Symposium:

Primary Care Psychology: Pathways to Effective Care in General Practice
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PRIMARY CARE PSYCHOLOGY

• Patient-led Primary Care Mental Health Treatment: Efficient and effective

Associate Professor Tim CAREY
(Flinders University and Charles Darwin University; Central Australian Mental Health Service)
• Primary care psychology in the bush: Opportunities and challenges

Dr. Louise ROUFEIL (Australian Psychological Society; Mount Isa Centre for Rural & Remote Health, James Cook University)
Primary Care Psychology in a Regional Setting: Analysis of a year in a Regional NSW Practice

Dr. Robyn VINES (Russell St. Medical Centre, Bathurst NSW; School of Primary Health Care, Monash University)
FOCUS of PRIMARY CARE PSYCHOLOGY

• The **CONTEXT** in which we practice our profession;
• How we can best address and contribute to the public mental health needs of our country?
Primary Care Psychology:

**Definition:**

- A model of care in which appropriately trained psychologists work collaboratively with GPs/Family Physicians ‘in situ’ in the general practice setting, providing early intervention mental health service delivery.
Primary Care Psychology

- The key idea of primary care psychology is to emphasise the following descriptors in relation to service delivery:
Access and Equitability:

- **Equitable Access** for those with mental health disorders regardless of means, socioeconomic status, geographic location, educational background, etc.
Provision of services:

Primary Care Psychology focuses on the following parameters of mental health service delivery:

- When?
- Where?
- How?
When?

- Early intervention
- Prevention of evolution of:
  - more serious disorders, loss of work, family breakdown, etc. - and
  - consequential greater exposure to trauma (which psychiatric hospitalisation still often results in)
Where?:

In the primary care setting as it:

Prevents:

- stigma of treatment in mental health/illness facilities, and
- delays in & avoidance of help-seeking
Where?

- In a **familiar setting**: with the family physician facilitating transition to specialist care ‘in situ’
- Sometimes the clinical psychologist can attend the doctor’s appointment, establishing endorsement by the GP
How?

“Tailored”, evidence-based intervention for mental health issues, often comorbid with physiological disease (e.g. heart disease (AF, etc), diabetes, asthma, Parkinsons, etc) and alcohol & other drug (A&OD) disorders.
How?

- Statistics indicate comorbidity is the norm rather than the exception.
- Highly experienced practitioners are needed, as most referrals and presenting problems in primary care are complex and multi-faceted.
Type of care

- Comprehensive, multi-disciplinary, team-based: research evidence indicates better outcomes from treating the “whole person” across a number of different modalities.
Type of care

- **In-depth CBT** interventions and
- **Lifestyle management** (sleep, diet, exercise, alcohol and other drug consumption: cigarettes, marijuana, dope, caffeine, etc)

Both need to be integrated for patients
Advantages of co-location in the primary care setting?

For the patient:

- Prevents stigmatisation of mental health issues; “normalises” help seeking, ensuring it is part of the normal health sector.
- Facilitates treatment of co-morbid physiological conditions
Advantages of co-location in the primary care setting?

- Early intervention: prevents the misery of developing/evolving mental illness and deterioration; prevents the need for hospitalisation and institutionalisation
Advantages of co-location in the primary care setting?

In terms of systems of care:

- Facilitates communication with GPs – via conversations; notes etc – “in situ”
- Collaborative, team-based care leads to better patient outcomes
- Co-location facilitates this.
Benefits of Co-location

- **Patient:** better more comprehensive treatment
- **GP:** improvement in psychological literacy and possibly their own mental health!
- **Psychologist:** collegiality, better integrated into national health objectives
Our training frameworks still neglect the context in which we can optimally provide our expertise.

We still focus on one-on-one competencies and evidence-based practices with clients, rather than bigger context and value issues.
Training frameworks

Lack of a “big picture” orientation:

- where we might create best “bang for publicly-funded buck”
- in what context can we make the biggest contribution to our population’s mental health needs?
What is needed?

A “social engineering” approach in which funding is made contingent on:

- provision of services in the optimal location
- participation in team-based care
What is needed?

- It has been said in Australia that we are good at ideas (primary care psychology was researched and advocated 13 years ago). However, implementation and follow-through of systematic, visionary models has been poor.
The original Concept

- Was to train primary care psychology registrars in evidence-based primary care service delivery
- Gradually develop skilled graduands to contribute to a growing expert primary care workforce
What has developed

- Has been very different indeed from this systematic training and workforce development model
- With optimistic beginnings, it has gone sadly off track.
Why has this model of care been slow to get off the ground?

1. Rigidity and silo-mentality of our profession:
   - Out of 29,000 registered psychologists in Australia, only “a handful” (a couple of hundred) actually practice in primary care.
Why is this model of care slow to get off the ground?

3. The **free market mentality** of our political parties: both sides of politics seem reluctant to place conditions on access to medicare rebates, once a profession is included.
We need

A big picture mentality where we, as a profession, are concerned about public health objectives and policy, to facilitate maximum contribution from our profession to the general and mental health needs of country.
Key dilemmas emerging

- Slow up-take/inclusion of the model in training programmes/curricula has meant lack of adequate preparation of post-grads for work in this area under government funding.

- (Original model included a full training framework).
SUMMARY

- We are light years away from where we were 15 years ago
- There are many opportunities ahead for redressing some of the problems emerging within roll-out of these services.