Providing psychological treatments in general practice

Rationale and practicalities

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This is the first article in a series on psychological treatments. Over the next four issues of *AFP*, we will discuss behavioural strategies, structured problem solving, cognitive behavioural therapy and referring for psychological treatments.

The 'Psychological treatments in general practice' series encourages greater integration of evidence based psychological strategies into routine general practice. We believe this can best be achieved by assisting general practitioners to become skilled in psychological strategies that are likely to lead to genuine benefits for patients,[1] as well as tackling the practical issues for GPs.[2] While interest in GP provision of psychological treatments is not new in Australia,[3] currently the recognition of such expertise as part of the Better Outcomes in Mental Health Care (BOiMHC) initiative[4] has raised GP awareness and wider community acceptance (*Table 1*). This series aims to assist GPs to further expand their repertoire of psychological strategies and improve patient outcomes for the vast number of people in the community suffering from common mental disorders (eg. depression and anxiety).

Why GPs?

Clearly, GPs are a central part of Australia's mental health workforce.[5] Consultations for mental disorders make up a substantial component of any GP's workload.[5,6] Indeed, the National Mental Health and Wellbeing Survey suggests that of those people in the community with a mental disorder who seek out professional care, more than 75% will present for assistance to a GP.[7] From a population health perspective, any concerted response to address the large burden of disease attributable to common mental disorders[8,9] will need to engage Australia's widely dispersed and cost effective GP workforce. This shift toward primary care as an important mental health resource is likely to continue in the Third National Mental Health Plan, with GPs playing an ever increasing role as providers of mental health care, and at the same time further integrating with other components of the mental health system.[4,10]

Being so central to mental health care, we believe that GPs need to provide an increased number and range of specific evidence based psychological and behavioural interventions as part of treatment for common mental disorders.[11] In most parts of Australia, specialist providers are unavailable or unable to meet demand for services.[12] Even with the introduction of increased access to allied health referrals, too many patients still do not receive care.[13] For these patients, their best chance of receiving effective psychological treatments is from their GP.

Table 1. Focussed Psychological Strategies – Medicare Benefits Schedule (MBS) item descriptor[4,6]*

- 'Focussed Psychological Strategies' are specific mental health care management strategies, derived from evidence based psychological therapies that have been shown to integrate the best research evidence of clinical effectiveness with general practice clinical expertise.
- These strategies are required to be provided to patients by a credentialled medical practitioner and are time limited; being deliverable, in general, in up to six planned sessions. In some instances, following review by the practitioner managing the 'Three Step Mental Health Process', up to a further six sessions may be approved in any 12 month period to an individual patient.
- Medical practitioners must be notified to the Health Insurance Commission by the General Practice Mental Health Standards Collaboration that they have met the required standards for higher level mental health skills.
- A session should last for a minimum of 30 minutes.

* MBS Book, November 2002; 46:88 for full description.

Table 2. Useful CBT techniques in general practice

Behavioral strategies
- Sleep-wake cycle management
- Activity planning
- Slow breathing exercises
- Muscle relaxation exercises
- Graded exposure
- Stress management

Structured problem solving

Cognitive restructuring

Recent data suggests that only a minority of patients receive evidence based psychological treatments from their GP.[14] SPHERE: a national depression project, found that of 8304 patients receiving nonpharmacological care, 83% received nonspecific counselling and support while 17% received specific evidence based treatments.[14] Similarly, Meadows et al found that of those patients who perceive a need for psychological treatments, approximately 57% received such care from their GP.[15]

For GP provision of psychological treatments to be effective, training is clearly essential. While there is evidence to suggest that GPs can be successfully trained to deliver psychological treatments,[16–18] more GP based research is needed.[19] Promising studies have been reported involving GP provision of cognitive behavioural therapy (CBT)[16,17] and structured problem solving (SPS).[18] Interpersonal therapy delivered to primary care patients also shows positive results.[20] With refinement of GP training in psychological care and adequate support, we argue that GPs can acquire the necessary skills to provide effective treatment.

Perhaps the strongest argument for GP provision of psychological care is the public's preference. In two large Australian community surveys, the public rated GPs as their first choice (ahead of specialist mental health providers) if seeking professional assistance for depression.[21,22] Possible explanations for this preference may be the public's familiarity with the GP, or less perceived stigma in receiving care from a GP than from a specialist provider. These same two studies also reported the public's clear preference for psychological treatments ahead of pharmacological treatments for depression.[21,22] Despite these findings however, a significant proportion of the public still hold reservations about GPs' ability to manage mental disorders.[23] For example, a national survey of 1014 Australians reported that only 41% of respondents believed GPs had the skills to adequately manage depression.[23] This suggests there is still more room for building the public's confidence in GPs' mental health care skills.

Which psychological treatments?

General practitioners already provide 'supportive counselling' as part of usual clinical care,[14] and the value of this approach has been well described by Bloch.[24] He notes the derivation of the word 'support' being 'to carry' and aptly describes this technique as literally 'carrying' the patient.[24] Components of 'supportive counselling' include: reassurance, explanation, guidance, suggestion, encouragement, and changing the patient's environment.[24] Not surprisingly, in the world of evidence based medicine such techniques are harder to research and the evidence is sparse. Even so, supportive counselling and the relationship between the doctor and the patient are widely accepted as the foundation for most effective psychological treatments.[25]

Choices regarding specific psychological strategies for use in general practice are made on the background of ongoing debate among specialists about the effectiveness of specific psychotherapies. Commentators have disputed both the evidence for particular techniques,[26] and the evidence based approach to psychiatry itself.[27] A case in point is CBT, an approach recommended by the American practice guideline for the treatment of patients with major depressive disorders.[28] Detractors argue that its superiority is more apparent than real,[29] and it is a technique that has benefited from a 'drug trial' research culture that values symptom change over changes in relationships.[30] Supporters cite research within an evidence based framework which demonstrate its short and long term effectiveness for many common mental disorders.[11,31–33]

While GPs who choose to provide psychological treatments are not spared this debate, they can at least exclude the protracted psychological treatments that are incompatible with routine general practice. A greater concern, even if one accepts the evidence based framework, is the scarcity of general practice based research.[19] Differences between general practice and

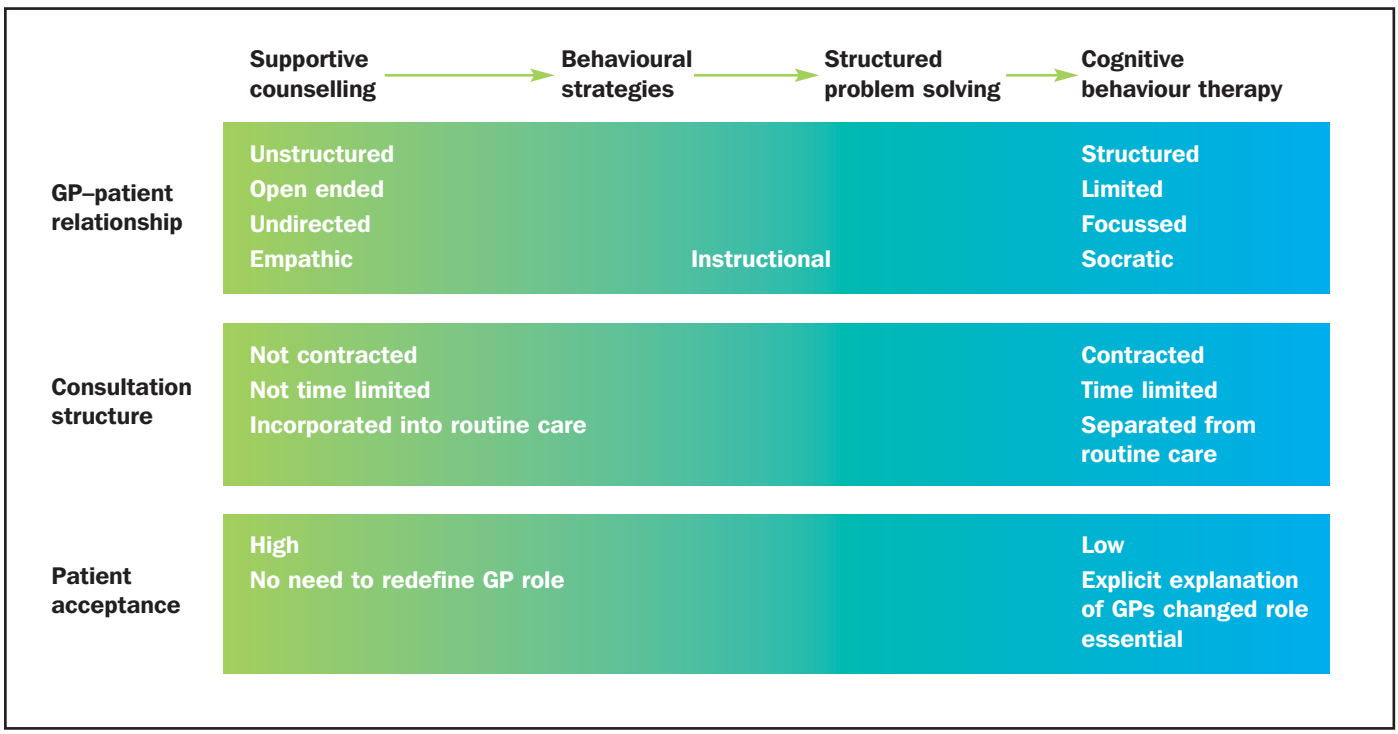

Figure 1. The spectrum of GP psychological care

specialist settings are profound,[34] and are likely to influence the delivery of psychological treatments and successful patient outcomes. Currently, the best we can do is make inferences from the small number of GP studies and the wider experience of specialist providers.

In this series we have selected some specific psychological strategies, based on a CBT approach, which we believe will be valuable to GPs and their patients (*Table 2*). At the same time, we acknowledge that many other effective techniques exist. The approaches that we describe can be used individually or together, and are particularly suited for high prevalence conditions such as depression and anxiety. Gaining skills in these techniques usually requires a combination of understanding theory through reading, and rehearsal of skills within a face-to-face teaching setting.[35]

Practical issues for GPs who provide specific psychological treatments

Compared to the relatively well controlled environment of specialist care, we believe that for GPs to provide successful, specific, psychological treatments, substantial planning is required to address practical issues. Three key tasks for GPs to consider in advance are: management of the change in their role, documentation of psychological consultations, and sourcing ongoing support.

Change in GP role

The provision of psychological treatments by GPs is a change from the usual role as providers of routine care. We propose a model, the spectrum of GP psychological care, which highlights the change in a GP's role as the complexity of psychological intervention increases (*Figure 1*). The nature of care provided impacts on:

- the GP-patient relationship
- structure of the consultation, and
- acceptance by the patient of the GP as a provider of psychological care.

Care provided by the GP can be conceptualised as a progression from 'supportive counselling' (eg. listening, empathy, advice) to behavioral approaches (eg. activity planning, sleep-wake cycle), to SPS (eg. assisting patients to make their own difficult decisions) to CBT approaches (eg. challenging unhelpful negative patterns of thinking). In reality, general practice consultations do not progress in such a linear fashion. An iterative and reflective process will determine which techniques are used according to the nature of the patient's problem, their preferences and the skills of the GP.

GP-patient relationship

Provision of techniques at the supportive/behavioral end of the spectrum do not generally require a significant change in the usual GP relationship with the patient. Listening, empathy, provision of advice and specific instruction fall well within routine GP care. However, providing SPS and CBT often requires GPs to adapt their relationship with their patients, taking on a more focussed and often socratic role. This means the GP is drawing out solutions from the patient, rather than providing advice, which can be difficult for GPs who are used to offering solutions to patients. These techniques rely on specific psychological frameworks and involve setting goals and

assignment of tasks, beyond the expectations of routine practice. Perhaps most importantly, GPs need to be aware that as they venture into emotionally charged territory, the relationship becomes more complicated and boundary issues become more important.[36]

Consultation structure

Adjustment of the GP-patient relationship has implications for the structure of sessions, especially in view of time pressures and competing demands typical of general practice. An open agenda can accommodate the less complicated psychological techniques, but is unsuitable for managing more in depth approaches. The success of SPS or CBT relies on being able to focus patients' attention on specific psychological tasks. Psychologists describe a phenomenon called 'therapeutic drift' where the patient strays from the therapeutic goals of treatment.[37] The risk in general practice is that psychological treatment is 'washed away' by the distractions of routine general practice resulting in a 'therapeutic rip'. For example, GPs need to plan how they will manage requests for physical care in the course of psychological treatment.

Engaging the patient in regular planned sessions of a set duration of time becomes more important as treatment becomes more complex. Having planned consultation sessions conveys to the patient that a specific course of psychological treatment is being undertaken with a beginning and an end. It also allows GPs to dedicate uninterrupted time, and to assign the patient tasks to undertake between appointments. Apart from the practical advantages to practice management, planned regular consultations also serves a psychological function of containing a patient's distress within a set time and place. It is easier to tease out a patient's emotional problems within a framework of planned limited appointments, than during patient initiated visits of uncertain duration.

Patient acceptance

In delivering SPS or CBT, the change in the role of the GP and structuring of consultations need to be actively communicated to the patient. Otherwise, patients may continue relating to the GP in an open ended manner characteristic of routine general practice. In a sense, the GP won't have the patient's permission to limit the consultation to a psychological agenda. Many patients also have reservations about a GP's capacity to treat mental disorders,[23] so GPs need to spend some time enhancing their credibility by emphasising their relevant further training and experience. The use of written materials and worksheets for psychological treatments may also enhance the patient's confidence that their GP is working within a specific psychological framework.[38] Perhaps most importantly, the consulting style will determine how willing patients are to explore psychological issues with their GP.[39]

Documentation of psychological consultations in general practice

Although paperwork is a time consuming and often frustrating part of general practice, in some sense, the documentation of consultations shapes the way GPs think about, and manage, patients. This is especially true in the case of psychological consultations. The sensitive nature of the content of these consultations means that extra care is required in the recording and handling of information.

Confidentiality of GP records is not a concern limited to psychological care.[40] However, the implications of documenting intimate details that arise in the course of psychological care need to be considered, especially where records are widely accessible to practice colleagues and staff. The management of multiple family members within a single general practice is another reason for careful quarantining of sensitive medical record information.

Good records of psychological consultations are however, part of good clinical practice. They help the GP keep track of the key issues between sequential consultations. Given the high rate of relapse for common mental disorders,[41] records act as a memory prompt for the GP and assist with management of recurring difficulties in the long term. Thorough medical records also better facilitate referrals to specialist colleagues. Perhaps one of the most important functions of records is that they help formalise the framework in which the psychological treatment is provided (eg. through articulating goals and monitoring responses with outcome tools over time).[42]

Legal and bureaucratic requirements also influence the documentation of psychological consultations in general practice. A well documented clinical risk assessment is the best evidence of a GP's thoroughness should legal matters arise. For those GPs who choose to access the 'Focussed Psychological Strategies' component of the BOiMHC initiative[4] it is worth planning in advance how to meet the specific paperwork requirements.

From a practical point of view, individual GPs will document psychological consultations differently according to their circumstances. Variables include: the nature of the patient's problem, complexity of psychological treatments, practice size, and whether records are paper or computer based. General practitioners need to consider if notes are to be integrated or separate from routine notes. Widely used medical software programs (eg. Medical Director) allow practice staff different levels of access to medical records information, whereas paper based practices may choose to use a sealed envelope or separated notes to store sensitive information.

Ongoing support

Most mental health clinicians, including specialist psychiatrists and psychologists, embrace a system of ongoing clinical supervision. Currently in Australia, there is no formalised framework for the provi-

sion of peer support or supervision for GPs working in mental health care. However, some divisions of general practice have developed programs including peer support groups, case conferencing, teleconferencing and video conferencing models.[43] Other educational providers have explored internet based systems.[44]

We argue that incorporation of relevant forms of clinical supervision into general practice is a future challenge which needs to be addressed if the quality of GP delivered psychological care is to be maintained.[45] Possible sources of expertise include state based mental health services, private psychiatrists and psychologists, specialists providing treatments through the allied health pilots, and GPs with independent qualifications in mental health. This will require greater integration with general practice and consideration of the time commitment and costs of supporting clinical supervision.

Conclusion

We argue that some evidence based psychological treatments can be delivered effectively by GPs. From a public health perspective, the rationale for supporting GPs in this role is sensible, since specialist mental health services are unlikely to ever fully meet community demand for psychological services. Cognitive behavioral therapy has some advantages for GPs as an evidence based approach that can be delivered in a time limited fashion. Integrating such techniques into general practice requires attention to the practical issues such as managing changes in the GP-patient relationship, consultation structure, documenting psychological sessions, and identifying sources of ongoing GP support and training.

Conflict of interest: Dr Grant Blashki and Dr Hugh Morgan assisted with the development of the cognitive behavioural therapy training module associated with SPHERE: a national depression project. This training module is also an approved 'Focussed Psychological Strategy' program. Professor Ian Hickie is the Co-Chair of the Committee for Incentives for Mental Health, which is concerned with the development of the Better Outcomes in Mental Health Care initiative (2001-2005). Previously, he was the national director of SPHERE: a national depression project.

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