Submission to the Federal Senate Select Committee on Mental Health 2005

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Recommendations in this submission.

1. **There is need for a greater and more central role for Clinical and Counselling Psychologists in the National Mental Health agenda.**

2. **Six years training in Psychology should be the minimum professional standard accepted by government departments and agencies, for professionals treating psychological disorders**.

3. **The Federal Government should dismantle the *Better Outcomes in Mental Health* initiative and provide these funds directly into MedicarePlus for consumers to be able to *directly* access six year trained Psychologists for the provision of psychological health care.**

4. **There needs to be many more positions made available to six year trained Psychologists in Community Health Centres and public mental health services so that consumers can access these services.**

5. **Non-drug therapies should be supported and promoted as the first line of therapy for mental health problems such as depression and anxiety, with medications used as a last resort – not the other way around.**

6. **There needs to be a shift away from the concept of mental health problems being *mental illnesses,* especially for the high prevalence disorders of depression and anxiety.**

7. ***Ministers for Mental Health*, at both State and Federal Levels, with a separate portfolio and budget from the Health portfolio, need to be created.**

8. ***Divisions of Psychological Health Care* in each state should be developed and supported, similar to Divisions of General Practice.**

Introduction

The Senate inquiry into mental health services is certainly welcomed at this point in time. Both Federal and State Governments have been involved in mental health policies and initiatives for a number of years now and mental health services still appear to be inadequate and not fully appropriate to community needs. One important factor impeding the proper development of mental health services is the lack of financial commitment to this important area of health. There are statistics to show that funding levels into mental health services by the Australian Federal Government are amongst the lowest levels, in terms of percentage of National expenditure (approximately 8%), in comparison to other western democracies. Only very limited *real change* can be achieved if the financial commitment is inadequate. The Federal Government needs to become more cost-effective and needs to discover that large savings from the health budget can be achieved if they put appropriate resources into mental health. These savings would be in the form of preventing or reducing the impact of chronic and complex health and mental health problems, which greatly increase Medicare and pharmaceutical costs. Plus reducing the flow on effects of untreated mental health problems in the form of lost workplace productivity, family disintegration, and drug and alcohol problems, which significantly burden businesses and community members.

There is considerable evidence already available to show that non-drug psychological therapies produce positive outcomes in mental health and wellbeing for individuals and families, whilst also reducing the need for drug therapies and hospital stays. There is also considerable evidence to show that psychological therapies contribute greatly to positive therapeutic outcomes for people with many *physical health* problems.

The many Federal Government initiatives that have been developed over the last few years have provided a positive start to trying to address some of these issues. However the Governments attention to detail and direction at the service level of policy delivery, has been sadly lacking. This has resulted in some good general policies being established, but with useful and practical flow through to consumers, being poor.

This document aims to comment on some of these issues, which in turn will address a number of the Terms of Reference in the Senate inquiry, and will hopefully contribute in a positive way to the mental health debate.

Is there a need for more Mental Health Services?

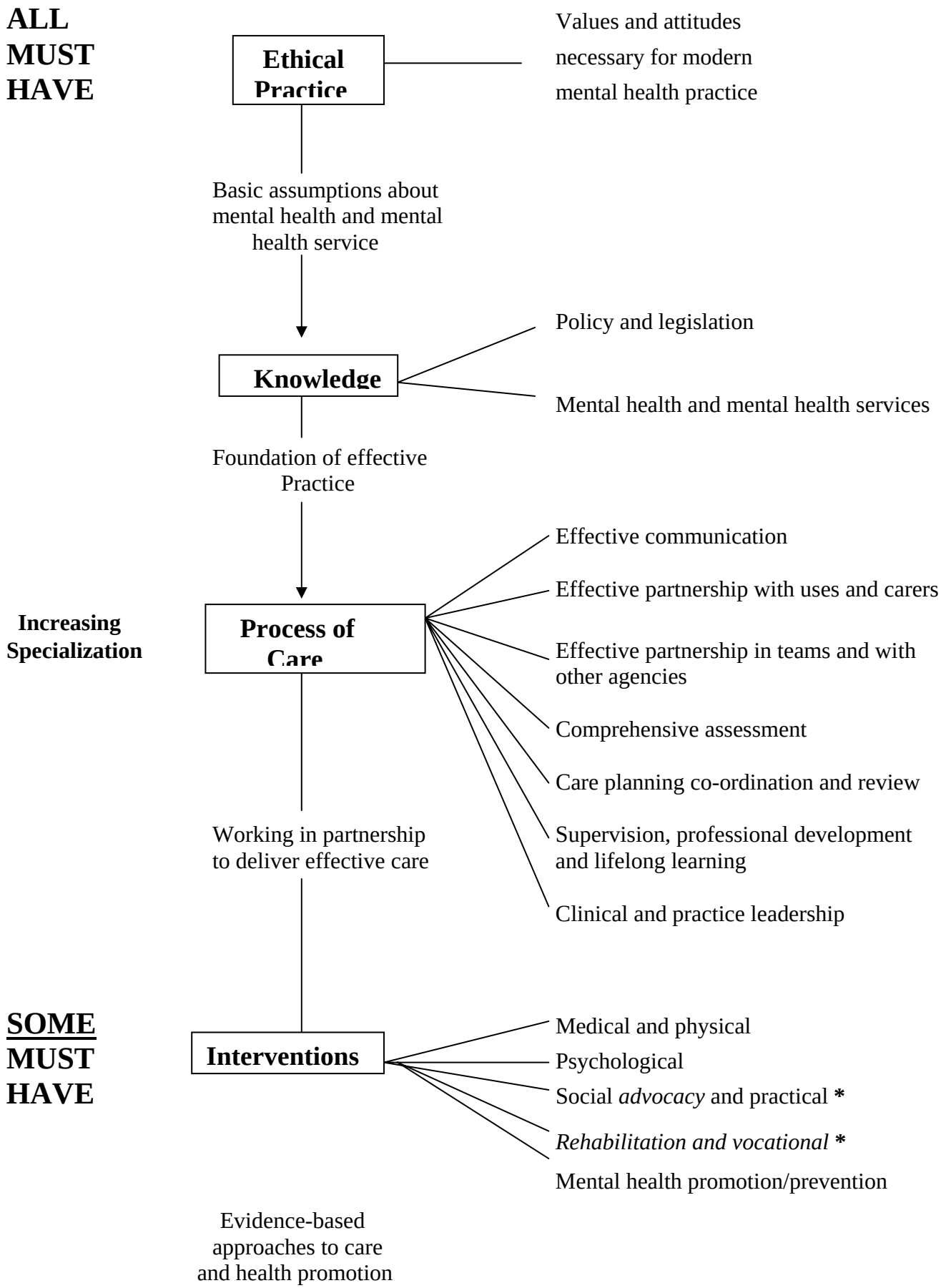
There is considerable evidence showing a high and growing demand for psychological therapy and counselling. A survey conducted over a twelve month period in Australia found that 11.6 % of the adult population had been diagnosed with a depressive disorder and 19.1% had been diagnosed with an anxiety disorder (Commonwealth Department of Health and Aged Care, 1999). A projection by the World Health Organization suggests that depression in particular, will be second only to heart disease as a major health concern in the near future. The high levels of unmet need produce considerable financial and emotional costs in the community and for the Government. The Burdekin Report (1993) went so fare as to claim that the restriction of community access to Clinical Psychologists "results in the denial for individuals to evidence based and cost effective treatment options…….. which is incompatible with human rights and is economically unsound".

What is meant by Mental Health Services?

Mental Health Services are currently provided in a range of settings and from providers with a range of training and expertise. Mental Health care is of course not the domain of any one profession. This is because there are many factors which impinge on peoples lives that can negatively effect their mental health. For example, life circumstances such as unemployment, financial problems and debt, limited access to low cost housing, physical health problems, or accident and injury, can all be factors which negatively impact on a persons or families wellbeing. Specific psychological problems can also arise as a consequences of these difficult circumstances, or can be a contributing factor in the development of such problems. How best to deal with these different issues and what training and expertise are required needs urgent attention. It would be reasonable to suggest that the best outcome for consumers would result from collaborative work between the different professional groups, who work from their own professional training and expertise base, to deal with the multi-leveled and complex problems presented by the individual. No one profession has sufficient capacity, expertise or training to do it all.

An interesting report produced in the UK by the Practice Development and Training Section of the Sainsbury Centre for Mental Health (2001), identified the need to separate out different skills in the mental health workforce. The Sainsbury document aimed to assist in the development of a

UK National set of general mental health competencies, but additionally to develop a concept of professional "capabilities" in mental health practice. They indicated that previous competency projects in the UK emphasized the notion of "core" or "common" competencies or skills that should be shared by all mental health practitioners. They contended however that practitioners require more than a prescribed set of general competencies to perform their role. They also require specific "capabilities" to be able to *apply* the necessary knowledge, skills and attitudes to a range of complex mental health problems and in changing settings, based on profession specific skills and expertise. To develop this concept they produced a list of the essential specific mental health skills required, in a number of different intervention areas, to map competence based profiles for professionals who would provide these services. Their report titled "The Capable Practitioner" produced a useful diagram showing the different competencies required by all mental health professionals, with increasing specialization as one moves closer to the "intervention level". This is reproduced on the next page for discussion.



* **Italics indicate an addition to the model for purposes of this paper**

The diagram indicates that ethical practice standards, a sound knowledge of mental health policy and legislation, and the *general* skills required in the processes of care of people who have mental health problems, need to be present and at a high level in all practitioners dealing with mental health care. Then there needs to be increasing professional specialization the closer mental health care input comes to the "intervention" level. Training and skill differentiation of the practitioner needs to occur at this point and who then provides the intervention should be matched to the particular needs of the consumer or consumer group. Each of the intervention areas have separate and different training bases, and this needs to be the case as no one profession can do it all. The authors of the Sainsbury report also indicated they "do not seek to promote the rise of the generic mental health worker" (p.g.6). Instead, they suggested that particular occupational standards for the promotion of a particular level of expertise in any given area, should be undertaken in conjunction with the particular professional training programs (Universities) and professional accreditation bodies involved, to get the best outcomes for consumers.

The Australian Federal Government has also attempted to look at the issue of standards in mental health care and several documents have been written for the Australian Health Ministers Advisory Council, National Mental Health Working Group on this issue. The first document titled, the "National Standards for Mental Health Services", was submitted and endorsed in 1999 and a second document, titled the "National Practice Standards for the Mental Health Workforce", was submitted in 2002. Both documents provide outlines of important general standards of training and knowledge that all professionals and agencies dealing with people who have mental health problems should have. The Australian National Mental Health Working Group also identified five professions that make up the bulk of the mental health workforce in Australia. These were Psychology, Social Work, Occupational Therapy, Psychiatry and Mental Health Nursing. It could be argued however that these documents did not go far enough, in that they did not attempt to *differentiate* the specific skills (based on the different training programs and professional competencies) needed in the mental health workforce and the consequent workforce planning issues requiring attention.

Given that psychological diagnosis and psychological interventions make up a significant proportion of the mental health care needed by consumers, it would be important to look at the profession with the most dedicated training and competence in these skills. The profession of psychology, it could be readily argued, has to date the most comprehensive training in psychological theory, research and therapy. There are well established

professional Psychology training programs developed at most Universities throughout Australia and there are Psychology Registration Boards in all states of Australia requiring professional registration before a Psychologist can practice. To be able to specialize in psychological diagnosis and psychotherapeutic interventions the training in Australia consists of:

- a four year University degree in psychology,
- two year post-graduate specialist therapy and research training at Masters level (e.g. Clinical Psychology) and
- two years, weekly therapy supervision by a fully registered and highly experienced 6 year trained Psychologist.

The Australian Psychological Society (APS), which the largest professional body representing psychologists, established a Professional Standards Advisory Group who wrote a discussion paper in 1996 titled "Competencies for Psychologists to ensure an effective, skilled and professional discipline". They covered the range of knowledge and skills that should be possessed by a Psychologist who has completed 6 years of university training and is about to enter the profession. The Advisory Group outlined eight competencies.

COMPETENCY 1: DISCIPLINE KNOWLEDGE

This set of competencies is concerned with the knowledge base in the discipline of psychology and is achieved after the completion of a 3 year Degree in Psychology. The Advisory Group stated that this basic training in Psychology is essential to provide the ability to investigate, describe, explain, and predict human behaviour, cognition and affect. It includes the possession of knowledge of psychological theories and models, empirical evidence for them, and the major methods of psychological enquiry. What is important about this competency, is that the Advisory Group stated that: "***It is the foundation upon which the other competencies depend*",** indicating that the undergraduate Degree in Psychology is highly relevant and should not be done away with, in favor of just teaching psychology therapy skills.

COMPETENCY 2: RESEARCH

Highlights the capacity to identify research problems, design research investigations, conduct research investigations, evaluate research findings and communicate research findings. This competency should be obtained after completion of a 4 year Degree in Psychology, with further development of these skills in postgraduate programs.

COMPETENCY 3: FRAMING, MEASURING AND SOLVING PROBLEMS

This set of competencies is concerned with the organization and planning in systematic psychological assessment, evaluation and problem solving with individual, groups, organizations and the community. It involves the capacity to define the problem, gather and evaluate data, determine strategies and implement ongoing evaluation.

COMPETENCY 4: SERVICE IMPLEMENTATION

This set of competencies draws on the knowledge base of the discipline and problem solving skills. It covers the steps involved in the planning, design, provision and evaluation of psychological services to individuals, groups or organizational clients.

COMPETENCY 5: PROFESSIONAL LEGAL AND ETHICAL APPROACH

This set of competencies is concerned with the legal and ethical aspects of professional psychological practice, as well as the ability to apply informed judgement and current scientific principles in the workplace. Its component parts involve the capacity to recognize boundaries of service provision, behave in accordance with relevant ethical and legal regulation, behave in a responsible and autonomous fashion, manage professional activities and maintain and update knowledge base through ongoing professional development.

COMPENTENCY 6: COMMUNICATION

The ability to be able to clearly convey psychological ideas derived from discipline knowledge, research and practice, and includes the response of psychologists to feedback and information from others. This includes the capacity to communicate effectively and appropriately, appraise research and communicate information to wider audiences and communicate information about relevant psychological services to potential clients.

COMPETENCY 7: PROFESSIONAL AND COMMUNITY RELATIONS

The capacity to adopt and independent or team approach as appropriate, engage the client or clients, clarify roles and responsibilities in consultation with other relevant individuals, accept and initiate supervision of projects or people as appropriate and apply knowledge to the community.

COMPETENCY 8: INFLUENCE AND CHANGE

This covers the role of psychologists as agents of change by adapting psychological principles to assist clients and organizations to achieve positive outcomes, to promote the implementation of appropriate recommendations and to show leadership.

(Taken from Competencies for Psychologists: A discussion paper, APS 1996)

It would appear that the profession of psychology has a thorough training program, and has well articulated professional skills and competencies. These standards for psychological assessment and psychological therapy in mental health care, should be the ***minimum*** professional standards accepted by government departments and agencies, for professionals treating psychological disorders. They should also be the minimum training standards in Psychology for private psychological services to attract Medicare or MedicarePlus rebates.

Unfortunately this is far from the case. When looking at the range of mental health services available in Australia there appears to be a significant blurring of professional roles and very varying requirements for appropriate training standards. In fact, the Federal Government actively supports and promotes significantly lower training standards than that described above, and a lack of skill differentiation in the mental health workforce.

One clear example of this is in the Better Outcomes in Mental Health (BOMH*)* initiative. This initiative gives GPs ***20 hours*** of training in "focused psychological therapy" and then encourages them to provide psychological interventions to their patients. The Federal Government further facilitates this process by giving financial incentives via the Health Insurance Commission and extended Medicare rebates to GPs for these services. Given that this initiative is one of the Federal Governments show-pieces in mental health care it deserves more specific comment and analysis.

The BOMH initiative started in 2001 and was funded to a level of $120.4 million over four years. It has received further funding at an increased level under the current National Mental Health Plan. It has three main aspects to it and these are:

1. Linking Psychiatrists in an advisory and supportive role with GPs, so that GPs can receive timely advice and assistance, especially when a patient presents in crisis or with a mental illness.

2. Linking mental health professionals to GPs and encouraging GPs to refer patients to them for psychological counselling, so that a more collaborative, shared care model of health care can be provided.

3. Providing short courses in mental health assessment (level 1 training) and several psychological therapies (level 2 training) to GPs for them to use with their patients.

When a GP decides to be involved in the BOMH training program they firstly have to register with the Health Insurance Commission. Then they can undertake Level 1 training, which lasts approximately *6 hours*, and teaches how to conduct mental health assessments, mental health planning and how to undertake a mental health review process with their patients. GPs can then choose to do Level 2 training, which lasts approximately *20 hours*, and this course teaches them what has been called "Focused Psychological Strategies" (usually Cognitive Behaviour Therapy and/or Inter-Personal Therapy). Once a GP has completed this second course they can then provide psychological therapy to their patients. There appear to be very few restrictions on what psychological problems, or with which patients GPs can engage in psychological therapy with, as indicated in the Australian Divisions of General Practice Familiarisation Training Manual (2003). (See Appendix 1 and Appendix 2).

There are major concerns with this sort of packaged training. Firstly, a 20 hour course in psychological therapy *techniques*, is a considerable departure from the thorough and lengthy training considered important for the specialist area of psychological health care provision. It is unclear why lower training standards are being promoted by the Federal Government as being acceptable for the provision of these specialist services.

Not only is the training remarkably short, the content of the training programs, which are provided by a range of community groups and providers, have not been scrutinized by University Psychology Departments or by Psychology Registration Boards. Instead a committee called the General Practice, Mental Health Standards Collaboration (GPMHSC) committee, has been given the power to "accredit" the short training programs as being adequate for the GP provider to obtain Medicare rebates. This committee can also allow GPs to completely bypass both Level 1 and Level 2 courses, if they have done other training deemed acceptable by the committee, and apply for and receive the option of "Recognition of Prior Learning". There is one APS representative on this committee of

approximately six members, and in personal communications with her, she has indicated that she has raised on numerous occasions that this training is not adequate or thorough enough for the provision of psychological therapy, but her voice has been largely ignored.

There are also no objective or independent examinations or assessments to evaluate the GPs level of knowledge and competency in the psychological assessment and therapy skills learnt. There are also no appropriate levels of clinical supervision required to ensure that competency in assessment and therapy has been achieved. Would similar standards of training be accepted by the Medical profession for someone to practice medicine? That is highly unlikely. Consumers should be able to trust and expect that whomever the Federal Government funds to provide these services has the highest training and competency levels available.

In addition, if a member of the public does not benefit from the psychological therapy provided by the GP, the consumer may well conclude that the *treatment* is not effective, which then decreases the likelihood that they will seek other psychological assistance in the future. Or, they will have to use multiple services in order to get proper assistance, driving costs in the health budget higher. The BOMH initiative is both costly and wasteful of the mental health budget, and does not bring the much needed specialist psychological services to consumers.

Another second problem with this and other mental health programs is the Federal and State Governments placing of medical practitioners in the *centre* of primary care mental health services. Interestingly, the governments own documents, when listing those professional groups who make up the bulk of mental health care services, did not mention medical practitioners. The main argument provided in most government policy documents as to why GPs should be a centre focus in primary care mental health services, is that they are the *first point of contact* for people with mental health problems. This is in fact supported by research which indicates that up to 50% of GP consults are due to psychological and emotional reasons. However, this is *not* a valid or logical reason for GPs to then to provide psychological therapy.

In fact it could be argued that there are many reasons why it would not good practice to have GPs as centre focus in primary mental health care. One major reason relates to GP workforce issues and their capacity to provide mental health services. A paper written by the Primary Mental Health Care Australian Resource Centre, known as PARC, titled "Major issues facing

primary care mental health in Australia" (2001), has a section on GP workforce issues and succinctly summarizes the main concerns. It states:

"In metropolitan areas the overall number of GPs is static with a slowly increasing population. In addition to slow increases in population per full-time workload equivalent GP, the average age of Australia's population is increasing (Australian Bureau of Statistics, 1999), and this signifies a steady increase in general practitioner workload to support this aging community. For example the number of services for a person aged 75 years and over is approximately 20 per year, compared with the average across all other age ranges being 10 per year. The capacity for General Practice to expand its role into psychological interventions for mental health problems is extremely limited. This is particularly the case in rural and outer metropolitan areas where GP workforce is particularly stretched" (pg.2-3).

The PARC September 2004 newsletter also reported that some GPs who had used the extended consult times for patients with mental health problems, commented that conducting psychological therapy was time consuming and encroached on their medical practice, resulting in a need for them to contain the numbers of people treated for mental health problems (PARC update, September 2004).

These comments suggest that any initiative which burdens GPs further with other forms of health care are not in the best interests of GPs or the general public. There is already a shortage of GP hours for medical care, and consumers often complain about the difficulty in getting medical appointments. Why would the Federal Government wish to burden this sector further and make the hours for medical care even less available to the public, when there are clear alternatives? Wouldn't supporting a way to ease and re-direct the mental health burden from GPs make more sense?

It could be argued that it not only makes more sense, but is essential. The medical demands placed on GPs, and their workforce shortages, present a major challenge to this profession and the high level of workplace stress has already lead to serious personal and work place consequences. This has been highlighted in a report commissioned by the Royal Australian College of General Practitioners released in October 2004, titled *Emotional Health: Conspiracy of Silence among Medical Practitioners.* This report explored a number of general practice issues and indicated that the mental health of GPs is being significantly compromised by their work demands. They were in fact rated as number 2 on the list for professional suicide risk. With the need to maintain highly functioning primary *medical services*, any program

which appears to increase a GPs load and responsibility, should be very cautiously considered, especially when there are clear alternatives.

What alternatives exist?

Although there appears to be a large demand by consumers for affordable access to non-drug psychological therapies, access to Clinical and Counselling Psychologists for people with psychological health problems has not improved greatly during any of the three National Mental Health Plans. It could be argued that there is need for a greater and more central role for Clinical and Counselling Psychologists in the National Mental Health agenda. This is supported in the 2004 mental health report by SANE which states in one of their recommendations that "Medicare-funded access to psychological treatments provided by Clinical Psychologists" (pg. 1)

One of the main barriers for consumers to *private* Clinical or Counselling Psychologists is cost. As an example the table on the next page indicates the support provided by the Federal Government for consumers to access GPs in the BOMH initiative to do psychological counselling, compared with that provided for them to access psychologists under MedicarePlus.

It is important to note that the 5 sessions supported under MedicarePlus, are for the provision of all "allied health care" which comes under this scheme for a 12 month period. This means that if a person is referred to 3 sessions of physiotherapy then they only have 2 more sessions per year of other "allied health services". A person can also only access MedicarePlus if they are assessed by a GP to meet the criteria, and a written referral is made. This further increases the paperwork for GPs and has been shown to not be very popular for this reason. It also means that GPs become solely responsible for the identification of psychological health problems, acting as gate keepers for psychological referrals, something which, for a range of reasons, GPs have a poor track record with. (This gate-keeping role is the same in the BOMH initiative where a link is made to other mental health professionals).

If the Federal Government choose to place the same funds from the BOMH initiative into MedicarePlus, to support people to obtain psychological health care from 6 year trained Psychologists, this would resolve the cost barrier to high quality psychological health care, and be less expensive for the Government.

Comparison of the financial support provided by the Federal Government for the provision of Psychological therapy from General Practitioners Vs Psychologists.

Comparison Item	GPs	Psychologists
Health Insurance Commission Incentive payment.	**$150**	**Nothing**
Government rebates for Psychological therapy	**$ 61.45** (session lasting 30-40mins.) **$ 87.95** (session lasting longer than 40 mins.)	**$ 44.00** (based on a 20 min. session) No option of more rebate for a longer session
Service Incentive Payment - received when a review of psychological therapy occurs	**$150** ***per patient*** per review ($10,000 cap ***per GP per year***)	**Nothing**
Number of psychological therapy sessions supported per year, per client	**12**	**5**

A second major barrier for consumers to high quality Psychological services, in the *public* sector, is the lack of psychology positions in community based services and the blurring of professional roles amongst other professionals. A statement in a submission made to the Peter Costello in 1999 by the then President of the APS claimed that :

"After more than five years of the National Mental Health Strategy, there is reduced access for consumers to psychological services, partly because the number of psychologists in the public sector has declined and partly because many psychologist positions have been downgraded into generic mental health workers." This situation would appear to still be true today. (Quoted from "Models of primary health care psychotherapy and counselling", PARC 2002. Report to the Commonwealth Dept of Health and Aged Care.)

There needs to be many more positions available to six year trained Psychologists in Community Health Centres and public mental health services so that consumers can access these services. Psychological therapy positions should not be down graded into generic mental health worker

positions or to other professions with short training in a limited number of psychological therapy skills.

A third major barrier to consumers seeking mental health services is the concern of receiving negative stigma or negative perceptions from others. The wide-spread use of the term *mental illness* to describe psychological problems such as depression and anxiety is one way negative stigma is *increased*. Dr. John Read, Director of Clinical Psychology at the University of Auckland in NZ, co-authored a book titled "Models of Madness" (2004). This excellent book, which mostly focuses on schizophrenia but produces research and argument which apply to all areas of mental health, outlines the problems which occur when medical and biological psychiatry illness models are applied to psychological disorders. The book also focuses on the power of the pharmaceutical companies to manipulate research to promote the biological models of mental ill health and to promote their medications. He provides good evidence that the medical model of psychological disorders is not supported in research and argues for greater use of psychological therapies in the treatment of mental health problems. These issues need serious addressing by moving non-drug therapies into the first line treatment approach, especially for the high prevalence disorders such as depression and anxiety, with medications used as a last resort – not the other way around.

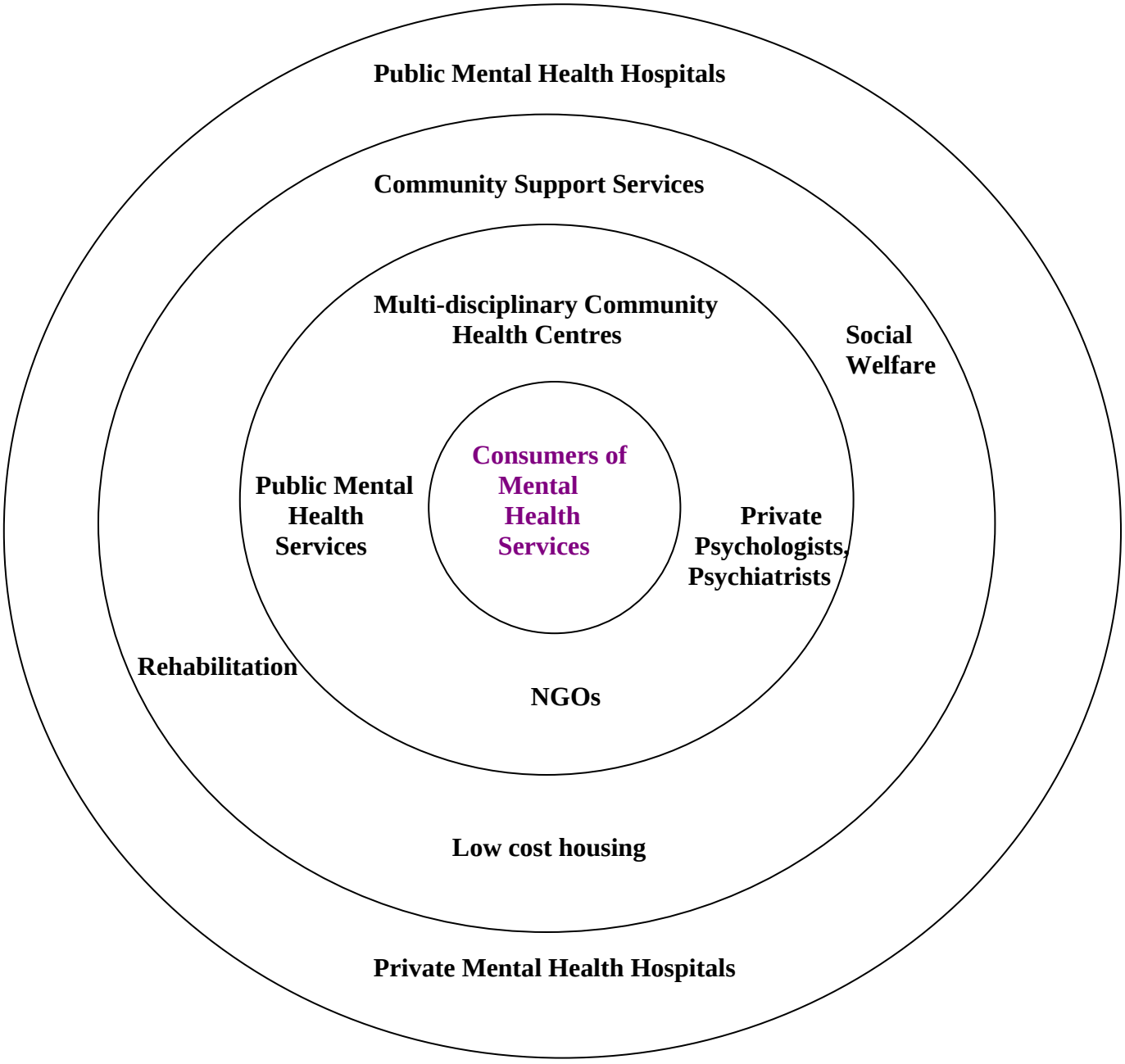
Fourthly, it is very concerning that psychological or mental health often does not get a clear platform under the term "health care", but the focus in "health care", has been, and remains medical and physical health. If one looks at the website portfolio listing of Health Minister Tony Abbot, it does not list mental health at all, but lists only issues relating to medicine, hospitals and GPs. Psychological health care is not well served when it is subsumed under medical care and delivered or distributed by medical services. With depression being one of the leading health problems experienced by the population in Australia, it could be argued that mental health care, needs to have an independent platform from medical health care. The creation of Ministers for Mental Health, with a separate portfolio and budget from health care, at both State and Federal Levels, would be more effective for providing this much neglected area with appropriate attention and funding. Apparently there is already a Minister for Mental Health in the Shadow Cabinet in NSW.

Finally, it could also be argued that the development and support of Divisions of Psychological Health Care in each state, similar to those established for the Divisions of General practice would allow the profile and

services of Mental Health in each state to be developed and supported more appropriately.

Lastly, the diagram below may be a useful summary of a consumer access model to psychological health care in Australia. Unlike other models which have GPs and secondary mental health services at the forefront to mental health service delivery, I would like to suggest that consumers and their families need to be at the heart of the services, with direct and affordable access to all mental health services.

Diagram 1. Consumer access model, with direct affordable access to all services.



Appendix 1 Taken directly from the GP Familiarisation Training Manual

Focussed Psychological Strategies

An element of the Better Outcomes in Mental Health Care Initiative is the introduction of MBS rebates for Focussed Psychological Strategies (FPS) that can be provided by GPs who satisfy the relevant education requirements set by the GPMHSC.

What are Focussed Psychological Strategies (FPS)?

FPS are specific mental health care treatment strategies, derived from evidence based psychological therapies. They have been shown to integrate the best research evidence of clinical effectiveness with general practice clinical expertise.

What is the remuneration for provision of FPS?

In recognition of the enhanced mental health care skills and expertise required for GPs to provide FPS, MBS rebate levels have been set at approximately 20% above the current Level C or D Attendance items and include two time bands:

- 30 to 40 minutes; and,
- longer than 40 minutes.

What strategies can be provided by GPs under the MBS item numbers for FPS?

The strategies and treatments that have been approved for use by GPs under the Better Outcomes in Mental Health Care Initiative are limited to:

1. **Psycho-education**
2. **Cognitive-behavioural therapy including:**
   - Behavioural interventions
     - Behaviour modification (especially for children, including behaviour analysis and contingency management)
     - Exposure techniques
     - Activity scheduling (including pleasant events, mastery and time management)
   - Cognitive interventions
     - Cognitive analysis, challenging and restructuring
     - Self-instructional training
     - Attention regulation
   - Relaxation strategies
     - Guided imagery, deep muscle and isometric relaxation
   - Skills training
     - Problem-solving skills training
     - Anger management
     - Stress management
     - Communication training
     - Social skills training
     - Parent management training
     - Motivational interviewing
3. **Interpersonal therapy (especially for depression)**

Hypnosis and family therapy have not been approved for use under the FPS item numbers. The major FPS that are shown to be evidence based for a number of psychological disorders are provided in Appendix I.

Appendix 2 Taken directly from the GP Familiarisation Training

Eligibility

Which doctors are eligible to participate?

The doctors eligible to participate in the Better Outcomes in Mental Health Care Initiative are medical practitioners including GPs, but excluding specialists and consultant physicians. For the purposes of brevity, future references in this manual to GPs include Other Medical Practitioners (OMPs) unless otherwise specified. These doctors need also to have completed the relevant training requirements and to be working from a PIP or accredited practice to register for the initiative.

Which patients are eligible to participate?

Under the Better Outcomes in Mental Health Care Initiative the patient group eligible for care is:

> 'all patients with a mental health disorder, including those with co-morbidity, who present in the general practice setting.'

A mental health disorder has been defined as, 'a significant impairment of an individual's cognitive, affective and/or relational abilities which may require intervention and may be a recognised, medically diagnosable illness or disorder.' The ICD-10 PHC version informs this definition[1].

The following disorders, taken from the ICD-10 PHC version can be treated under this initiative:

- Alcohol use disorders
- Chronic psychotic disorders
- Bipolar disorder
- Phobic disorders
- Generalised anxiety
- Adjustment disorder
- Unexplained somatic complaints
- Eating disorders
- Sexual disorders
- Conduct disorder
- Bereavement disorders
- Drug use disorders
- Acute psychotic disorders
- Depression
- Panic disorder
- Mixed anxiety and depression
- Dissociative (conversion) disorder
- Neurasthenia
- Sleep problems
- Hyperkinetic (attention deficit) disorder
- Enuresis
- Mental disorder, not otherwise specified

Please note: dementia, delirium, tobacco use disorder and mental retardation are excluded.

Footnote:

1. World Health Organisation International Statistical Classification of Diseases and Related Health Problems: Chapter V, Classification of Mental and Behavioural Disorders: Primary Health Care Version.