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OPTIMISING THE PRIMARY MENTAL HEALTH CARE WORKFORCE: HOW CAN EFFECTIVE PSYCHOLOGICAL TREATMENTS FOR COMMON MENTAL DISORDERS BEST BE DELIVERED IN PRIMARY HEALTH CARE?

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POLICY CONTEXT

Policy reforms in Australia have expanded consumer access to evidence-based psychological treatments.

In 2001, the Better Outcomes in Mental Health Care initiative (Better Outcomes) included a GP 3-step Mental Health Process, GP-conducted psychological strategies, and access to up to 12 psychological treatment sessions through the Access To Allied Psychological Services (ATAPS) component, through a program registered GP.

The 2006 Better Access to Psychiatrists, Psychologists and GPs (Better Access) program enabled increased access to psychological assistance by allowing all GPs to refer appropriate patients to registered psychologists, social workers, and occupational therapists for up to 12 sessions of psychological treatment.

Both the Better Outcomes and Better Access programs have been taken up with great enthusiasm.

Most evidence for the effectiveness of psychotherapy is derived from studies in secondary care settings. This review compiles the evidence base for effective treatment for anxiety and depressive disorders in primary health care populations.

We addressed two questions:

1. What is the evidence for the effectiveness and cost-effectiveness of generalist versus specialist providers of psychological treatments in primary care?
2. How effective and cost-effective are models of collaboration in providing psychological treatments in primary care, and what are the elements of successful models?

KEY FINDINGS

GP PROVISION OF PSYCHOLOGICAL TREATMENTS IN PRIMARY CARE

- Good evidence that GP delivery of problem-solving therapy for depression is superior to usual treatment and equivalent to treatment with antidepressant medication
- Limited evidence that GP delivery of guided, manualised bibliotherapy for panic disorder is as effective as referral to a secondary care therapist
- Inconclusive evidence for the effectiveness of cognitive behavioural therapy or interpersonal therapy delivered by GPs
- No studies identified regarding the cost-effectiveness of GP-delivered psychological treatments

ALLIED HEALTH PROVISION OF PSYCHOLOGICAL TREATMENTS IN PRIMARY CARE

- Good evidence that psychologist delivered psychotherapy has similar treatment effects to medication for depression. Limited evidence for panic disorder and generalised anxiety disorder
- Good evidence that psychologist delivered psychotherapy is superior to usual treatment or placebo for major depressive disorder, and panic disorder, but not for dysthymia. Limited evidence for generalised anxiety disorder
- Good evidence that psychologist-delivered therapies represent good value-for-money, but all Australian studies used modelling methodology
- Limited evidence that social workers can effectively deliver psychological therapies for depression and anxiety
- No studies identified regarding the effectiveness of psychotherapy by occupational therapists, Indigenous health workers

COLLABORATIVE PRIMARY MENTAL HEALTH CARE

- Good evidence that collaborative interventions involving psychotherapy, multi-professional approach, structured management plans, scheduled follow-up and enhanced communication are superior to treatment as usual in primary care for depression, panic disorder and generalised anxiety disorder
- Limited evidence suggests that collaborative interventions are cost-effective for depression and panic disorder
- Limited evidence that collaborative programs involving psychotherapy under the Better Outcomes program produce reduced symptoms. Australian models with greater collaboration (direct-referral with co-location) produced superior results

POLICY OPTIONS

SUPPORT COLLABORATION

- Continue to support collaborative service incentives like Better Outcomes, ATAPS and Better Access programs by GPs and allied health providers
- Fund more infrastructure to support non-psychologist allied health providers workforce to use existing service incentives
- Continue to support locally developed collaborative models like ATAPS

- Develop systems that provide GP supervision and support by psychologists or other allied health providers
- Give additional financial/training support to GPs providing limited psychological treatments, especially in areas where there is a dearth of specialist services

TRAIN THE WORKFORCE

- Fund targeted professional training of GPs focusing on training in mental health assessment, planning, reviewing, problem solving and behavioural treatment, gate-keeping and matching therapist-patient according to need (stepped care)
- Fund targeted psychologist training, focused on working with primary health care populations
- Fund targeted training of non-psychologist allied health providers, directed at training in focused psychological strategies, problem-solving and working with primary care populations
- Promote primary mental health care workforce training approaches that incorporate an emphasis on early inter-professional training, training in primary health care settings and make explicit a coherent career pathway

UNDERTAKE STRATEGIC EVALUATIONS

- As part of scheduled evaluations, commission a national evaluation strategic framework that includes data on clinical outcomes
- Within scheduled evaluations, monitor psychological-service use and cost to consumers, especially for geographic or demographic groups less able to access services
- Identify and support [priority research areas](#)

METHODS

This document reports on a systematic review of the literature using key outcome measures of clinical improvement (depression, anxiety) and cost-effectiveness and search terms relevant to “primary care”, “psychotherapy” and “depression or anxiety”. One reviewer screened all articles based on [specified inclusion/exclusion criteria](#) using abstracts and titles. Additional studies were identified through hand searches. A subset of papers was independently cross-reviewed by separate reviewers. Included studies were with patients recruited from general practice, that detailed an intervention involving psychotherapy (specifically, a CBT/problem-solving/interpersonal therapy approach), that were not limited to specific medical populations, and that were published in English and after 1979. Health-economic studies could also include modelled studies, but had to include cost and outcome data, and have a comparative arm. Following identification, full articles were scrutinised to determine the final 69 primary studies included in the review. Articles were classified into four main areas (GP-provided care, allied health-provided care, collaborative models, health economics/cost-effectiveness), although articles were allowed to be in more than one category. Data was separately extracted for each category according to relevance.

For more details, please go to the [full report](#)

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