Integrating Psychologists into the Canadian Health Care System: The Example of Australia

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ABSTRACT

Canada and Australia share many similarities in terms of demographics and the structure of their health systems; however, there has been a divergence in policy approaches to public funding of psychological care. Recent policy reforms in Australia have substantially increased community access to psychologists for evidence-based treatment for high prevalence disorders. In Canada, access remains limited with the vast majority of consultations occurring in the private sector, which is beyond the reach of many individuals due to cost considerations. With the recent launch of the Mental Health Commission of Canada, it is timely to reflect on the context of the current Canadian and Australian systems of psychological care. We argue that integrating psychologists into the publicly-funded primary care system in Canada would be feasible, beneficial for consumers, and cost-effective.

Key words: Mental health services; psychotherapy; mood disorders; anxiety disorders; primary health care

La traduction du résumé se trouve à la fin de l'article.

Can J Public Health 2009;100(2):145-47.

Mental illnesses such as depression and anxiety disorders make up a substantial component of the disease burden of Canada and Australia,[1,2] with over 10% of the population having a disorder in any one year. If left untreated, such disorders lead to substantial personal misery, disability, functional impairment, disruption to family, increased health care costs, and increased rates of suicide. However, research shows that these disorders are responsive to certain well-defined psychological treatments,[3,4] suggesting that the use of such evidence-based therapies is one avenue whereby a large proportion of the disease burden could be averted.[5] For example, the evidence-based guidelines of the National Instititute for Health and Clinical Excellence in the UK recommend depression-focused psychological treatment (problem-solving therapy, brief cognitive-behavioral therapy [CBT] and counseling) or serotonergic medication for mild-to-moderate depression; and combined serotonergic medication and CBT for severe or treatment-resistant depression.[6] Such evidence and recommendations leave policy-makers in both countries with the question of how best to provide broad community access to evidence-based psychological treatments. In this paper, we compare the Canadian and Australian approaches to improving access to psychological treatments in primary care. We believe that such a comparison is timely, given that Canada has launched a national mental health commission to inform the development of sound public policies and to improve service delivery.[7]

Comparability of Canadian and Australian systems

Canada and Australia share many similarities in terms of their demographics, mental health needs, and models for providing health care. Both countries have a large landmass with an increasingly aged and highly urbanized population that is mainly of Caucasian descent, with a proportion of immigrants and Indigenous peoples. Both have relatively strong primary health care systems,[8] with provincial/state level governments being responsible for the provision of a substantial proportion of health care.[9] Both have a universal, publicly-financed health insurance, termed Medicare, which covers the majority of medical costs, although in Australia this is controlled federally rather than at province/state level. In both countries, family physicians/general practitioners operate at the centre of the health care system, performing a gate-keeping role, and operating predominantly on a fee-for-service basis.[9,10] In Canada, following the Romanow Report, different models of delivery and remuneration are being developed to increase access to family physicians and to encourage team or interdisciplinary approaches in primary care.[9-11]

Psychological care in Canada

Canadian family physicians have practices that are burdened by the most prevalent mental disorders (depression, anxiety) and welcome collaboration with psychologists.[12] However, such services

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Acknowledgements: This work was partially supported by a PHCRED Research Fellowship for author Grant Blashki.

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remain generally inaccessible.[12-14] Below, we describe the typical Canadian experience of primary mental health care.

Within the Canadian publicly-funded primary care system, a range of mental health interventions is offered, with the family physician at the core. Low-prevalence mental disorders such as schizophrenia are generally referred to psychiatrists for pharmacological treatment. High-prevalence/common mental illnesses such as depression are treated either within the public or private system. In the public system, usual care involves drug therapy and/or generic counseling delivered by the family physician. Such psychological interventions primarily entail emotional support and counseling (listening/giving advice) rather than formal psychological treatments.[15]

Alternatively, the family physician can refer a consumer to see a professional such as a psychologist. In 2001, approximately 80% of consultations with psychologists were within the private system, with a proportion covered by private insurance and the remainder funded predominantly by consumers' out-of-pocket expenses.[13,16] In a recent survey, Ontario family physicians reported such costs to be the greatest barrier to referring consumers to psychologists.[12]

Recent primary care reform has facilitated the development of alternative service delivery models involving interdisciplinary care teams. Examples include "Shared Mental Healthcare" initiatives,[17] which most frequently involve collaboration between family physicians, psychiatrists and mental health workers or social workers.[15,18] Consumers with severe and/or persistent mental illnesses or those requiring a psychiatric consultation along with emotional support are served well with this model, but the most prevalent psychological problems do not necessarily require psychiatric interventions. Family Health Teams (FHT) in Ontario and Family Medicine Groups (FMG) in Quebec aim to promote interdisciplinary care.[19] Again though, while FHTs increase access to mental health services, they are generally rendered by counselors/social workers, with psychologists incorporated into only a few FHTs and none of the FMG teams.[20]

We believe that the move towards multidisciplinary teams is to be applauded. However, there are approximately 15,000 psychologists working in Canada;[21] a workforce that has undergraduate and graduate-level education and training (e.g., in Ontario it takes approximately 10 years to achieve autonomous practice) and who are licensed with authority to exercise controlled acts. We find it of concern that, despite their range of expertise as diagnosticians, consultants and providers of evidence-based psychological treatments as opposed to generic/supportive counseling for a range of mental disorders, this workforce is mostly excluded from the primary care component of mental health treatment.

Psychological care in Australia

Australian psychologists traditionally operated in similar settings to Canada, including hospitals, community health centres and private practice. In the former two settings, access has been free at the point-of-service for some time, but until recently, consumers incurred significant out-of-pocket costs if they visited a private psychologist.

In 2000-01, the Australian Government provided funding for the Better Outcomes in Mental Health Care program (BOiMHC). The BOiMHC involves a number of components, one of which explicitly aims to improve access to psychologists. Divisions of General Practice (locally-defined networks of GPs) are provided with capped funds to manage Access to Allied Psychological Services (ATAPS) projects. These projects enable GPs to refer consumers to psychologists (and other selected allied health professionals) for up to 12 sessions of free or low-cost evidence-based mental health care. Like the Canadian FHTs, the ATAPS projects are tailored to meet local needs. For example, some Divisions directly employ their psychologists while others contract them on a sessional basis, and some co-locate their psychologists with GPs whereas others encourage them to operate from their own rooms. Ongoing evaluation suggests the projects are achieving positive outcomes for consumers.[22]

In 2006, the Federal Government instituted the Better Access to Psychiatrists, Psychologists and GPs through the Medicare Benefits Schedule (Better Access) program, which now sits alongside the BOiMHC program. This program increases access to private psychologists via a different means, namely by making services eligible for a rebate through the Medicare Benefits Schedule. The program enables a consumer to receive up to 12 sessions of evidence-based mental health care from registered providers, when their GP, in consultation with the consumer, judges such services to be of benefit. The GP retains his role as the provider of continuing care, with psychologist feedback to the GP, and a progress review by the GP after six sessions.

Several factors seem to have been important in these Australian reforms, and these may be worth fostering in the Canadian context. First, consumer advocacy was a strong driver. In particular, reports by the Mental Health Council of Australia were widely distributed and had a major impact.[23,24] These reports highlighted unmet needs for basic mental health services, with many individuals relying on increasingly overworked GPs for such services. Second, there was an increasing appreciation of the cost of mental illness. The Australian Burden of Disease Study, for example, found that mental illness had the greatest burden through Years Lost due to Disability (YLD) of any illness.[25] Third, a series of Australian cost-effectiveness studies provided compelling evidence that psychological services represented value-for-money from a public health perspective.[26] Fourth, there was an increased policy recognition of the role of primary care providers in the delivery of mental health care.[27,28] The National Mental Health Strategy emphasized the need for partnerships between primary and secondary care; and the General Practice Strategy emphasized that mental disorders could be more effectively treated with improved primary care services.[27] A major theme of an Australian Senate report on mental health,[29] which immediately preceded the Better Access program, was the heavy load on primary mental health care workers such as GPs. As a solution, they report psychiatrist Professor Ian Hickie's submission: "If the Commonwealth were to immediately recognise the number of psychologists who would automatically meet that [standard of training]… we would immediately double the mental health specialist work force, and it would not kill the Treasury" (ref. 29, p.146). Fifth, and related to these policy drivers, there was strong interprofessional advocacy, with various multidisciplinary groups promoting developments in primary mental health care, including the incorporation of psychologists into the primary care workforce.[28,30]

CONCLUSION

The multidisciplinary primary care teams in some parts of Canada share similarities with Australia's mental health programs, with

their emphasis on management of mental illness in primary care and their flexibility to suit local needs. However, in the Canadian programs, underutilization of the psychologist workforce is an issue, given their specialist training in providing diagnostic/treatment/consultative services and the evidence for the efficacy of psychological treatments in treating high-prevalence mental disorders in primary care.[4] We hope that reflecting on the conditions leading to Australian reforms will provide some principles-of-value in increasing access to psychologist-provided diagnosis, consultation, and treatment within the Canadian context, providing a cost-effective and immediately available solution to an overworked primary mental health care workforce, and improving outcomes for consumers experiencing mental illness.

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Received: April 21, 2008
Accepted: November 11, 2008

RÉSUMÉ

En termes de démographie et de structure de leurs systèmes de santé, le Canada et l'Australie partagent de nombreuses similitudes; cependant, on note une divergence dans leur approche et leurs politiques en ce qui concerne le financement des services psychologiques. Les réformes récentes des politiques en Australie ont considérablement augmenté l'accès de la population aux psychologues pour des traitements fondés sur les preuves dans le contexte des troubles mentaux de forte prévalence. Au Canada, l'accès aux psychologues demeure limité, la grande majorité des consultations se produisant dans le secteur privé; la majeure partie de la population ne pouvant avoir accès à ces services pour des raisons économiques. Le lancement récent de la Commission de la santé mentale du Canada suggère que le moment est opportun et qu'il est pertinent de se pencher sur le contexte actuel des systèmes canadiens et australiens en ce qui concerne les soins psychologiques. Nous suggérons que d'intégrer les psychologues dans le système de soins de santé primaires au Canada est réalisable, bénéfique pour les consommateurs, et coût-efficace.

Mots clés : Services de santé mentale ; psychothérapie ; troubles de l'humeur ; troubles d'anxiété; soins de santé primaires