, are the responsibility of the Australian Government and have been further discussed at the February 2006 meeting of the Council of Australian Governments. The Department is committed to working closely at a senior level with clinical psychologists to better use the specialised skills that they bring to service delivery and to improve the quality of care and the cost effectiveness of interventions.

I am also advised that the NSW Chief Allied Health Officer, located in the Department, has the responsibility of liaising with allied health professions. This position was created in 2002 and is similar to positions in Queensland, Tasmania, Western Australia and the ACT.

The Department is working with the Australian Psychological Society (APS) on workforce issues. A document, *Towards a more efficient & Effective Mental Health Service In NSW Health: The Development of An Effective Clinical Psychology Workforce*, has been produced. Both the Centre for Mental Health and APS are addressing the recommendations from this paper to advance the current status and future directions of psychology services.

The document was produced in collaboration with a group of Senior Clinical Psychologists from NSW Area Health Services, the Centre for Mental Health and the APS. It aims to facilitate the work of NSW psychologists and maximise the specialised skills that they bring to deal with mental health issues in general health settings, promotion, prevention and specialised mental health services (in both community and inpatient systems) across the age spectrum.
The initiative has led to the formation of the State Health Senior Psychologists Forum, which includes representatives from the APS and meets quarterly. NSW Public Health psychologists now meet as the Psychologist Advisory Council (PAC), a consultative group with senior practitioner expertise in mental health and child and adolescent and from general hospitals across all NSW Area Health Services.

Should you require any additional information, please contact Dr Michael Paton, Deputy Director - Clinical, Centre for Mental Health, on (612) 9391 9211.

Yours sincerely

Cherie Burton MP
Minister Assisting the Minister for Health (Mental Health)
Monday 31st March, 2008

The Hon Nicola Roxon MP
Minister for Health and Ageing.
MG 50, Parliament House
Canberra ACT 2600

Dear Minister,

Re: Collaborative Primary Mental Health Care

I am writing in strong support of current improvements in access to psychological services in the community. The system now in place, centered on the collaboration of GPs and psychologists, has opened up treatment options previously unavailable. The opening up of these services on an affordable basis taps into the widest range of mental health issues at the point of contact with the public health system in general practice. Australia is in advance of a number of other western democracies where collaborative care between GPs and psychologists is viewed as desirable and cost-effective, but as yet remains unfunded. Australia’s new developments have been cited internationally as a model of what is possible in primary mental health care in Canada and elsewhere.

I have responded in detail (see attachment B) to a number of statements made in recent press articles (see Hickie & Russell: "The Australian", March 15). Key points are as follows:

- Contrary to what is claimed, Better Access does not switch the focus from collaborative primary care; rather it builds upon earlier BOMHC/ATAPS and MAHS programs and provides a clear framework for community-based multi-disciplinary treatment of clients with mental health problems.
- Better Access is not responsible for declines in CDM funding -- it needs to be recognized that current CDM under-funding was due to covert cost-shifting by the previous Howard Government (“robbing Peter to pay Paul”) which claimed that COAG mental health funding was “new”/“fresh” (this anomaly was discovered at Senate Estimates). Better Access should not be judged for not being a chronic disease program. It was always a mental health initiative and should not be blamed for the previous government’s cut in CDM funding.
- The decline in utilization of psychiatric services under Better Access does not necessarily imply that patients are not getting “better access”. It may actually mean that they now have a long-overdue choice and that they, and their GPs, are choosing psychological rather than repeat-medical care. The aim of Better Access was to “free up psychiatrists” to treat the “deep end” of the psychiatric spectrum (psychotic, bipolar and comorbid disorders). However, genuine psychiatric outreach programs (such as those initiated by Nick Kates in Canada) are required to reach these patients. Medicare-funded psychiatrists may need to change their fixed, “office-bound” ways of working for this to happen.
- It is misleading to claim that Better Access is not reaching “new” patients, or that “RRR” (i.e. regional, rural and remote) Australia is not being better serviced. Rural practitioners indicate that Better Access/medicare-funding has significantly improved mental health service delivery.
As a mental health professional in “RRR Australia”, I can say that what we have now under Better Access is in stark contrast to what existed before. Patients seen under the new collaborative care arrangements are new (ie. not serviced under previous initiatives); they would not be able to access or afford these services without government support; they previously would have been referred to the one local psychiatrist in our community and, after a long wait, been prescribed medication - this frequently would not have been helpful, nor would it have been the patient’s or their GP’s treatment of choice. The patients I see are getting better under psychological treatment, most in four-six sessions, some require follow-up to approximately nine sessions. It is an effective model of early intervention, preventing the development of more severe conditions, and subsequent hospitalization in a number of patients (a huge cost-saving).

Building upon this local experience, it is now time for national assessment and review of these initiatives and the cost-savings they have generated throughout the country. This could entail:

a) **proper evaluation of current HIC/medicare data** across all professionals involved in mental health service delivery (psychiatrists, GPs, psychologists - clinical and other, mental health nurses and other allied health professionals) to include the following parameters:
   - diagnostic codes of patients;
   - fees charged (scheduled fee, gap and total);
   - length and numbers of sessions per patient;
   - geographic/ARIA locations of practitioner and patients (and socioeconomic classification of these)

There needs to be “an open, transparent system of evaluation and accountability” in which HIC/medicare data is analysed on an ongoing basis across all professions and results used publicly to provide feedback and determine policy.

b) **recognition that medicare allocation was never seen as the entire answer** - (see proposed multi-faceted model sent to COAG in 2006 - attachment A). It is, however, a necessary part of harnessing the current mental health workforce in regional, rural and remote (RRR) Australia. There are ways in which geographic maldistribution can be tackled without dismantling what clearly works already but needs to be supplemented.

Continued support for Better Access is needed to build on current gains in primary mental health care - particularly in regional, rural and remote Australia where access has traditionally been difficult but the new initiative has improved things considerably.

Yours sincerely,

Robyn Vines MSc, FAPS  
Clinical Psychologist/  
Honorary Senior Research Fellow  
Department of General Practice  
School of Primary Health Care  
Faculty of Medicine, Nursing and Health Sciences  
Monash University, VIC 3800, Australia/  
PO Box 1783, Bathurst NSW 2795  
Mobile: 0429 778268; Phone: 02 6331 8320  
Fax: 02 6332 1020; Email: robynvines@bigpond.com

cc. The Hon. Bob Debus, Minister for Home Affairs, MP for Macquarie.  
(Attached: letters to previous PM and COAG, early 2006, and relevant articles written at the time RV.)
Attachment B: Response to key points (in quotes) of recent newspaper articles

Article 1: Professor Ian Hickie: “The community will expect the Rudd Government to get it right” (Opinion, The Australian, March 15, 2008)

- “Past governments of all persuasions have made promises but not delivered on national mental health reform”:
  Wrong – at least at the Federal level. Substantial changes were made under the previous government with support from Julia Gillard and Labor (despite some reservations about the structuring of services). The Access to Allied Psychological Services (ATAPS) Initiative was a highly successful program and the forerunner of further steps forward in collaborative mental health care. The long-overdue provision of Medicare funding for psychological services via the Better Access to Mental Health Care Initiative was also a huge step forward. Numbers of patients using these services indicate that it “unleashed” an un-met need, not dealt with by psychiatry. Whilst not perfect, Better Access has been an enormous step in the right direction.

- “There are still no clear mechanisms for monitoring progress” - (true) – “and the reform process is still directed by the same state-based bureaucracies that failed to deliver previously.”
  Wrong. Whilst many aspects of mental health service delivery are still under state control, huge reforms have been enacted at the federal level (Better Access itself is a federal initiative). Further federal control is required to ensure generic national frameworks are rolled out coherently across the country - to include the “deep end” psychiatry disorders (psychoses, bipolar and personality disorders) which are being woefully dealt with by state-based services.

- “Better Access to Mental Health Initiative..... is a narrow dysfunctional model strongly supported by doctors and psychologists.”... “there is little evidence of a shifting of services to those who did not receive help previously” ...... “a myriad of cross-referrals and an explosion of disconnected office-based practitioners”.
  These points are a gross misrepresentation of what exists, certainly in our region. We have close liaison with referring GPs, many practitioners are co-located for at least some of the week (room shortages preclude full time, but close relationships exist from part-time work together). What is described has been applicable to Medicare-based psychiatry for many years: GPs complain of patient referral to psychiatrists where patients are “never seen again”, where they are prescribed medication (which GPs could have done themselves), many remaining ultimately un-helped in resolving the problems leading to their distress in the first place.

- “If Better Access were better structured, linked to new GP super-clinics and delivered in combination with other new national community nursing, youth, housing and employment initiatives, it could still be a stand-out example of what can be achieved in this country”: Better Access is already linked to the new GP super-clinics where services (GP, psychiatric, psychological, nursing) can be/will be accessed under medicare (when these new clinics are ready). Better Access also provides for a number of the functions outlined above (eg. it covers the bulk of psychological services delivered through the new “headspace” youth initiative; and some mental health nursing/outreach services (linked to psychiatrists and GPs) are included under the program.) It is important to emphasise that the initiative backs/supports well-thought-out models of collaborative care (with mechanisms of accountability back to the coordinating GP). However, it does not do the thinking for individual communities about how they arrange their care. GP super-clinics are not the answer nation-wide. In some under-
serviced locations, they may well provide an improvement on what is on offer. However, what exists (ie. numerous smaller, well-functioning general practices across the country) need to be supported as well, with provision of access to cross-professional input. Many patients prefer the personalized continuity of care and “anonymity” of smaller practices; “big juggernauts” may not maintain the confidentiality required (particularly in smaller communities). They are also extremely expensive (and it remains to be seen whether the rural-based super-clinics can/will recruit sufficient numbers of GPs). It’s best to build economically and productively on what we already have, rather than role out yet another expensive tier of care (and infrastructure) across the country.

- “Increases in out-of-pocket expenses and centralization of high quality services in harbour and beachside suburbs of Sydney and Eastern Melbourne”: this may be true, as it is indeed (and has been for many years) of psychiatry. If some psychologists have replicated the greed (big fee gaps on top of already large scheduled fees) and metrocenism of psychiatry, this does not negate the value of the new program. It is providing new, funded services in “RRR” Australia which were previously not available. If such concentration of services is to be “corrected”, such correction needs to include medicare-"disconnected-office-based" psychiatry as well as such psychological services. Patients are voting with their feet so, if any are to be dismantled, it may be best to leave the clinical psychological practices in tact which may provide more time/cost-efficient services.

- “...the minister will have to overcome bureaucratic inertia as well as those professional organizations that fight intrusion of government into business practices of doctors and psychologists”: Does Professor Hickie include the RANZCP amongst this group of organizations? Psychiatry has been one of the best at “fighting intrusion by government” and the required close monitoring of its own metrocenism, fee structure(including gaps), and numbers of sessions provided per patient. (My own experience of the Commonwealth Department of Health and Ageing does not include a sense of “bureaucratic inertia” but has entailed an interaction with people who are extremely responsive and doing their best to create new ways of addressing the nation’s health problems.)

- “Financial incentives that promote collaborative care must replace those that still prop up isolated and disconnected forms of practice”: Better Access does promote, indeed requires this (whether or not services are co-located): frequent accountability by the psychologist/allied health practitioner back to the GP is mandatory under Better Access (often non-existent in previous community-based psychiatric care and state-based mental health care). Sessions are limited to six (after the detailed 2710 referral); contact between doctor and psychologist is required upon completion of these six sessions. If further sessions are needed, re-referral under a 2712 referral is made after collaborative discussion between patient, GP and psychologist.

- “Let’s hope the new minister acts quickly to correct the strategic and administrative errors of her predecessors....immediately instituting a new national advisory structure reflecting community rather than industry or state-based priorities”: The reality is that Better Access emerged over many years of the Commonwealth Department of Health and Ageing assessing community-based collaborative care models. It built on previous successes under MALS, BOMHC/ATAPS and government-funded evaluation studies (such as the “Clinical Psychology in General Practice Project”). Federal health bureaucrats worked long and hard to come up with models that redressed some of the previous inequities in mental health service delivery under the public health system (psychiatry was the only medicare-funded speciality). Professor Hickie was closely involved in the discussions that led to the new developments. There was cross-party
agreement that medicare should move to include previously inaccessibe services. It is not clear what his sweeping statement above means, except that perhaps he wants to be included in a process that winds back decisions that he was part of making.

Article 2: Lesley Russell: “Mental health money misses the most needy”  
(The Australian, March 15, 2008)

- “Better Access to Mental Health Care Initiative ... switches the focus for the provision of mental health services away from the established coordinated system of medical and psychological care, as provided under programs such as Better Outcomes in Mental Health (BoMH), More Access to Allied Health Services (MAHS) and Chronic Disease Management (CDM) to an independent provider system with fee-for-service rebates, despite evidence that these collaborative approaches are superior” later in the same article. “the number of mental health services delivered by psychologists under CDM declined.....it is assumed that these patients with chronic and complex conditions are now accessing psychological services through Medicare.”
  - Better Access actually builds on BOMHC/ATAPS and MAHS, and psychologists and GPs continue to work closely in an interdisciplinary framework/model of care (much of it co-located - even if some, by necessity (shortage of rooms) are seen “off the GP premises”)
  - To say that Better Access has switched focus away from CDM/chronic disease management is misleading and unhelpful. It is not has never been a “chronic disease initiative” (COAG Feb. 2006 deliberations – out of which Better Access grew - were focused entirely on mental health) The fact that Howard Government moved funding from BoMHC to CDM and back to Better Access (they admitted this in Senate Estimates) does not mean that Better Access is flawed/has failed. It simply means that the Howard Government mis-led people that the funding was “fresh”/”additional” rather than a result of “cost-shifting”(what’s new?!) The fact that CDM is now short-funded is not a basis on which to judge Better Access – and should not be rolled out as an argument against it. It is not good logic/is damaging as it confounds many factors. Arguments should be mounted for new CDM money – rather than dismantling mental health initiatives to provide this - it reeks of what the Howard government did in the first place! (CDM had nothing to do with mental health care - any mental health service delivery through the program was minimal - the session numbers too few and the rebate for these a joke!)

- “The new system has no incentives or requirements for co-location of services, effective geographical distribution of services, provision of early interventions for young people or treatment of patients in greatest need at low cost. ... under these new Medicare arrangements, most of the beneficiaries were those who were already receiving treatment who could afford the large gap payments. An analysis of data from the Medicare Australia website highlights that these concerns are well-founded.”(she says later in the same article: “it is not possible to really know how much of the Better Access program is new funds serving new patients.” (!))

Certainly, our experience in “RRR Australia” is that these assertions are not true. We are seeing new patients who could not afford the services if medicare-funding were not available (ie low cost intervention for those in greatest need), we are co-located and collaborate closely with our referring GPs (Better Access ensures this); we do provide
early intervention for young people as well as adults. It is not clear how current “analysis of the Medicare data” actually proves that patients now seen were already receiving treatment. Where are the figures? Certainly patients we see are new! (as mentioned above)

- “Although patients are entitled to 12 services in a calendar year (and 18 services in some circumstances), it is clear that most patients are getting dramatically less than this. In fact, it is not unreasonable to claim that having a mental health care plan is no guarantee that a patient will get access to further mental health services”: It is absurd to say that the fact that many patients are getting less than the 6/12/18 sessions allowed under Better Access means that the services are not working/the patients are not getting adequate treatment. Quite a number of patients get better in four (well-spaced) sessions (with homework); many after the first round of six (under the 2710 referrals), some need a few of the six “follow-up” (“2712 referral”) sessions (which can be used to monitor progress over a longer period of time, provide “set-back prevention?stress inoculation”, after the main treatment has been provided in the first 4-6 sessions). Only the complex BPD’s/comorbid A&OD/PTSD patients need the full 12-18 sessions. If treatment is focused and effective (which it can be for the common mental disorders: depression, anxiety etc) it is efficient!

- “It is very clear that patients are not getting better access to out-patient psychiatric services as a consequence of this new initiative. Last year there were 119,647 fewer psychiatric consultations reimbursed under Medicare than in 2006. One obvious explanation is that there is a small number of psychiatrists in Australia -- around 1800, nearly all of whom are in the leafy suburbs of Sydney and Melbourne -- and they are so busy that they do not have time for new patients. The increased fees provided under the Better Access initiative may have encouraged them to do less for the same income levels.”; the decline in out-patient psychiatric services under Better Access does not necessarily mean that patients are not getting “better access” but that, now that they have a long-overdue choice, they are choosing (as are their GPs) to refer themselves to a (primary care) psychologist/clinical psych. It may have nothing to do with psychiatrist choice “to do less”, but more to do with patient choice to go elsewhere. The Better Access plan was supposed to increase access to psychiatry services but it clearly hasn’t done that. However, it is not clear that this the “fault” of Better Access? — It may have more to do with the “fixed ways” in which medicare-funded psychiatrists have worked for many years. As outlined above, it can be argued that many patients (and their GPs) are now voting with their feet—choosing treatment options with psychologists (a long-overdue choice). The aim of Better Access was to “free up psychiatrists” to see the more chronic, “deep-end” population (psychoses, comorbidities, etc). However, these patients are not being/cannot be reached by psychiatrists sitting in their consulting rooms in (eg) Macquarie St. They require genuine “outreach” programs into the community (such as that used by Nick Kates in Canada for many years) in which the psychiatrists actually liaise (physically) with referring GPs (in much the same way as psychologists are doing for “common mental disorders” — many of which are also severe and chronic—the fact that they’re “common” does not make them “easy” or “on the cusp of being ‘worried well’ ”). What is becoming apparent is that psychiatry, as it currently works is:

a) Frequently not the treatment choice for patients & their GPs,
b) is not actually reaching the population it is meant to target by remaining isolated and “office-bound”.

- “There are a number of confounding and unknown factors that make it difficult to properly evaluate the first full year of operation of the Better Access program from
the publicly available data. However, on current information the most obvious conclusion is that this is a poorly designed policy initiative, not just poorly targeted but also poorly modelled and costed.” The figures need to be analysed properly, and their meaning made clearer, before such sweeping assertions are made (particularly in the Press!). It can be very damaging to make assertions before discovering (on a true “evidence base”) what is actually going on.

- “Last year the cost of the Better Access program was $143.3 million, well in excess of the $100 million estimated when the program was announced. Given the huge level of unmet need for mental health services, this is neither surprising nor unwelcome.” Agreed. It is important to emphasise how long these needed services have not been available for! It is perhaps surprising that “cost blowouts” were not greater, given the need to catch up!

- “...we really need to know more about how effective this program is in delivering needed mental health services, who is getting these services and whether the services provided deliver improved mental health outcomes. We also need to know how many patients miss out on needed services because of a shortage of mental health professionals in the areas where they live or because they cannot afford the out-of-pocket costs to attend services which do not bulk bill.” Agreed. However, the earlier parts of the article have prejudged the outcome indicating that Better Access has failed, rather than being open to what is truly going on and working out how to improve it.

Robyn F. Vines
(31.3.08)
Robyn Vines

From: Robyn Vines [robynvines@bigpond.com]
Sent: Monday, March 31, 2008 6:57 AM
To: 'bob.debus.mp@aph.gov.au'
Subject: Email 1: Primary Mental Health Care
Attachments: a)HealthMinister(31.3.08).rtf; A,1)SummarySubmission31.3.08.doc; A1)HealthMinister (31.3.08)B.doc

The Hon. Bob Debus
Minister for Home Affairs
PO Box 6022
House of Representatives
Parliament House
Canberra ACT 2600
Springwood Office: PO Box 376
Springwood NSW 2777

Dear Minister,

I am writing to you as a member of your electorate to request support in relation to the attached letter to the Federal Health Minister.

Over a number of years, Commonwealth-funded trials of primary care mental health service delivery were run in Bathurst, Armidale and Ballarat (and a number of other regional, rural and remote locations – primarily in your electorate), evaluating collaborative care arrangements between GPs and psychologists. The results of these trials were highly successful and were one of the key factors leading to long-overdue allocation of medicare rebates to primary care psychological services. The COAG Better Access to Mental Health Care Initiative has been running successfully since November, 2006. However, recent attempts (via misleading press articles) to undermine the initiative, and to appeal to the Minister to cut these services in preference for other health priorities, are of great concern.

Given that mental health is such a key priority across the country, and particularly "RRR" (regional, rural and remote) Australia, we would be extremely grateful for your assistance in ensuring that current gains are not "wound back" – but indeed helped to develop further.

I have attached (in three following emails) earlier submissions to COAG in 2006, an earlier submission to Tony Abbot (November, 2003 – prior to the 2004 budget) and various articles outlining our approach and supporting the submissions.

Please do not hesitate to contact me should you need further information.

Yours sincerely,

Robyn Vines

Robyn Vines  MSc, FAPS
Clinical Psychologist
PO Box 1783, Bathurst NSW 2795
Honorary Senior Research Fellow
Department of General Practice
School of Primary Health Care
Faculty of Medicine, Nursing and Health Sciences
Monash University, VIC 3800, Australia
Mobile: 0429 778268
Phone: 02 9331 8320
Fax: 02 9332 1020
Email: robynvines@bigpond.com
Dear Ms Vines

Thank you for your letter of 31 March 2008 to the Minister for Health and Ageing, the Hon Nicola Roxon MP, regarding access to mental health services, in particular to the Better Access to Psychiatrists, Psychologists and General Practitioners through the Medicare Benefits Schedule (Better Access) initiative. The Minister has asked me to reply on her behalf.

Feedback regarding how the Medicare items for mental health care are operating in practice is welcomed and appreciated, and I thank you for sharing your views with the Australian Government. I would also like to take the opportunity to acknowledge your on-going commitment to improving the care of people with mental disorders and your work with the Department of Health and Ageing on the role of a clinical psychologist in the general practice setting.

The Australian Government is continuing to closely monitor the uptake of the Better Access Medicare items. You may be interested to know that a post-implementation review of the Medicare items introduced under the Better Access initiative will be undertaken in 2008. The review will focus on the implementation, uptake and use of the Better Access items over the first 12-18 months of operation. The results of the review will inform the Australian Government’s consideration of whether there are any practical improvements which could be applied in the short-term. The post-implementation review will complement a full evaluation of Better Access, to be based on four completed years of operation of the initiative.

While it may not be possible to consider or address all issues identified during the post-implementation review, it is important that issues are identified so that they may be considered as part of the broader evaluation of the Better Access initiative. Accordingly, your correspondence will be brought to the attention of the Departmental officers managing these activities.

Yours sincerely

Lana Racic
Acting Assistant Secretary
Mental Health Reform Branch
14 May 2008
Ms Robyn Frances Vines
60A Mitre St
BATHURST 2795

Dear Ms Vines

Thank you for detailed correspondence on 31 March 2008 regarding your support for the Council of Australian Government’s initiatives in the area of mental health.

The Australian Government is committed to ensuring that people who need mental health services can access high quality care that is appropriate to their needs. The Better Access to Psychiatrists, Psychologists and General Practitioners through the Medicare Benefits Schedule initiative provides better access to mental health care by general practitioners, psychiatrists, clinical psychologists, psychologists and other appropriately trained social workers and occupational therapists. It forms part of the Commonwealth’s component of the Council of Australian Government’s National Action Plan on Mental Health 2006 - 2011 (enclosed).

The government is continuing to closely monitor the uptake of the Better Access Medicare items and will be undertaking a post-implementation review of the initiative in 2008, as was committed to by the previous government. Any review of the Better Access Medicare items will be designed to ensure that patients are accessing the most effective and appropriate services.

I have forwarded your correspondence to the Federal Minister for Health, Nicola Roxon asking how you might contribute to a post-implementation review of these arrangements. The Ministers office has indicated that your correspondence and supporting documentation will be considered in relation to any review.

Thank you for taking the time to write to me about such an important issue for our local community.

Best wishes,

Bob Debus MP
Federal Member for Macquarie
28 April 2008
5. A long-term national health strategy

COORDINATED HEALTH SERVICE DELIVERY: A Federal Framework Required

Australia's public health system is often cited with envy by other first world countries. Despite this, however, there are a number of core problems, including equitability of access to and coordination of "front-line" services, i.e. primary care prevention, early intervention and follow-up.

Patients with any degree of complexity in their illness often experience the health system as confusing, fragmented, frustrating, bewildering and exhausting. There is little cohesion between state and federal jurisdictions, inadequate communication between different health professionals involved in their care and often seemingly random outcomes in treatment and follow-up. Additionally, intra-professional fragmentation, disorganization and "turf disputes" (eg. disjunctions between general practice organizations; the RACGP, Divisions and GPET; the split of psychologists across state jurisdictions, between APS colleges etc.) makes it hard to achieve progress in collaborative service delivery improvements. Primary care reform requires GPs, medical specialists, nurses/nurse practitioners, psychologists and other allied health professionals to work more effectively together in delivery of appropriate care. Improvements in front-line service delivery must be coordinated nationally.

Australia's 22,564 GPs and 7,525 practices bear the brunt of most healthcare across the country, with the vast majority of Australians accessing GP services at least annually. 119 Divisions of General Practice (including 66 rural Divisions) provide information and support to general practices in an attempt to prepare them for evidence-based treatment of the nation's health priorities - i.e. the high prevalence conditions of chronic disease, mental illness, comorbidity, lifestyle/socially-induced conditions such as AOD, obesity/eating disorder-related conditions, etc. The Federal Government is responsible for funding and managing these primary care services, with recent interventions from COAG providing a useful precedent in coordinated introduction of new collaborative care arrangements in the area of mental health and wellbeing, by-passing confusion at state level.

For true service delivery reform to occur, federal coordination is required for: • data collection (mapping of service delivery is still woefully inadequate - eg. a standard (ARIA) methodology for assessing geographic distribution of professions is required); • development of generic models of optimal multi-disciplinary care for key health priority areas (eg. the collaborative service delivery between GPs and psychologists for mental health) - preferably with co-location involved; • a "hub-of-the-wheel" approach to service outreach to GPs (eg. of clinical psychologists, nurse practitioners, other allied health professionals), coordinated by Divisions of Primary Care or alternative Federal Area Health Authorities (which would subsume Divisions).

Only the Federal Government can redress the current fragmentation and consequent bewilderment of the patient; rationalize duplication of infrastructure across federal and state jurisdictions, develop optimal generic collaborative models of care for key national health priorities and roll them out equitably across the country. We need to simplify "over-government", develop a hub-of-the-wheel approach (from COAG out) to optimal service delivery and ensure that the public is getting the best coordinated care possible, with best "bang for buck" in use of health resources.