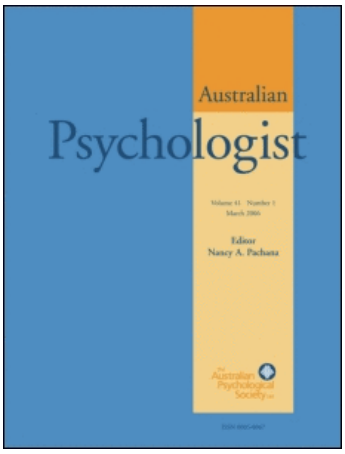

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General practitioners' perceptions of psychologists: A response to the Medicare changes in Australia

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Abstract

General practitioners (GPs) have historically been at the centre of primary health-care delivery in Australia, including delivery of mental health-care services. Recent changes, however, by the Australian Federal government have led to the creation of a number of mental health-care items provided by psychologists that are now available on the Medicare Benefits Schedule. The aim of the present study was to examine GPs' perceptions of psychologists and the ways in which GPs have responded to these policy changes in making referrals for mental health patients. Nine GPs were interviewed regarding the provision of mental health-care services. Analysis of the interviews indicated a number of themes including the benefits of the new Medicare policy in increasing accessibility of psychologists, GPs' frustrations with the bureaucracy surrounding the use of this policy, GPs' knowledge about the specific skills and training of psychologists, and the importance of GPs' matching patients and clinicians. Recommendations are made to facilitate the professional and clinical relationship between GPs and psychologists.

Key words: *GP perceptions of psychologists, Medicare Benefits Schedule, thematic analysis.*

Provision of accessible and effective mental health services has become an increasing priority in Australia over the last decade. This increasing attention may be attributable to the growing recognition that the effects of mental health problems are pervasive and economically significant. The proportion of adults with a diagnosed chronic mental health disorder or behavioural problem in Australia has increased over time from 5.9% in 1995, to 9.6% in 2001 and then 11.0% in 2004 (Australian Bureau of Statistics, 2006). In addition to the enormous personal and social costs of mental illness, the economic effects are substantial. For example, depression alone accounts for a minimum of 6 million work days lost each year in Australia and a further 12 million days of decreased productivity. In 1999 the cost of lost productivity in Australia as a result of mental illness was estimated at $AU34bn per annum (Brain Dynamics Centre, n.d.).

Acute and severe psychiatric services have generally been provided by public inpatient and outpatient mental health services. The majority of mental health services, however, for patients in the community with a range of less severe disorders has traditionally been provided by general practitioners (GPs) (Andrews, 1994; Australian Government: Department of Health and Ageing, 2002; Harrison & Britt, 2004). Harrison and Britt (2004) reported that the most common mental health symptoms presented to GPs were ''mood disorders, stress related disorders, behavioural syndromes and disorders due to psychoactive substances'' (p. 781). A study of mental health treatment services in France, the United Kingdom and the Netherlands found that GPs were the primary medical carers for psychological stress as well as providing in excess of 80% of the prescriptions for psychotropic medications (Norton, David, & Boulenger, 2007). GPs are particularly likely to provide the bulk of mental health services for people living in rural and remote areas, due to the scarcity of psychologists and other mental health specialists in these areas (Caldwell et al., 2004).

It is likely that GPs' substantial role in delivery of mental health services is partly due to funding

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structures that have allowed patients to obtain a significant rebate for health care provided by a GP compared to other health service providers. Both the Australian Government (n.d.), and GPs themselves (Royal Australian College of General Practitioners [RACGP], n.d.), however, have explicitly supported GPs as being providers of mental health services. In addition several authors have highlighted the important role of GPs in providing professional help in the first instance for generalised mental health problems (Andrews, Henderson, & Hall, 2001; Britt et al., 2004; Charles, Britt, Fahridin, & Miller, 2007). With specific regard to depression, Hickie, Pirkis, Blashki, Groom, and Davenport (2004) noted that ''Australians rank their GP as the professional they would most likely turn to if they were experiencing depression'' (p. 15).

Psychologists have long argued for a larger role in the provision of publicly funded mental health services (Australian Psychological Society [APS], n.d.), reasoning that as specially trained providers of mental health care, psychologists are best positioned to provide the level of care that will effectively reduce the burden of mental illness in the community. Various levels of government in Australia have recently responded to reports from parliamentary inquiries and independent reviews acknowledging the need for an increased level of participation by psychologists in mental health-care service provision. The history and context surrounding the development of these policies is covered clearly in other documents (Moulding et al., 2007; Perkins et al., 2007, van Gool, 2007). In conjunction with this, a range of individual government departments have highlighted the need for coordination of inter-agency services to provide a more seamless and integrated mental health-care system (Council of Australian Governments, 2006). This paper examines responses of GPs to a Federal government scheme designed to increase access to psychologists for patients with mental health problems.

Policy changes to increase access to psychological services

In recognition that the majority of people utilised their GP as the primary practitioner for help with mental health issues and that the specialised services of psychologists are underutilised, the Australian Government has developed policies to better integrate the mental health-care services provided by GPs with more specialised mental health professionals.

The Better Outcomes in Mental Health Care (BOIMHC) scheme, introduced in July 2001, was the first of these policies. BOIMHC had two main objectives. First it provided 6 hr of level 1 training to GPs to enable them to identify mental health problems and refer patients to more specialised mental health-care professionals, such as psychologists. Second, it provided 20 hr of level 2 training to GPs, which was designed to allow them to deliver Medicare-funded items referred to as focused psychological strategies. A significant component of the BOIMHC program is the Access to Allied Psychological Services scheme, which has been comprehensively described and discussed in a series of papers (Morley, Pirkis, Naccarella et al., 2007; Morley, Pirkis, Sanderson et al., 2007; Pirkis et al., 2004; Pirkis et al., 2006). The findings of these reports have been very well summarised in a more recent document (Kohn et al., 2007). While both the Department of Health and Ageing (Australian Government: Department of Health and Ageing, 2002) and the APS (n.d.) noted the positive effects of the BOIMHC scheme with regard to improving access to psychological services, the APS has argued that the program did not go far enough. Specifically they suggest that it restricted the use of allied psychological services to only those 20% of GPs who had completed the program, thus failing to adequately increase access to psychological services (APS, n.d.).

In order to address the limitations of the BOIMHC, a second mental health access policy was developed: the ''Better Access to Psychiatrists, Psychologists and General Practitioners through the MBS'' scheme. This scheme, introduced in November 2006, was developed in conjunction with GPs and led to the creation of a number of mental health-care items that are now available on the Medicare Benefits Schedule. (Throughout the paper, we refer to this policy as ''the Medicare changes''). The items have been designed to assist GPs to engage in the early detection, assessment and intervention of patients with mental health problems, and generate referrals to psychologists and other allied mental health service providers. Under the scheme, as part of a GP Mental Health Care Plan, patients can receive rebates of up $AU131 per session with a clinical psychologist and $AU96 per session with a general psychologist for up to 12 sessions.

There are two major ways the system is naturally used. The first is GP driven, whereby the patient presents spontaneously to the GP, who then makes an assessment and subsequent decision to refer for psychological assistance. The second pathway is more patient driven, with the patient deciding to seek psychological treatment (perhaps in consultation with a psychologist) and visiting a GP with the express purpose of arranging a GP mental health-care plan. According to the APS this scheme has had unprecedented success in increasing access to psychological services, with psychologists participating in the survey reporting that ''approximately 73% of their patients would not have been able to access

psychological services without a Medicare rebate, demonstrating the huge, previously unmet need of the Australian population for access to affordable psychological treatment'' (APS, 2008).

The introduction of the Medicare changes raises a number of interesting questions. The primary objective of the Medicare changes was to improve access to psychological services and the first question asks whether or not this has been achieved. A second related question concerns the effectiveness of the changes and the bureaucracy linked with the Medicare changes. The third question is focused on the factors that GPs take into consideration when making referrals to psychologists, and how this has changed with the introduction of the Medicare rebates for psychological services. Sigel and Leiper (2004) found that GPs in the UK made referral decisions based on their perceptions and views of psychological disorders as well as their professional interactions with psychologists. The final question investigates the extent to which GPs are aware of psychology as a profession and the skills and qualifications that psychologists possess to enable them to take on a large share of mental health-care provision.

To this end, nine GPs were interviewed to ascertain their views on a range of subjects related to psychologists and the provision of psychological care, in the new climate created by the Medicare changes.

Method

Participants

Participants were all GPs currently practising in a regional city in Queensland. There are 36 GP practices in this regional centre and participants were recruited by contacting general practice clinics and requesting the practice manager to distribute an information flyer to all GPs. Upon expression of interest from GPs, the interviewer then made a mutually convenient time, date and place to conduct the interview. All interviews were conducted at the GP's place of work, apart from one interview that was conducted at a GP's home at her request. The length of interviews ranged from 12 to 27 min. The total combined time of interviews was 2 hr 49 min, with the average time for each interview being just over 18 min. All participants reported having made referrals to psychologists since the introduction of the Medicare changes.

Interview format

The interview followed the same format for each participant, allowing for responses to specific questions as well as elaboration on those responses. The following topics were covered in each interview: a brief outline of the participant's experience as a GP; whether they had any special interest or additional training in mental health; factors considered in referring a patient to a psychologist; expectations of services received from a psychologist compared to a psychiatrist or counsellor; the participant's sources of knowledge about psychologists; understandings of the type and amount of training undertaken by psychologists; the nature of the participant's contact with psychologists; perceptions of their patients' views of psychologists; any reservations about referring patients to psychologists; and whether their referral pattern had changed since the introduction of the Medicare changes.

All interviews were audio-recorded and then transcribed orthographically. All participants were de-identified, and any individuals or institutions referred to in the transcript have had their names removed to preserve anonymity.

Analytic approach

A thematic analysis (Braun & Clarke, 2006) was used to explore the issues that emerged across the interviews with the GPs. A thematic analysis ''is a method for identifying, analysing and reporting patterns (themes) within data. It minimally organises and describes your data set in (rich) detail'' (Braun & Clarke, 2006, p. 79)., These authors also note that a theme ''captures something important about the data in relation to the research question'' (p. 82). The inherent flexibility of a thematic analysis, its ability to provide a comprehensive and systematic description of the data, and the opportunity it provides to focus on and illuminate specific aspects of the data make it an appropriate choice for the methodology in this study.

The analysis began with a close reading of all interview transcripts, followed by a second reading in which recurring themes were identified. Extracts that best exemplified the themes were excerpted and analysed. Once the major themes had been identified, the interview transcripts were read again in their entirety in order to identify any counter-instances and to ensure that the analysis provided a fair representation of the data.

Results

Several themes recurred prominently across the interviews, and are discussed in turn below.

Accessibility

One of the major themes evident in the data concerned the extent to which the Medicare changes

had made psychological services more accessible to the general public. There was a mixed response from GPs with regard to the impact of the Medicare changes on affordability and accessibility. For example in Extract 1, P was very positive about the Medicare changes.

Extract 1

P: *and I have to say that the Medicare changes have been fantastic around access . . . because it's made it financially accessible to people who otherwise just couldn't really do it or could do it for a couple of sessions maybe (·) but would really struggle to do it.*

Similarly, K was generally positive about the effect of the Medicare changes, citing improvements in access and cost to support the point.

Extract 2

K: *I mean one of the reservations up to now has always been the cost issue and availability so (·) ummm (·) you know there was the public system where people didn't have to pay anything but they often had to wait a considerable period (·) which could have been a problem (·) and then if they wanted to go privately they've got concern about expense (·) with the introduction of the mental health items that has certainly improved (·) and ummm so that reservation about just access and cost has improved considerably*

Some GPs, however, were more circumspect as can be seen in the interview with D, who acknowledges an increased referral rate based on improved affordability, while also conceding that the gap between Medicare rebate and the upfront fee of some psychologists is more than some patients are able to afford.

Extract 3

D: *I'm probably referring more of those who said that they couldn't otherwise afford to go using the mental health (·) plan . . . . I did a mental health care plan for someone and she still couldn't afford the difference so she's on the program through the division where they pay a ten dollar co-contribution.*

The assumption that private psychological care was now affordable for patients was also questioned by B, who in addition to pointing to the substantial gap between the cost of a psychological consultation and the Medicare rebate also noted the negative effects of decreasing the availability of services through the public mental health system.

Extract 4

B: *patients are generally disappointed cos they expect it's gonna cost them nothing and it still costs them quite a bit with most psychologists . . . . it's a little bit more affordable for some people but it actually hasn't solved the affordability problem and the other thing that's happened is it's pretty much impossible to get much done in the public system now cos they just all flick it and say you can get it through Medicare (·) so they see them once and then say go back and see your GP and get a mental health care plan.*

Thus although most GPs considered that the Medicare changes had improved the accessibility of psychological services, some were still keen to point out that financial barriers to access still exist for many patients, and that the new policies have not solved access issues entirely.

Bureaucracy

A second theme that was evident in the interviews relates to the processes involved in using the new mental health-care plans to allow patients to access psychological treatment through the new scheme. The overwhelming trend pattern across the interviews was for GPs to express frustration related to the process of completing the GP mental health-care plans, as evidenced by the following extracts:

Extract 5

K: *there's always the initial frustration of the . . . paperwork and bureaucracy involved in making a referral (·) there's no way you can do a decent job of a GP mental health care plan in fifteen minutes (·) I tend to get people to come back for half hour appointments so I can do a reasonable job of it.*

K refers explicitly to the ''frustration'' the ''paperwork'' and the ''bureaucracy'' involved in completing the mental health-care plans. The impossibility of completing a mental health-care plan in the typical GP session of 15 min is also outlined as is K's solution, which is to book a second longer appointment for patients who require this service. This reference to the bureaucracy surrounding the mental health-care plans, and the strategy of booking double appointments is also supported by A in extract 6.

Extract 6

A: *this bureaucratic process really just gets in front of it (·) I've made that point I think probably in spades (·) the problem is that now it's almost a disincentive to the GP in the sense that to do a mental health care plan properly (·) and to administer the tool properly and so forth is the work of thirty minutes.*

In addition to referring to the time required to complete a mental health care plan, A makes the point that rather than making it easier for patients to access psychological services, the new mental health-care plans can actually act as a ''disincentive'' for

GPs. Implicit in this comment is the notion that prior to the introduction of the mental health-care plans it was easier and thus more common to refer to psychologists. Hence it can be seen that according to A, the bureaucracy involved in completing the mental health-care plans may have nullified some of the intended positive effects such as increased accessibility. This is further highlighted when A comments as follows.

Extract 7

A: *well certainly the bureaucracy (·) the so called Medicare changes have not made it easier . . . and there is still a vast pool of treatable psychopathology sitting out there in the community unaddressed because the system makes it so hard.*

The theme of mental health-care plans being unwieldy and time consuming is continued with M who states the following.

Extract 8

M: *the other thing that I have . . . on a frequent basis recently since they've started is the mental health care plans . . . with psychologists referring people (·) just telling people just go and see your doctor and get one of these knocked out so they book a standard consult and the paperwork is not something that can be done in a standard consult for a new patient (·) ummm and but they come with the expectation it will all be done (·) I'd say the vast majority of the people don't fit the criteria . . . . (·) so they don't actually fit so but then it turns into the GPs all lying (·) I turn into the bastard because I say you don't fit this qualification.*

In this extract M also supports the notion that a mental health-care plan cannot be completed within the time constraints of a standard GP appointment. Moreover, in this extract we also see the beginnings of some of the relationship dynamics and subsequent tensions between GPs and psychologists with regard to the writing of mental health-care plans and the provision of psychological services.

Essentially, GPs rely on psychologists to provide high-quality, effective psychological interventions for their patients. Psychologists, on the other hand, rely on GPs for a percentage of their referrals, and patients who desire Medicare-funded intervention from a psychologist can access this benefit only with a referral from a GP. GPs, however, are clearly stating that they do not have adequate time to thoroughly generate and process these referrals. Compared to the usual medical process of writing a referral letter to a specialist, the current bureaucracy surrounding the mental health-care plans is seen as cumbersome. Consider the following extract from A who outlined the limitations of the Medicare changes.

Extract 9

A: *the current Medicare system (·) is atrocious . . . and the reason why it's atrocious is that I have to prepare a mental health care plan (·) which presupposes some form of mental illness (·) and presupposes that first of all that I know and can adequately administer you know an assessment tool (·) which I can't (·) I was never trained to you know the ones that you know (·) and then that somehow or another I'm going to administer the same tool six weeks or six sessions down the line and somehow or another sit in judgement over my colleague as to whether they've (·) you know (·) I mean the system's ludicrous (·) if I want your heart cut out I write a letter to the cardiothoracic surgeon that's all I need to do (·) if I need some assistance with some CBT which is a technique I'm not trained in (·) I ought to be able to send somebody off to a colleague for a reasonable Medicare rebate with as little fuss as possible.*

The tensions that are generated between GPs and psychologists are seen again in this final extract from B, who provides one further piece of evidence that mental health-care plans cannot be completed in a standard GP consult.

Extract 10

B: *some psychologists will just tell the patient to come here and (·) and get a mental health care plan so they can access the rebates . . . which doesn't really work when you've got 10 minutes to do it.*

It seems clear, therefore, that GPs feel that they do not have adequate time to attend to the mental health-care plans that are necessary for the patient to receive a Medicare rebate. The frustration felt by GPs at trying to complete a mental health plan in a standard 15-min consultation was clearly expressed across the interviews. This frustration can perhaps be seen as somewhat self-inflicted, because the recommended fee of $AU153 for a mental health plan is intended to provide for a long consultation (30 min), and perhaps some of the dissatisfaction around the bureaucratic processes would be reduced if this time allocation were recognised. But although the time burden was a major concern for most GPs, other issues, including the lack of training and expertise needed to assess the mental health problems of patients, and the expectations of patients that GPs would simply ''rubber stamp'' their requests for a mental health plan, were also a significant source of concern.

Issues in making a referral

A third theme that was evident in the data was the concern and consideration taken by GPs when referring their patients for psychological care. GPs were generally very conscious of matching their patients' needs with a psychologist who could

provide an appropriate psychological intervention. Moreover, GPs showed a marked preference for referring their patients to a psychologist with whom they (the GPs) were familiar.

Matching

Throughout the course of data collection there were a number of issues that spontaneously arose when asking GPs about their referral process. One of these was the issue of matching patients to psychologists where possible. The GPs who participated in this study seemed routinely aware of the subtle nuances involved in psychotherapy and commented on the importance of matching their patients with an appropriate psychologist. Some of the issues that were seen to be important in achieving a suitable match between patient and psychologist were factors that are routinely used to organise and assist with the smooth running of society such as gender, age spirituality and sexuality. Other factors, however, were more specific to the realm of health care, including the type of disorder exhibited by the patient, and the financial considerations inherent in receiving psychological care. The importance of gender when matching patients to a psychologist is outlined in the following extract.

Extract 11

P: *I worry about my younger female patients that I'm referring (·) I would feel (·) . . . a lot of them would have had abuse histories . . . and (·) ummm (·) so I try and choose (·) a psychologist that the patient will feel overtly very safe with (·) right from the beginning . . . and I think gender for a lot of my patients is a very big (·) I mean I have patients who who won't even see male doctors.*

In this extract P has outlined the importance of gender with regard to referring young female patients to male psychologists. In addition to this P has also made a direct association between the gender match between patient and psychologist and the subsequent ability of the psychologist to provide an overtly safe environment for the patient.

The issue of matching patient/psychologist personality is complex and important and patients can be easily deterred from seeking psychological assistance following a negative experience with a mental health provider. Personality, however, is one area of matching that is difficult to control, as acknowledged in the following extract provided by K.

Extract 12

K: *yeah (·) and ummm and whether it's the right person for the patient (·) and to some extent that's never going to be possible to answer entirely cos you can never entirely predict whether any given person is going to hit it off with any given psychologist (·) there's always that to some extent (·) personality aaah (·) which you can't predict.*

Known versus unknown psychologists

A second issue that spontaneously arose when asking GPs about their referral process was the notion that GPs tend to refer to psychologists they know, rather than psychologists per se. This is illustrated clearly in the following extract from B.

Extract 13

B: *well my main reservation would be not knowing the individual and what they're like and (·) there's not really good opportunities to find out ummm (·) or none that I'm aware of (·) to find out what individuals are like ummm so (·) that would be my main reservation (·) . . . as a group referring to psychologists I don't have a problem but (·) they do vary a lot and without knowing what each individual's interested in or what they're like (·) yeah it'd be (·) I'd be a bit reserved with someone I knew nothing about.*

In this extract B emphasises the importance of knowing the psychologist to whom referrals are made. In the following extract, A takes responsibility for referring patients to a psychologist who is considered trustworthy and raises the stakes from knowing the psychologist to trusting the psychologist. In this context, the concept of trust in a professional relationship between GP and psychologist, could reasonably encompass overall clinical competence and reputation, and specific clinical competence to deal with particular disorders or issues. When asked if he had any reservations about referring patients to a psychologist, A replies as follows.

Extract 14

A: *provided it's a psychologist that I trust (·) and it's up to me to make sure that the referrals are appropriate (·) no*

A makes clear in this statement that referring patients to an unknown psychologist, just because they are a qualified member of the profession of psychology, is not adequate. Rather, the importance of knowing and trusting the individual is highlighted. This is further emphasised by P, who makes an explicit distinction between knowledge of the individual compared to knowledge of the profession of psychology.

Extract 15

P: *I would have a particular person in mind (·) someone if it's maybe a man with PTSD or something like that I have*

(·) there are particular psychologists I use but that's more from personal knowledge of them rather than (·)

Int: *knowledge of the profession per se*

P: *yes exactly*

Finally, K offers a similar view based on matching the patient's needs to the psychologists expertise when he says the following.

Extract 16

K: *one of the reservations is you just don't know as much as you'd like about that psychologist or counsellor (·) what their strengths and weaknesses might be (·) whether they're going to be right for the particular patient that's sitting in front of you (·)*

It can be seen across these extracts that GPs don't necessarily refer their patients simply to qualified psychologists. Rather, they refer their patients to qualified psychologists they know and trust and who have the skills for that particular patient. This orients us, however, to the point raised by B in extract 13 who lamented the lack of opportunities to get to know individual psychologists. It seems clear that GPs take the notion of the therapeutic relationship seriously, and prefer to refer their patients to a psychologist who is likely to be appropriate for their patient with regard to age, gender and clinical need.

Professional identity

The previous section shows that GPs have a clear preference for making referrals to psychologists with whom they have an existing relationship. But if there are indeed limited opportunities for GPs to get to know individual psychologists, are GPs comfortable in referring to psychologists on the basis of their professional identity? In the following extract, A suggests not.

Extract 17

A: *that's where it comes from (·) look (·) this is a very difficult art and (·) as I've mentioned before not everybody can turn the trick (·) the ones who have seen people who really do it (·) they're not a problem they understand (·) it is my view that there are lots of people sticking their hand up saying I can listen to your problems (·) that really don't have either the training or if they've got the training don't have the expertise to really be effective (·) ummm that's clouded by the fact there are a lot of people out there with so many problems and so few resources that (·) you know nobody's really gonna be terribly successful (·) but there's also a lot of people out there charging people money for being a very sympathetic ear (·) and no more (·) that really makes it difficult for the good clinical psychologists (·) you know there really needs to be a much more effective regulating mechanism (·) you know just so you get some idea (·) I understand the size of what I've said (·) on the one hand if there was a banner saying I am a clinical psychologist and I could depend upon that in the same way as I could depend on somebody having had say a surgical degree to be able to conduct the business of clinical psychology then I'd be very grateful for that*

Int: *mhmmm*

A: *not everybody who has a fellowship of the College of Surgeons is a good surgeon*

Int: *mhmmm*

A: *lots of people who have a FRACS will never ever get to see a patient of mine if I can help it*

Int: *mhmmm*

A: *but at least I have a banner there that says we've whittled down the ummm list and you can pick from here and you've got a reasonable chance within this group of finding what you want (·) that really doesn't clearly exist (·) at least from my perception in clinical psychology (·) I referred also to this great well of psychopathology that's sitting out there people who are emotionally uncomfortable (·) and . . . are seeking you know more emotional comfort (·) if you took away all the willing ears and just left the clinical psychologists (·) that problem of access would become even worse (·)*

Int: *mhmmm*

A: *ummm and so (·) what I'm suggesting (·) is that there needs to be a clear sort of a label (·) yes I have been trained in among you know in clinical psychology and in the techniques of clinical psychology . . . and (·) I appreciate there are labels and so forth (·) they're just (·) they're not visible you see*

Int: *I mean it sounds like you've had experience with people who are clinical psychologists or at least call themselves clinical psychologists who don't deliver the sort of service that you're after*

A: *I'm afraid there's too many of them*

Int: *yep*

A: *yeah (·) I'm afraid there's too many of them (·) and I suspect that that's because there isn't (·) across Australia (·) you know any university can offer a degree just about that it calls clinical psychology (·) there isn't a body like for example the Australian Medical Council that goes around accrediting medical schools and says listen this isn't just up to specs (·) sorry you're going to have to do this again otherwise you won't be able to use this label for your graduates . . . that sort of raising of the standards of education so that if you've got a qualification then across Australia everybody knows you've reached a certain standard I think that's important*

Int: *and that's not in place for clinical psychologists*

A: *well it's not my perception that it is*

Int: *excellent*

A: *yeah it's not perception that it is (·) if it is it needs to be you know (·) you know trumpeted more eh (·) . . . so . . . you know (·) a labelling system which allows patients to understand (·) what it is that they're actually buying (·) I think is important (·) I'd have to say too that (·) the psychological profession as a profession I don't think has been particularly good (·) compare it to chiropractic (·) everybody knows what a chiropractor does (·) you know it's much harder it seems to me for clinical psychologists to let people know what it is that they do (·) or more importantly what it is that they don't do (·) yeah*

In this extract, A clearly expresses the perception that there is not a governing body responsible for accrediting psychology courses in universities in Australia; an inaccurate perception because this role is carried out by the Australian Psychology Accreditation Council (APAC) on behalf of the State and Territory Registration Boards. There are also some other problematic messages contained in this extract. First, when A states that there needs to be a ''clear sort of a label'', the subtext to that message would seem to be that currently the label of ''clinical psychologist'' does not have as much validity or currency as might be expected. According to A, a GP runs a ''reasonable'' chance of finding a ''dependable'' surgeon following a referral to someone who has a surgical degree. In contrast to this, the business of referring a patient to a clinical psychologist is not considered dependable. A points out the importance of marketing, branding and labelling for the profession of psychology and makes an unfavourable comparison to the profession of chiropractic, which has successfully educated the public as to its scope of practice.

During the course of interviews GPs were asked to outline their understanding of the type and amount of training undertaken by psychologists as well as the various sources from which they had gained their knowledge of psychologists. This question yielded a range of results, but GPs were rarely in possession of the full facts with regard to this issue. Some responses were vague.

Extract 18

Int: *and (·) what is your understanding of (·) ummm (·) the training that psychologists undertake*

C: *(·) right well I assume it's a fairly intensive training and analysing problems and different therapies to deal with that as opposed to just your medicinal ones (·) mmmm*

Most responses, however, did include the notion that psychologists completed a university degree and some further training consisting of either placements or further postgraduate study. For example K states that the following.

Extract 19

K: *the average psychologist has probably been through (·) at least sort of three maybe four years of university training (·) and then I'm not sure about post university placement whether there's like a supervised period*

And B supports this notion of a university degree with further training and supervision with the following statement.

Extract 20

B: *well obviously you need a university degree first (·) and then I understand you need your clinical ummm (·) to get your clinical psychology you've got to do some more training and supervision and get assessed but I don't know details*

Sources of knowledge

During the course of interviews GPs were also asked to outline the sources of their knowledge about psychologists. Many of the GPs interviewed identified a range of secondary sources such as information from their medical degree, patient comments, working in the same locality as a psychologist, or even letters from psychologists about their patients as their major source of information. For example M openly conceded his lack of contact with psychologists and suggests that written correspondence with psychologists has been his primary source of information about the profession.

Extract 21

Int: *from where have you got your existing knowledge of psychologists*

M: *aaah look I actually don't know any of them ummm (·) I haven't met any of them ummm (·) vaguely ummm (·) a lot of the time again it's self referral so people rock up and say I've booked an appointment with whatever whoever I just need a referral ummm and (·) basically correspondence is the main way I've sort of done it*

B also outlines written correspondence as a major source of information about the profession, but in this instance verbal correspondence is also identified as a primary source.

Extract 22

Int: *whereabouts have you got your existing knowledge about psychologists from*

B: *hmmm (·) well from (·) talking to psychologists (·) or from patients back and forth (·) letters that they've sent (·) basically that I guess*

Later in the interview, however, B reinforces the importance of written correspondence as a source of

information about psychologists, and adds that patient comments relating to their experience with a psychologist can also provide useful information about the profession.

Extract 23

B: *patients will come in telling me someone was particularly good and they were very happy with them (·) umm (·) and the other (·) if I got a good letter back giving me good information (·) that's helpful to me when I'm seeing the patient as well*

Int: *so does the (·) your patient feedback shape your perception of psychologists*

B: *well fairly largely because that's the main access I have to any information (·) or letters if they do send a letter*

This lack of direct experience of psychologists as a source of information about the profession is reinforced with S and K, who suggest their primary source of the profession as information received during their medical degree. For example S states the following.

Extract 24

Int: *from where have you got your existing knowledge of psychologists*

S: *ummm just through my medical degree*

And K supports this with the following statement.

Extract 25

Int: *from where have you got your existing knowledge about psychologists*

K: *aaaah (·) ok (·) got to think about that (·) I mean obviously there was some (·) introduction to it through the undergraduate medical degree*

For those GPs, however, who work in a clinic that has a resident psychologist, the response can be very different. For example, P works in a GP clinic with a number of psychologists. In contrast to the previous extracts in which GPs identified a range of secondary sources as their primary supply of information about the profession of psychology, P identified working directly with psychologists, and the immediacy and frequency of communication and interaction as a major influence on her perception of the profession.

Extract 26

P: *and I can understand that that's fine and that's probably all you've got time for and it's probably adequate (·) but the difference between that and being able to (·) have a cup of tea with the clinical psychologist you know the psychologist who saw your patient the previous day and you've seen that patient the next day (·) and to be able to say well tell me what happened what do you think how's it going (·) is completely different.*

Int: *so that's the major factor that it's ummm (·) the proximity and the immediacy*

P: *it's the immediacy and the frequency . . . of the feedback you know so I can say to . . . D I really need to speak to you just really quickly about so and so . . . what do you think (·) how do you think he's going and she'll say blah blah and I'll say that's great I'll follow that up at the next appointment or so it's that . . . kind of team approach that I work very happily in*

And later in the same interview P further emphasises the role of proximity by commenting on the experience of working with psychologists off site compared to those on site. The construct of confidentiality is seen as a crucial factor that outlines the difference between working in close proximity with psychologists, and having a less direct working relationship with them.

Extract 27

P: *interestingly the psychologists that work off site are far more (·) seem to be a lot more (·) leery of conversations (·) it's almost like they are more worried about patient (·) inappropriately worried about patient confidentiality . . . whereas the ones I work with (·) we are able I think to have very effective conversations without impairing patient confidentially you know I don't need the content of what they're talking about but just the broad strokes and I find that very helpful whereas the telephone conversations can be a bit (·) ummm (·) more circumspect (·)*

There is a clear sense that the ability of a GP to work effectively with a psychologist is influenced by factors such as proximity and medium of communication. This is illustrated by P's comments when she acknowledges the role of proximity in allowing for immediate and frequent communication that produces more ''effective conversations'' than are available when working with psychologists who are not physically co-located, and where the conversations can be more circumspect.

Discussion

The Medicare changes were designed to increase the availability of psychological services for patients with mental health-care needs. On the one hand, the APS have declared the changes a resounding success, although, having lobbied cogently and vehemently for these changes for some years prior to their introduction, it could be argued the APS has a vested

interest in the success of the new changes. In contrast, GPs working at the interface of policy change and clinical service provision are somewhat more equivocal. While some GPs are openly optimistic about the changes, others are ambivalent or even negative. It should be noted, however, that even the GPs who are negative about the current Medicare changes are not negative about increasing community access to psychological services per se. Rather, they have criticisms about how the changes have been set up and administered. Moreover, a large portion of these criticisms are related to the bureaucracy of the GP mental health-care plans, which are time consuming to complete. The major issue appears to be GP workloads and the increased burden of paperwork that has arisen with the new Medicare changes.

With regard to the second two questions related to referrals to psychologists and professional identity, the interviews suggest that GPs want to know more about the psychologists to whom they are referring. It seems clear that GPs prefer to deal diligently with the notion of matching their patients with an appropriate provider of psychological services. It also seems clear that the GPs interviewed have a limited understanding of the type and amount of training undertaken by psychologists. This raised two important issues for GPs of knowing and trusting the psychologists to whom they are referring. It could be argued that to know a psychologist is a relatively straightforward process that begins with being aware of their credentials and qualifications. Trusting a psychologist, in contrast, is more complex, requiring that, in addition to knowing the amount and type of training undertaken, one must also be aware of other details about the person: their ability to empathise with a patient; their reliability with correspondence; their proven clinical efficacy over a significant period of time. These constructs of knowing and trusting are seen by the GPs interviewed in this study as being inextricably linked with issues of proximity and the subsequent immediacy and frequency of communication.

Limitations

The purpose of this research was to address a set of questions about the recent Medicare changes related to accessibility, bureaucracy, referrals to psychologists, and GP perceptions of psychologists. We have provided some preliminary answers to these questions on the basis of interviews with GPs who are working within the new mental health-care frameworks provided by the Australian Federal government. There were a number of limitations, however, to the present study. The number of participants in this study was relatively small and it would be useful to follow up the experiences of GPs with the Medicare changes using survey research with a larger sample of respondents. One of the benefits, however, of the qualitative approach used in this study is that respondents were easily able to express their ambivalence about the consequences of the Medicare changes when referring patients for mental health care, and their opinions of the professional identity of psychologists. Furthermore, although there was some variation across participants in their satisfaction with the Medicare changes, on the whole the issues raised by the GPs as matters informing their practices of making referrals to psychologists were remarkably consistent, suggesting that these issues are likely to be relevant for many GPs.

All participants in this study were drawn from a single mid-size regional city in Queensland, potentially limiting the generalisability of the findings. Although GPs are likely to encounter many of the same issues wherever they practice, there may also be systematic differences between metropolitan, regional and rural practitioners that we were unable to address in this study. Future work that addresses the particular issues facing practitioners in different regions and with a range of practice profiles would be valuable.

Recommendations

In response to the issues outlined above, a number of recommendations are made. First, to facilitate the process of GPs getting to know who psychologists are and what they do, it is recommended that an appropriate body gain access to the training arena of new medical graduates to provide detailed information to medical students. This information could encompass issues such as recognising mental health disorders, appropriate referral criteria, and the best way to make and maintain professional relationships with psychologists. Moreover, once these medical students have graduated, it would be appropriate for more specialised information to be provided to new graduates who are working as GPs and are enrolled in the 2-year GP registrar program. The Mental Health Professionals' Association (MHPA) consists of four prominent mental health bodies in Australia including the Royal Australian College of Psychiatrists (RANZCP), the APS, the RACGP and the Australian College of Mental Health Nurses (ACMHN). These four bodies oversee the clinical and operational standards for each of their professions. A possible model to commence the training of new medical graduates and established GPs could see the RANZCP, the APS, and the ACMHN providing information to the RACGP, who then formally educate their GP members.

A second means of assisting GPs in knowing and trusting psychologists is the co-location of GPs and psychologists. It is anticipated that co-location will enhance communication, increase trust between the professions and lead directly to improved outcomes for those patients presenting to GPs for mental health disorders. This is not a new recommendation: the APS have previously lobbied for more formal links between GPs and psychologists in the form of co-locating (APS, 2005). Indeed, the APS has taken this argument further, suggesting the need for the restructuring of the Divisions of General Practice into Divisions of Primary Care, which would then accommodate GPs, psychologists, nurses, physiotherapists, podiatrists and a range of other allied health-care providers. But although co-location of psychologists with GPs has been associated with better health outcomes (Moulding et al, 2007; Perkins, et al, 2007), there are potential disadvantages that also need to be considered. For example, while psychologists who are embedded in general practice may have more opportunity to engage in informal liaisons with GPs, this also leads to an increased risk of psychologists losing contact with mental health services. Second, the issue of GPs actually having rooms available becomes an issue, and finally the notion of co-location means that the referral base for psychologists is somewhat limited, with GPs being reluctant to refer outside their general practice. Nevertheless, whichever path is ultimately taken, it seems that the proximity that allows for immediate and frequent face-to-face contact between GPs and psychologists is a crucial factor in improving communication.

Finally, to reduce the bureaucratic load on GPs with regard to the GP mental health-care plans, and facilitate the smooth referral of potential mental health patients to psychologists, it is recommended that a significantly abridged referral process be introduced for GPs allowing them to quickly and easily request an initial assessment by a psychologist. If this initial assessment indicates the presence of a diagnosable mental health disorder, the psychologist could then direct the patient back to the referring GP with initial clinical findings and the advice that a 30-min session is required for the construction of a mental health-care plan. The benefits of this approach are that the GP may circumvent the writing of a mental health-care plan for those patients for whom it is not appropriate; and second, that psychologists can provide valuable clinical advice for GPs, which may then be used in writing the mental health care plan. With this model the psychologist is compelled to direct patients back to the GP for the mental health-care plan, and the GP remains at the hub of primary health-care provision. In addition, however, the GP also receives useful clinical advice that can be used in formulating the mental health-care plan. Furthermore, most psychologists are familiar with the various outcome measures such as the Kessler Psychological Distress Scale and the Depression, Anxiety and Stress Scale, which are required by Medicare at assessment and review. Hence they could administer and interpret these tools at assessment, review and discharge (which is part of their expertise), thereby further reducing the workload of GPs. It is anticipated that this increased role of psychologists would enhance the processes of assessment and mental health-care formulation for patients seeking publicly funded psychological care on Medicare. Moreover, it would lead to a reduction of the bureaucratic load on GPs while still respecting their role as the principal provider of primary health-care services.

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