# Allied health professionals providing psychological treatments in general practice settings

## *What options are there?*

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**BACKGROUND** This article is based on a literature review and discussion document developed for the Commonwealth Department of Health and Aging to assist in its deliberations on the structure of the Better Outcomes in Mental Health Program (BOMH).
**OBJECTIVE** This article examines issues regarding the engagement of allied health professionals in the delivery of specific time limited and evidence based counselling interventions in the general practice setting.
**DISCUSSION** Specific issues examined include employment and administrative arrangements, citing of these services, communication between general practitioners and counsellors, as well as clinical supervision and support.

Access to allied mental health services is one component of the Better Outcomes in Mental Health Initiative (BOMH), which resulted from the 2001 Federal Budget commitment to general practice and mental health. General practitioners who have completed Level 1 Mental Health training and are eligible to receive Service Incentive Payments will be able to refer their patients to allied health professionals for time limited psychological treatment. Implementing this program will require the development of new models of service provision, or the modification of existing models.

Funding will be held by divisions of general practice, with a number of pilot sites around Australia being announced shortly. The pilots will run for 12 months and test models of implementation, which will be extended to all divisions of general practice from mid 2003.

Some divisions of general practice have nearly 10 years experience in working with psychologists and other mental health professionals providing counselling services, using a variety of models of employment, contracting, communication and service support. These activities have been undertaken with specific project funding through the More Allied Health Services (MAHS) Initiative. The accumulated knowledge from these projects, including the experience in the United Kingdom and international peer reviewed literature, highlights a number of emerging issues in establishing primary care counselling services which have been fully addressed in the literature review on which this article is based.[1]

### Infrastructure and management

As divisions of general practice will be fund holders for this initiative, employment arrangements for the allied health professionals need to be resolved. Several divisions have previously outsourced employment to mental health services. Reasons for outsourcing may include:

- insufficient funding for administrative support
- lack of expertise with recruitment, induction, and supervision, and
- lack of office space.

Outsourcing may overcome these shortcomings but with the risk of less control over the activities of the allied health employee who then reports to the mental health service rather than to GPs or their divisions. The ultimate responsibility of

the professional must be to the patient and any method of employment needs to reflect this. Direct employment or contracting of the professional by the division has the advantage of ensuring that governance and lines of responsibility are clear. Adequate communication can be detailed in contracts and position descriptions.

A second concern is if this initiative provides extra mental health services, then state services may retract services they have previously provided. This has been addressed in the administrative arrangements behind the MAHS program but requires continuing vigilance. Even if existing services are not retracted, vacancies could fail to be filled, or planning for new services influenced. State mental health services are realising that greater liaison with primary care is essential and joint planning with divisions is one way in which this can occur.

The location of the allied health professional also affects communication, the creation of linkages and nonstigmatising access for clients. When workers are sited in mental health service premises, links with these services provide support through existing administrative and management structures. The downside is that links and communication with GPs may be less satisfactory. The PARC Review of Mental Health Shared Care 2001[2] revealed that GPs are having difficulties in establishing and maintaining communication with mental health services. However, this model may provide opportunities for improving minimum standards for liaison.

If allied health workers are located in general practice settings this allows clients to access counselling and psychological services in a familiar, less threatening environment, creates opportunities for early intervention, and facilitates the use of coordinated psychological and pharmacological treatment.

## Interaction between allied health professionals and GPs

Referral, reporting and the interaction between GPs and counsellors are extensively discussed in the UK literature. A tension exists between the well established individual confidentiality ethic of counselling and the more open practice of sharing information between treating practitioners, or within a treatment team.

In a 1995 study of primary care counsellors in the UK[3] just over half of counsellors reported regularly to the referring GP, however, there was a great deal of variation in information sharing. Kell[4] reported that different general practices had different levels of compatibility with the counselling culture of confidentiality. He argued strongly that high levels of counsellor confidentiality must be maintained in the general practice setting and sees this as an equity issue. Since high income earners can access private counsellors with assured confidentiality, there should not be a difference for those using the public health system. However, this culture of minimal communication can produce isolation of the counsellor, lack of peer support and marginalisation within the practice. One would also expect that better overall treatment plans can be developed with improved information sharing.

The Code of Ethics developed for the UK Association of Counsellors and Psychotherapists in Primary Care[5] takes a middle ground. It recognises that when counsellors work as members of a medical team, there should be provisions for reflecting the client's progress, but that the personal content of sessions remains confidential after due consideration of legal requirements.[5]

Other clauses include: clients being informed of the confidentiality boundaries of working in a team, and the client being able to request that a particular piece of information is kept confidential from the team. This can be overridden where there is a risk of self harm or harm to others. There are similar issues of confidentiality when a patient is referred to a private psychiatrist or psychologist, in that many GPs feel there is not enough feedback on progress.

Differences exist between the UK and Australian health systems, with the UK system making more extensive use of allied health workers within general practice. Substantial government funding supports salaries and practice infrastructure. They do not have the separate state health systems that, in Australia, provide access to allied health through community health care centres. Some of the models being tested in Australia closely resemble arrangements in the UK with divisions being fund holders and allied health being cited in practices or in external premises servicing a number of practices.

## Practitioner support

It is assumed that allied health professionals providing counselling services will be highly skilled, and many allied health professionals in Australia have well established clinical supervision arrangements. However, the general practice setting requires further specific competencies. These include counselling people with medical conditions and somatic presentations of mental illness, knowledge of the place of drug based therapies, as well as knowledge of the medical and health structures within which they will be operating.

Curtis-Jenkins and Henderson propose a four element model of counsellor supervision containing peer support between counsellors in an area, managerial supervision, a formal relationship with a qualified supervisor and the availability of expert consultation by telephone to gain specific advice.[6]

In response to the perception that many primary care counsellors were untrained and that primary care counsellors should not continue as an unregulated profession, the UK Association of Counsellors and Psychotherapists in Primary Care was established in 1998.[7] This association has a register of members who have achieved defined education standards, a code of ethics and a complaints procedure. The association has many useful resources available on its

website at: www.cpct.co.uk.

Key issues in developing the system have been:

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

A paper by the Royal College of General Practitioners,[8] raises the dilemma of defining what the target population should be, the appropriateness of referral and the evaluation of outcomes.

## Conclusion

The BOHM initiative will allow specific psychological treatments to be made available for those in the community without private health insurance and who are unable to pay privately. It is important these services are well integrated into primary care, evidence based, and accessed by those patients who have been assessed as having a need and being likely to benefit from such services. Careful planning and evaluation will enable these arrangements to meet at least some of the mental health care needs of the Australian community.

## Recommendations

Clear governance structures for allied mental health practitioners should be constructed in order for the needs of patients, their GPs, and the divisions to be met. Communication between the allied health professional and the GP needs to be effective to allow good treatment planning, but also flexible enough to allow patient confidentiality for sensitive issues. Existing clinical supervision arrangements for allied health professionals need to be made more widely available, and standards should be set for the types and quality of supervision provided.

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