Association for Counselling Psychology

Submission for the
Senate Select Committee on Mental Health

Executive Summary

The Association for Counselling Psychology (ACP) is a representative group for Counselling Psychologists in Western Australia. The mission of the ACP is to provide an independent local body to represent the interests of Counselling Psychologists in WA, and to promote the role of Counselling Psychologists as professional practitioners in the mental health field, in industry and the wider community. In our activities as an association we value and promote mental health and well being, integrity, high professional ethics and high professional standards.

Similar to psychologist's who practice in other specialist areas, Counselling Psychologists hold a Masters degree from a specialised program accredited by the Australian Psychological Society. Counselling Psychologists provide assessment, counselling and psychotherapeutic services to individuals, couples, families, children and groups. Counselling Psychologists are trained to work with a wide range of psychological difficulties and disorders. This includes assisting clients with challenging or prolonged difficulties encountered in the usual course of living. Counselling Psychologists also work with complex psychological problems and disorders such as depression, anxiety, self-esteem, eating disorders, post-traumatic stress and personality disorders.

In late 2004, the ACP produced a position paper about the Commonwealth initiative *Better Outcomes in Mental Health Care* (BOMHC). The position paper summarised key concerns about the initiative and offered recommendations, with the aim of informing policy makers and contributing parties about how the BOMHC initiative might be improved. Our submission to the Senate Select Committee on Mental Health is drawn from the ACP position paper on BOMHC, and therefore refers directly to this Commonwealth initiative.

In short, recognising the strengths and limitations of the BOMHC initiative, the ACP recommends the following:

1. The positive outcomes of BOMHC can be enhanced by:
   (a) Direct allocation of funding to mental health specialists for providing services,
   (b) Public awareness campaigns for mental health consumers, and
   (c) Better education for GP's, to help clients access mental health specialists.
2. Much more emphasis must be placed on training GP's in basic psychological assessment techniques, to improve the accuracy of GP assessment and referral.
3. Familiarise GP's with the range of different types of psychological approaches that mental health specialist's use.
4. Limit the training of GP's to basic behavioural modification techniques and familiarisation with psychological 'self-help' methods.
5. Reserve the delivery of psychological interventions to appropriately qualified licensed and experienced mental health specialists.
6. Promote a multidisciplinary approach to mental health by including incentives for psychologists to collaborate with GP's. Under the current BOMHC system, only GP's are encouraged to liase with psychologists.
7. Raise public awareness about mental health issues via means that address the public directly rather than through GP's. This could be achieved with media and public education campaigns. Doing so gives clients choice about who to consult.

Terms of Reference

The following summary of concerns about the Commonwealth initiative *Better Outcomes in Mental Health Care* (BOMHC) spans several aspects of the Senate Committee's terms of reference. Primarily, the focus of concerns amongst Counselling Psychologists is about:

- The degree of adequacy in the care provided through BOMHC (criteria b),
- The different roles of general practitioners and psychological specialists in mental health care delivery (criteria h),
- Standards of education for those delivering psychological interventions (criteria i).
- Supporting the choice of mental health consumers (criteria i), and
- Ensuring that mental health consumers receive quality mental health care based on broad principles of evidence-based practice (criteria o).

There are four related areas of concern, namely:

1. Concerns about the basis for BOMHC,
2. Concerns about the competence of GP's trained in 'FPS',
3. Concerns for clients, and
4. Professional concerns.

Acronym Key:

ACP = Association for Counselling Psychologists.	APS = Australian Psychological Society.
BOMHC = Better Outcomes in Mental Health Care.	GP = General Practitioner.
AHP = Allied Health Professional.	FPS = Focussed Psychological Strategy.
CBT = Cognitive Behavioural Therapy.	IPT = Interpersonal Therapy.

Concerns about the Basis of BOMHC

1. The BOMHC initiative is largely based on 'Beyondblue' a national mental health reform agenda targeting depression (Hickie & Groom, 2002). The supporting arguments for BOMHC draw heavily on data collected for Beyondblue that deal specifically with depression (Blashki, Hickie, & Davenport, 2004). This means that the basic justification for BOMHC rests upon the assumption that all issues relating to psychological distress are akin to those we see for depressive disorders.
2. In addition to this, psychotherapy techniques have been presented in a simplified manner to justify the position that such techniques can be trained to and delivered by GP's with little to no prior training in psychology. Given that the stated agenda for BOMHC is to improve public access to *appropriate* psychological care, simplifications and generalisations of this kind are at odds with the fundamental basis for the initiative.
3. Prior to undertaking this initiative, an official review was carried out to inform the government about the proposed format of BOMHC. In regard to whether there are enough specialists available for current demands for psychological services the review states, "it is unclear just how much under-utilised capacity there is out in the community" (p. 14, Bowers et al., 2002). Therefore, the claim that the pool of mental health specialists available in Australia cannot meet current demands (Blashki et al., 2003), has little basis and seems to have disregarded the above review. In short, the decision to train GP's to deliver simplified psychotherapy does not follow.
4. Given the above, the ACP believes it is in the best interests of the public for GP's to refer their clients onto a specialist for psychological treatment.

Concerns about the Competence of FPS trained GP's

1. The fact that psychotherapy techniques have been simplified for training GP's compromises standards of psychological care. The training standards outlined for the initiative also pose considerable problems (GPMHSC, 2004a):
   i) No pre-requisite criteria for entry to training.

ii) Evaluation targets self-rated effectiveness rather than client-rated outcome.
iii) Approval for training is co-ordinated by medical professionals, not specialists.
iv) Only 60% (12 hours) of FPS training must be delivered face-to-face. As technologies such as video-conferencing are deemed equivalent to face-to-face contact, FPS training can be delivered entirely on-line.
v) Knowledge and acquired skills are not assessed at the end of FPS training.

2. Under BOMHC, psychotherapy interventions have been taken out of the context of the research, training and empirical standards that have been established by the profession of psychology, and into the medical context without regard for fundamental differences between the work of psychologists and GP's.
3. The content of FPS training reflects an assumption that CBT and IPT are effective for all psychological problems. Even by the most stringent criteria for 'Empirically Validated Therapies', this assumption is contradicted (Chambless et al., 1998).
4. Given the simplified nature of training and the narrow scope of psychological methods taught, GP's are likely to remain unaware of critical aspects of psychological work.
5. With these factors in mind, GP's are unlikely to be able to make an accurate psychological case formulation, decreasing the likelihood that appropriate psychological interventions will be used.
6. Reports that many GP's decide not to carry out CBT after participating in FPS training, show that funds would be better spent supporting psychologists to deliver interventions and improving the accuracy of GP assessment and referral. It is unreasonable to expect the public to invest in GP training programs that will not be followed through as intended.
7. Survey results contradict the above reports, indicating that many GP's do express satisfaction with FPS training (Morgan et al., 1999). The problem with relying on GP satisfaction to justify FPS training is that confidence does not amount to competence.
8. Despite such concerns, public funds from both State and Commonwealth sources are spent on FPS training for GP's. Firstly, the Commonwealth Department of Health and Ageing 'Budget 2001-2002 Health Fact Sheet 2' confirms that Commonwealth funding allocated to BOMHC are directed at the training of GP's in mental health treatment. Secondly, the Professional Development Officer for Mental Health at GPMHSC confirms that funds from Division's of general practice are received for the purpose of FPS training. Thirdly, Anna Roberts from ADGP confirms that not only are BOMHC funds used for FPS training, but also additional public funds are drawn from State sources. What's more, funds have also been drawn from other sources such as pharmaceutical companies.
9. Even those supporting BOMHC argue that the evidence-base for GP training in FPS techniques is "lagging behind" (p. 24, Blashki et al., 2003). The current available evidence demonstrates that such training has little effect on clinical outcomes (Morgan et al., 1999). Objective clinical trials demonstrate no impact of training on competence and no relationship between the perceived competence of GP's and actual client outcomes (King et al., 2002). The above trials show that GP's undertaking short CBT courses are likely to overestimate their ability to work with complex psychological issues. This matter is further complicated in the case of the BOMHC initiative by the fact that GP's are encouraged with economic incentives to do so.
10. As a case in point, IPT training is one option for Level II FPS training, yet, the prerequisites for training in IPT are (a) several years psychotherapy experience, (b) clinical experience with the disorder being targeted, and (c) ongoing clinical supervision (Markowitz & Swartz, 1997). GP's are not screened for these prerequisites and are not given ongoing supervision (Davies, 2003).
11. IPT is only designed for specific psychological disorders, namely depression and eating disorders (Markowitz, Svartberg, & Swartz, 1998), yet under the BOMHC initiative, GP's with level II FPS training in IPT are permitted to treat a wide range of psychological issues.
12. A leading authority on IPT, John Markowitz, stated that the IPT training that BOMHC offered, "seems deficient in providing an orientation but no clinical training" (personal

communication, 2 July, 2004). It's noteworthy that GP's have previously confused IPT with its more simplistic form - IPC (DeLacy, 2002).

13. In addition, the common mistake of using the acronym ITP instead of IPT in BOMHC policy (GPMHSC, 2004b) is considered an indicative feature of common misconceptions about IPT (Markowitz, Svartberg, & Swartz, 1998).[*] Such misconceptions raise serious concerns about the misapplication of FPS training.

Concerns for Clients

1. Keeping in mind our concerns about the misapplication of FPS training, it seems pertinent to point out that incompetent delivery of psychological interventions is both harmful to clients, and reduces the likelihood of clients seeking help in future. It is vital that we carefully consider how psychological therapies are being presented here, as such implications could be damaging for all parties.
2. Given the broad range of AHP's that divisions employ to deliver FPS interventions and the differences between each division in terms of how AHP's are selected, it remains unclear whether those AHP's receiving referrals are appropriately qualified (Bowers, Holmwood, & McCabe, 2002).
3. The restricted BOMHC funding arrangements, where particular AHP's deliver psychological care by GP referral, limits the choice of clients about who they wish to consult.
4. For most psychologists, this diminishes work opportunities by encouraging clients to see Level II qualified GP's and the AHP's they refer to, using public funds as an economic incentive.
5. Coupled with incentives for GP's to deliver psychological interventions themselves, further strain is placed on an already stretched system of general practice.
6. Overall, bringing psychological care into the domain of medicine has led to medicalisation of psychological issues. This is clearly evident from statements made in BOMHC policy equating psychological distress with "mental illness".
7. Because GP's may not have been educated in the subtleties of referring psychologically distressed individuals, there is also concern that clients with complex difficulties will perceive referral onto someone else as a crucial rejection.
8. The interests of clients would be better served by supporting the public in their efforts to consult psychologists directly should they wish to do so, and avoiding terms that equate psychological distress with 'illness'.

Professional Concerns

1. The treatment options made available under BOMHC implicitly presume the equivalency of GP's and psychologists in the delivery of psychological care. Consequently, the specialist knowledge, training, skills and clinical experience of psychologists are perceived as being de-valued. This is damaging to future working relationships between psychologists and GP's.
2. The range of opportunities available to enhance GP-psychologist collaboration has been overlooked in favour of a top-down GP-controlled system. Other opportunities include (a) education of GP's about liasing with psychologists, (b) educating psychologists about liasing with GP's, and (c) proactive incentives to encouraging psychologists to liase with GP's.
3. There is no guarantee that psychologists will remain in the principle role of trainers or as a major referral destination under the BOMHC initiative. In terms of possible advantages for the select group of psychologists involved in the BOMHC initiative (Matthews, 2004), there is no guarantee that such advantages will be maintained across time.

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[*] *We note however, that since our position paper was first circulated the GPMHSC has corrected the acronym used on their official web-site.*

4. The position of the APS that psychologists must be involved in the BOMHC initiative in order to effect change, presumes that psychologists are in a position of influence in the first place. This does not appear to be the case – BOMHC projects and funds are co-ordinated by the medical profession.
5. The BOMHC initiative has been seen by psychologists as equivalent to allowing psychologists to undertake brief training in medicine in order to prescribe drugs. In the US there is considerable opposition from the psychiatric profession over this particular matter (APA, 2004). In both cases, short-courses appear insufficient to deliver widely accepted minimal standards of health care.
6. The financial involvement of pharmaceutical companies in FPS training is also matter of serious concern (Morgan et al., 1999). The Project Co-ordinator of SPHERE (FPS training agency), stated that the commercial interests of Pfizer in funding FPS training workshops is to, "provide the company with opportunities to promote their products and services" (personal communication, 17 June, 2004). Such involvement represents a grave conflict of interest that undermines the focus of FPS training.

In Conclusion:

Recognising the strengths and limitations of the BOMHC initiative, the ACP recommends:

1. The positive outcomes of BOMHC can be enhanced by:
   (d) Direct allocation of funding to mental health specialists for providing services,
   (e) Public awareness campaigns for mental health consumers, and
   (f) Better education for GP's, to help clients access mental health specialists.
2. Much more emphasis must be placed on training GP's in basic psychological assessment techniques, to improve the accuracy of GP assessment and referral.
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