



Primary health care responses to onsite psychologist support

Helen Winefield*

John Marley[#]

John Taplin*

Justin Beilby[#]

Deborah Turnbull^{#*}

Ian Wilson[#]

Brian Williams*

** Department of Psychology, University of Adelaide, South Australia, Australia*

Department of General Practice, University of Adelaide, South Australia, Australia

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Abstract

With the aim of improving early intervention for mental disorders, the 'Better Outcomes in Mental Health Care' initiative is now providing funding for mental health specialists to work in Divisions of General Practice. A key determinant of how this innovation is received is likely to be the readiness on the part of General Practitioners (GPs) and their patients to accept psychological interventions. This paper reports a baseline study of the attitudes to integrated onsite psychological services, held by GPs, nonmedical staff, and patients at one large suburban family practice. An anonymous brief questionnaire was used to gather both ratings and comments. Information about the way the Psychologist worked was also collected. Surveys conducted in April 2001 and again one year later show welcoming attitudes to the Psychologist on the part of the practice staff and clients, with continuing reservations about the patients' need to pay fees, and GPs' continuing interest in learning more about mental health in primary care. Results are relevant to improved accessibility of community-level mental health care for common disorders.

Keywords

mental health care delivery, general practitioners, psychologists, multidisciplinary collaboration, referral

Introduction

The National Survey of Mental Health and Well-being (Andrews, Hall, Teesson & Henderson, 1999) revealed significant untreated psychological distress in Australians, and a heavy dependence on General Practitioners (GPs) for treatment, in the minority who did seek professional help. Calls for 'primary mental health care' have subsequently increased, most focussing on increasing GP skills to detect and provide treatment for psychological disorders, and on exploring models of including mental health specialists in primary health care delivery.

The report on shared mental health care by Holmwood, Groom and Nicholson (2001) showed that in 1999 true sharing of care between GPs and mental health specialists was being planned or carried out in only about a third of Divisions of General Practice. The British model of funding for mental health care being made available through general practices has resulted in trials in Australia of a similar model, whereby

trained members of Divisions of General Practice can employ mental health specialists to provide focussed psychological interventions (BOMHC: the Better Outcomes in Mental Health Care initiative). The proportion of Divisions including psychologists and counsellors rose from 7% in 1998-9 to 25% in 2000-1 (Modra & Kalucy, 2002), and can be expected to continue increasing (Littlefield, 2002). The options for this collaborative effort include Divisions outsourcing mental health care to existing public services, or locating allied health workers in general practice settings which has several advantages (Jackson-Bowers, Holmwood & Wade, 2002).

Psychologists are professionally trained to deliver evidence-based treatments for psychological disorders including the high prevalence anxiety and depressive disorders which cause so much distress and disability (e.g. see Chambless & Ollendick, 2001; Coyne,

Contact: Dr Helen Winefield, Dept Psychology, University of Adelaide, Adelaide, South Australia, 5005
Email: hwinefield@medicine.adelaide.edu.au
Tel: ++ 61 8 8303 3172

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Thompson, Klinkman & Nease, 2002; DeRubeis & Crits-Cristoph, 1998). Psychologist practitioners are registered with state authorities which also oversee standards of training and ethical practice, and investigate complaints. The Australian Psychological Society accredits professional training programs, both before registration through the universities and through continuing professional development. Clinical psychologists have not surprisingly been identified therefore as key partners for GPs in efforts to improve community mental health, but as these initiatives are new there is little information available about how such partnerships work in practice. The attitudes and expectations of primary care professionals and their patients need to be understood in order to facilitate the introduction of primary mental health care.

This paper reports the first stages of a project whereby an experienced Clinical Psychologist (BW) joined the staff of a large suburban general practice (the Family Practice Unit) for three days per week. Before the BOMHC initiative became available, he provided integrated primary mental health care on a fee-paying basis, and our aim was to monitor attitudes and experiences of the practice staff and their patients during the period of this service being established. This paper therefore reports on the work of the Psychologist, the attitudes of GPs and other practice staff to his work, and how GP attitudes changed over time.

Method

Participants

The Family Practice Unit (FPU) is a large general practice affiliated with an academic Department of General Practice and located in the outer Adelaide suburbs. It serves about 12,000 families and employs GPs (many working part-time), a practice manager, an accountant, four reception and clerical staff, and three practice nurses. The practice bulk bills for medical services. In addition a psychiatrist visits for one session per week, as do other medical specialists. Other health providers including a podiatrist and a physiotherapist rent space on a sessional basis and arrange their own accounts.

The GPs (n=12) who initially provided information in the present study had an average length of experience as a GP of 12.8 years (range 3-33 years); time working at this particular practice ranged from 3 months to 13 years. At the follow-up survey one year later, after one of the original GPs had left and five others had joined the practice, 12 GPs responded to the follow-up survey, and the 9 other permanent members of the practice staff underwent a brief structured interview. The second set of GPs did not differ from the first in experience (average 10.2 years) or in time spent at the practice (3.9 years).

The Psychologist was clinically trained and had over 20 years experience in assessing and treating adult psychological problems, in both private practice and the public mental health service. The Psychologist paid a proportion of his earnings towards practice management, and had shared access to patient records.

Procedure

GPs working at the practice were asked to complete a one-page anonymous survey of their needs and attitudes in April 2001. The initial survey was conducted within the first few weeks of the Clinical Psychologist's appointment to the practice, and thus assesses attitudes towards the new availability of the Psychologist onsite. A follow-up survey with similar questions was conducted in April 2002. At that time seven of the nine other practice staff were interviewed about their responses to the Psychologist's presence onsite, using a brief structured protocol.

GPs were asked to estimate the frequency of significant psychological difficulties in their patients and to rate the importance of various factors which might prevent patients from receiving psychological interventions. Ratings were from 0 = no importance to 3 = extremely important. They were also asked about what would influence their decisions to refer patients for psychological treatments, and invited to respond to open-ended questions about anything else the Psychologist might be able to contribute to the practice. In the follow-up survey a year later they were also asked about the number and

helpfulness of both the referrals they had made to the Psychologist and also of the informal consultations with the Psychologist over patient management.

The follow-up results from GPs have been treated as independent although there was an overlap in participants on the two occasions. No information about the extent of this overlap was possible because the ethical requirement for confidentiality of responses prevented any identification of respondents.

After one year, practice records were also used to summarise the nature of the Psychologist's work, including number and types of consultations per referral. As part of a longitudinal survey of patient psychological needs at the same practice (Winefield, Turnbull & Taplin, 2002), interviews were conducted with 64 patients who had agreed to have information about their levels of anxiety, depression and stress added to their medical casenotes at the practice. These patients' attitudes to psychological referral are summarised.

Results

Nature of the Psychologist's work at the practice

The Psychologist's patient contact work was to provide clients referred by the practice GPs with evidence-based treatment of psychological problems, also to help the GPs with assessment issues and medico-legal reports. In the first 12 months the Psychologist saw 133 patients whose presenting problems were categorised as depression 36.1%, anxiety, panic and stress 33.1%, post traumatic stress disorder 4.5%, relationships or self-esteem 16.5%, pain management 4.5% and other 5.3%. The average number of consultations across the first 119 patients was 5.7 (SD 6.0, range 1-37); median and mode both = 4 consultations per patient.

Other work activities documented by the Psychologist while at the practice included:

- using the patients' casenotes and the practice computerised records for communications (in both directions) with the GPs about patient needs and progress
- using opportunities to discuss patient needs and progress with referring GPs, on the spot at the practice; helping GPs to learn what a Psychologist can offer and which patients are likely to respond well to psychological interventions
- attending meetings and presenting talks to FPU staff and to GPs from other Divisions
- participating in the Mental Health Committee of the local Division of General Practice (e.g., helping to select screening measures for routine assessment of patients' psychological state)
- development of a catchment area referral network through liaison with the local Community Mental Health Service teams and clinics
- testing the suitability of the practice as a training placement for clinical psychology Masters students. Students administered psychometric tests and carried out straightforward therapeutic interventions at no cost to patients (not insurance-paid patients), under the supervision of the senior Psychologist.

GP attitudes

The response rate for the first survey of GP attitudes was 100% and for the second survey it was 75%. GPs' initial estimates of the proportion of patients with significant psychological difficulties ranged from 25 - 80% (average 42%). At the follow-up the average was 38%, not significantly different, although the range was even greater (10-90%).

Tables 1 and 2 show how GPs responded to structured questions about the reasons for patients with psychological difficulties not seeing a psychologist, and factors which would increase their likelihood of referring to a psychologist. There was relatively little change over the course of the study.

Table 1:

GP reports of reasons for patients with psychological problems not to have seen a psychologist. Figures show the percentage of respondents rating the item as very or extremely important.

Reasons for patients not seeing a psychologist	Initial survey	Follow-up
▪ Patients reject referral to any mental health specialist	18	36
▪ Patients can't afford the treatment fees for psychologists	100	83
▪ I feel prepared to treat many patients' psychological problems myself	55	50
▪ I prefer referring to a psychiatrist	27	18

Table 2:

GP reports of what would make it more appealing to them to refer patients for psychological treatments. Figures show the percentage of respondents rating the item as very or extremely important.

Factors affecting likelihood of referral to psychologist	Initial survey	Follow-up
▪ More information about the fees, including for uninsured patients	83	73
▪ More information about the appropriateness of possible referrals	58	67
▪ More information about what methods the Psychologist uses	83	73
▪ Time to test out the service and how patients respond	75	-

To the question 'How important is it to you whether the Psychologist works onsite?', 58% of the GPs replied that it was very important, on both occasions, while none preferred the Psychologist not to be onsite.

When asked 'Is there anything else that you think the Psychologist might contribute to the practice, beyond treating referred patients?', 75% of participants who answered this question on the first survey indicated a wish for the Psychologist to help them learn more about the mental health care of patients, and a third of those also saw co-treatment opportunities (e.g., case conferences). At the follow-up survey, 86% indicated a desire for more information about mental health care from the Psychologist.

GP experiences of the psychological service

At the follow-up survey the 12 GP respondents reported that they had referred an average of 9.1 patients (SD 6.6) to the onsite Psychologist. They rated these referrals as helpful (25%), very helpful (58%) and extremely helpful (17%); none chose the response option not very helpful. The number of referrals seemed to be related to the GP's years of work experience ($r = .40$).

The GPs were asked how frequently they had had informal consultations with the Psychologist about patient management, without necessarily

referring the patient concerned: 2 said never, 7 said occasionally, and 3 said quite often. These informal consultations were rated as helpful (60%), very helpful (30%) and extremely helpful (10%). When asked if they had any other comments about the usefulness or otherwise of having the Psychologist at the practice, GPs expressed general positive views such as that this was 'a great step forward', while more specific comments included 'definitely a help especially if unable to see a psychiatrist till 3 months later', 'broadens the services of the practice', and 'multi-disciplinary focus great, we're working on joint projects'.

Experiences of other practice staff

Four of the seven nonmedical staff reported that the Psychologist's presence at the practice had added to their workload because of having to send out accounts and reminders. However, attitudes to his presence were otherwise positive: comments included 'a big help to some of the clients' and 'someone to tap in to about psychological disorders and treatments'. It was also clear that patients used the nonmedical staff as sources of information about the Psychologist, with 4 staff members reporting that patients ask them what the Psychologist does and what he is like, and five reporting that patients ask them how they can get to see the Psychologist.

The patients' attitudes

When asked about their attitudes to seeing a Psychologist, half the patients (32 of the 64) who had agreed to have their psychological test results added to their casenotes, perceived no need for a psychological consultation. Of the others, 31% expressed various degrees of acceptance, ranging from 'open to the suggestion' (n=5), to 'highly recommend it' (n=10), while 17% were somewhat more negative: from 'prefer to talk to own doctor' (n=2) to 'lack confidence in psychologists' methods' (n=3). When asked about incentives to see the Psychologist, patients predominantly mentioned being enthusiastically referred by the doctor, and receiving onsite and preferably free treatment.

Discussion

GPs showed ready acceptance of clinical psychology services onsite from their commencement, and expected benefits for both themselves and their patients. They expressed considerable interest in learning more about what the Psychologist could offer and who could be referred. They saw the need for patients to pay for psychological services as the major obstacle to their receiving needed treatment. Little had changed for the GPs at the practice after one year's experience with the onsite availability of the Psychologist. However, some who were initially reluctant to refer their patients, had begun to do so. Perhaps during this time they were learning informally about which clients might benefit from such a referral; the responses unfortunately are not truly longitudinal as different GPs participated in each wave of the survey. The continuing expressions of interest by GPs, in learning more about psychological treatments, suggest the need for explicit professional development in this area (see below). The Psychologist expressed satisfaction with the work environment and reported that the clients were typical of those commonly encountered in a private practice. The time-pressured social environment of this co-located practice however was initially unexpected.

The acceptability to patients of the Psychologist's help was a function often of their GP's expectations. Negative attitudes towards

consulting a Psychologist were expressed by only 17% of interviewees, and it seemed that an enthusiastic referral from the GP and being onsite were key positive influences; the payment of fees for this service remained a problem for some, however. The introduction of salaried psychological services funded via the BOMHC initiative should circumvent this obstacle.

Possible difficulties in multidisciplinary mental health teams have recently been examined from the perspectives of several professions. For example, Herrman, Trauer & Warnock (2002) have analysed the obstacles to smooth teamwork between psychiatrists and others, Grey (2002) has offered some ideas about why evidence-based psychological interventions are not more widely used, and Jackson-Bowers et al. (2002) focussed on counsellors in general practice. Some valuable American material describes how psychologists and primary care physicians can learn to work well together (McDaniel & Campbell, 1997; Patterson, Peek, Heinrich, Bischoff & Scherger, 2002). The Australian Psychological Society is now offering advice on effective collaboration with GPs to its members, in support of initiatives like BOMHC that aim to increase the accessibility of primary mental health services for general practice patients (Wyman & Stokes, 2002).

Some of the common themes in papers on multidisciplinary collaboration involve role clarity for members of each profession, mutual respect for each other's expertise and expectations (including the issue of who 'owns' the patient), and realistic understanding of differing work styles and conventions. An important practical recommendation is that students in each profession should be explicitly trained and examined in clinical teamwork and the associated personal skills required. These are areas in which health professional education in Australia is not currently very advanced. For example, there are at present few or no opportunities for advanced medical and clinical psychology students to meet, share classes, or learn about each other's professional roles and expectations. With the crowded curricula common in both disciplines, it will take determination and persistence to overcome that obstacle to interprofessional collaboration.

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