

The Australian Psychological Society Ltd

**Submission**  
to the

National Preventative Health Taskforce

**APS contacts:**  
Professor Lyn Littlefield OAM

Mr Harry Lovelock

**December 2008**

## Introduction

The Australian Psychological Society (APS) has significant interest and expertise in providing advice to the National Preventative Health Taskforce. We have already provided a submission to the Senate Inquiry on Obesity, participated in a number of stakeholder reference groups on related areas such as diabetes and chronic disease and have a large number of psychologists with specific training in health and health related behaviour change.

The APS supports the submission provided by the National Primary Health Care Partnership and submits this proposal to provide additional detail in relation to the provision of increasing levels of support to help people with preventative health issues to make sustainable lifestyle changes. We would be happy to elaborate on the contents of this submission with members of the Taskforce.

## Background

The financial and social burden of chronic disease associated with lifestyle risk factors is well documented. In recognition of this, the Council of Australian Governments (COAG) meeting in February 2006 agreed to the *Better Health for all Australians Initiative* to promote good health, disease prevention and early intervention. In particular, COAG agreed to supporting lifestyle and risk modification through referral to services that assist people wanting to make changes to their lifestyle. There was also agreement to support active self-management of chronic disease with services ranging from group-based courses to various forms of counselling. More recently, the Australian Government established the Preventative Health Taskforce to examine and identify strategies to address the burgeoning impact of preventative health issues within the community.

The full benefits of both of these initiatives may not be realised if the complexity involved in reducing lifestyle risk factors is not adequately recognised. Apart from receiving guidance from medical practitioners, dieticians and exercise physiologists, people also need assistance to address the psychological factors that impact on behaviour change. There are many barriers (environmental, social, emotional, behavioural, and cognitive) to people making lifestyle changes, both in the early stages of change and while they are striving to enact and maintain the desired changes. Many people are unable to make or sustain lifestyle changes without psychological assistance to address these barriers. The profession of psychology is specifically trained in the fundamentals of behaviour change, maintenance and relapse prevention and is therefore a critical inclusion in the team approach to managing patients who are attempting to change diet, exercise or attitudes associated with the so-called 'lifestyle' diseases.

A substantial amount of research now exists demonstrating the cost-effectiveness of psychological interventions for a range of physical health problems (see Attachment 1). The diagnosis of diabetes, heart disease or other major illnesses typically requires the patient to change existing or take up new health behaviours (diet, exercise, blood tests, medication, medical appointments). Patients report a wide range of short-term and long-term motivation to make these medically recommended changes, and also report anxiety, depression and self-image problems associated with their illness. Following effective psychological

interventions, patients tend to have lower relapse rates, fewer GP visits and fewer hospital admissions leading to ongoing cost savings within the health care system.

There is also now substantial evidence demonstrating the effects of psychosocial factors (such as work and community-based support, social isolation, stress, personal attributes, and family dysfunction) on the incidence and progression of physical illness. Psychological treatments addressing these factors can therefore have a direct influence on the course of a physical illness, in addition to assisting with emotional adjustment to the health disorder. Psychologists who specialise in assessing and treating patients in medical settings work closely with medical practitioners using non-pharmacological strategies such as stress management, cognitive interventions for negative mood issues, pain management, motivation to change strategies and techniques for treatment adherence for patients with various health-related problems.

### **Proposed strategy**

The APS recommends the allocation of funding to provide psychological intervention in the prevention, treatment and management of chronic diseases associated with life style risk factors. This initiative involves more effective use of the existing psychology workforce in partnership with general practitioners and other allied health providers. It will enable the Australian community to gain improved access to effective psychological services to support lifestyle and health risk modification, thereby decreasing the burden of illness associated with often largely preventable diseases.

The APS has developed the attached model (see Attachment 2 for the schematic version) to demonstrate how access to these services would become available and the pathway to each. This model includes the use of other allied health professionals who could be trained in some areas and who also would contribute their own expertise to address specific chronic disease and/or preventative health advice and support.

### **How the model will work**

The model of care for both prevention and management of chronic health conditions, such as obesity, diabetes, heart disease, and smoking and alcohol-related diseases, requires two specific components:

- Effective assessment mechanisms to identify potential or existing health problems
- A '5-step' model of care where interventions cover education on disease, health behaviour change, and management of psychosocial determinants of poor health behaviour

The intervention stage of the model includes 5 steps of care, depending on the needs of the individual and the level of management required for positive health outcomes. This model represents a chronic conditions prevention and self-management (CCPSM) framework for positive health outcomes for patients. It would "sit" within a broader system of public health promotion campaigns, community awareness projects and traditional medical care systems.

### *Identification/Assessment (Stage 1)*

The CCPSM model proposes the establishment of a National Assessment procedure to readily determine the level of care required in stage 2 of the model. The assessment procedure could be undertaken by a Practice Nurse, Nurse or Allied Health Professional in a number of locations, such as General Practice, Hospitals, Community Health centres, or developed Primary Health Care centres. Referral to a health service for assessment could be from a GP, Specialist medical practitioner, community services, schools, or by self-referral.

### *Assessment Tool.*

A CCPSM assessment tool needs to be developed that covers specially the patient's knowledge of the condition(s), and their capabilities to manage the condition(s) to achieve the required health outcome. Additional to the assessment tool, materials outlining the referral process to one of the 5 steps of care need to be developed. Both the CCPSM assessment tool and the referral process (level of step-care) would be based on the evidence-based theory and practice in the medical and behavioural science literature, and constructed under consultation with health professionals and consumers.

### *Training in the Chronic Conditions Prevention and Self-Management (CCPSM) Assessment Tool*

Training in the CCPSM assessment tool could be achieved through an online/DVD based module of learning that incorporates a test component to ensure appropriate use and interpretation of the CCPSM assessment tool. The online/DVD training would also cover skills in communications that motivate the patient to engage into the appropriate level of stepped care.

### *The 5 Level Step-Care component of the CCPSM model (Stage 2)*

In line with the literature on health behaviour change, a 5-level step care model of intervention is proposed. This multi-level approach of care acknowledges that patients are at different points of readiness and have various capabilities to make health-behaviour changes, and therefore a range of interventions needs to be tailored to achieve a positive health outcome for all patients. Following screening, patients will be identified as being at one of five levels of intervention.

**Step 1** is the monitoring pathway and involves providing the patient with immediate support in the form of additional information to address any specific issues. No further intervention should be required. This information could be provided at the assessment interview or provided at the patient's next GP, medical specialist or allied health professional appointment.

**Step 2** is the education and supportive counselling pathway and involves a **single session** with an allied health professional or practice nurse to support patients with poor knowledge of health-behaviour change strategies, e.g., weight reduction interventions, smoking cessation or alcohol reduction programs. A patient would access step 2 services through the general practice, allied health, or other primary health setting in which the assessment was undertaken or referred onto a service external to the place of assessment.

**Step 3** is the enhanced education and supportive counselling pathway, entails an **additional two sessions** with a psychologist or allied health professional to provide further support and targeted resources to address the patient's specific issues with advice on techniques to help in behaviour change. These services would be accessed as outlined in step 2.

**Step 4** is the intensive education and support pathway and consist of **six sessions** with a trained psychologist or allied health professional to implement behaviour change techniques and reinforce new lifestyle habits. These services would typically be accessed through a referral to a psychology or allied health practice in the local area.

Lastly, **Step 5** is the Clinical Health Psychologist intervention pathway and involves up to **12 sessions** with a psychologist for patients with poorly controlled chronic conditions or behaviours (e.g. weight, smoking or alcohol use) and an inability to adhere to or maintain reduction interventions. These services would be accessed through referral to a Clinical Health Psychologist in the local area. Identification of Clinical Health Psychologist could be through the APS "find-a-Psychologist" website which allows a search option for selecting a psychologist who is a member of the College of Health Psychologists.

#### *Training in CCPSM step care interventions*

It is proposed that step 1 and step 2 require no additional training for health professionals with tertiary professional qualifications. Health professionals providing step 3 level of care would be required to demonstrate that they have received training in behaviour change support skills in their tertiary course or through continuing professional development recognised by their profession. Step 4 level of care would be provided by registered psychologists and health professionals who had undertaken an online learning module of training in health behaviour change and psychosocial factors related to chronic conditions prevention and self-management. Step 5 level of care would be provided by psychologists who are members, or eligible to be members, of the College of Health Psychologists.

## **Costings**

The APS has costed this 5 step intervention based on an initial target of 10% of the population. It is estimated that of this 10% of the population that 60% will access online and other targeted information without the need for any further support as identified in Step 1. The other 40% may require an assessment and advice with 60% of these requiring no further support. The percentage of people requiring increasing support decreases to 3% in Step 5. Based on these estimates, the cost of national implementation this initiative would be approximately \$13.3m. A breakdown of these costings is included in Attachment 3. A smaller number of pilots could be trialled to more accurately determine the take up rate and effectiveness of these interventions before implementing a national roll-out.