

Stepped Care in primary mental health services revisited

A 'non-medical' model

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Overview

1. Status and cost of PMHC
2. Why de-medicalise PMHC?
3. Stepped care as a model of PMHC
4. The role of psychologists/
psychotherapists in PMHC
5. A Prototype of non-medical PMHC:
Student Psychological Services

HSE Shared Care Guidelines, 2012

- ◆ Prepared for A Vision for Change working group
- ◆ Reflecting most up to date vision from HSE
- ◆ Advancing the shared care approach between primary care and specialist mental health services

HSE Shared Care Guidelines (2012)

- ◆ Acknowledges over-reliance on medication by GPs due to lack of access to psychological therapies.
- ◆ Acknowledges that Universal access to psychological and counselling therapies should be available.

HSE Shared Care Guidelines , 2012

- ◆ Acknowledges the need to ensure that sufficient numbers of professionals within primary care have the required skills and knowledge to work effectively with patients who have mental health issues.
- ◆ ? Psychologists / psychotherapists/ counsellors

HSE Shared Care Guidelines (2012)

- ◆ Aim : to improve communication between GP and specialist, such as psychologists.
- ◆ Indicates that GP is the 'gatekeeper'. Clinical governance not agreed.
- ◆ Is mental health care part of primary care or specialist care ?

PMHC – current status.

- ◆ GPs manage 90% of mental health presentations (incl 30% severe)
- ◆ GPs vary in their interest and competency in dealing with mental health issues.
- ◆ GPs are looking for non-pharmacological interventions.
- ◆ Lack of non-pharmacological options available.
- ◆ Service users want access to psychological therapies
- ◆ GPs do not provide talk therapy.

In support of GPs

- ◆ GPs are overwhelmed in their day to day work and need to be relieved of the huge burden of responsibility of being the first port of call for all mental health issues.
- ◆ Based on the available evidence, this role can be more suitably and competently undertaken by non-medical professionals in mental health care.

Challenging our assumptions

The de-medicalisation of PMHC services requires a radical paradigm shift.

We need to move away from having medical treatments as the first port of call for our PMHC services

The evidence for talk therapies

Talk therapies are most suited to the treatment of the vast majority of mental health issues and therefore ought to be at the core of any model of PMHC.

Talk therapies are recommended

The importance of considering psychological based interventions prior to offering medication is becoming accepted best practice, with psychological therapies recommended as the first treatment of choice for emotional and psychological difficulties

(Ward 2010.)

- ◆ **Psychotherapy and medication are equally effective in treatment of mood disorders and anxiety, but the long term benefits of psychotherapy outweigh those of medication.**
- ◆ **Combined treatment should not be considered the default treatment for mood and anxiety disorders.**

Otto et al 2005,

Wurz and Sungur, 2009,

Evidence for treatment of depression

- ◆ **Psychotherapy has an effect size comparable to anti-depressants.**

Cuijpers et al 2013a

- ◆ **Psychotherapy has an enduring effect following termination of acute treatment. No difference in relapse rates compared with continued pharmacotherapy**

Cuijpers et al 2013b

Can we afford to de-medicalise PMHC ?

- ◆ Everyone from service users to GPs are calling for more access to talk therapy, to help deal with mental health crises, but it is argued that there is a lack of funds for talk therapies. This is not correct.
- ◆ We can have direct access to talk therapy as the first step in the delivery of primary care mental health services, without any additional funding required.

Example

- ◆ **What is the current practice in treatment of depression in primary care ?**

Current treatment of depression

Mild

Moderate

Severe

10%

90%

Receiving
psychoth-
erapy alone

Receiving medication with limited
psychotherapy usage

◆ Ref: Olfson and Marcus, 2010

The Cost

- ◆ **Costs of antidepressants in Community drug schemes in Ireland, 2012**

- ◆ = **€52.5 million**

- ◆ (excl. cost of 5 million GP consultation, est. €75 million in 2010 for mental health).

- ◆ **Total cost of all psychological services in Ireland, 2012**

- ◆ = **€42.5million** (i.e. for 536 psychologists incl. 108 trainees).

- ◆ **National Counselling Service = €4.2million**

Recommended treatment of depression

S
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Mild

Moderate

Severe

70%

30%

**Recommended -
Psychotherapy only**

**Recommended -
Psychotherapy +
medication**

Ref: Zimmerman et al, 2002

Current treatment of depression

Mild

Moderate

Severe

10%

60%

30%

**Receiving
psychoth-
erapy alone**

**Innappropriately prescribed
antidepressants**

**Receiving
medication with
limited
psychotherapy
usage**

Re-distribution of resources

- ◆ **€35 million** (i.e. 66% anti-depressants bill) = **600,000 psychotherapy consultations per year** (@ €60 per consultation).



- ◆ = **12,000 consultations per week**



- ◆ This would provide **60,000 people per annum** with up to **10 X 1 hour sessions each**.

Stepped Care as a model of PMHC

Five fundamental features :

1. **People should not have to wait for psychological service** (White, 2010).
2. Least restrictive treatment that will provide significant gain, **should be offered first.**
3. The system should be self-correcting.
4. Requires a range of treatments of differing intensity (Bower and Gilbody, 2005).
5. Interventions rank ordered in terms of cost and intrusiveness.

Stepped care model for mental health services

- ◆ Seeks to treat service users at the lowest appropriate service tier in the first instance, only 'stepping up' to intensive/specialist services as clinically required.
- ◆ The level of professional input is augmented gradually, until satisfactory health status is achieved.
- ◆ Clinical and financial advantages.

Stepped care model for treatment of depression

Step 5: Inpatient care, crisis teams	Risk to life, severe self-neglect	Medication, combined treatments, ECT
Step 4: Mental health specialists including crisis teams	Treatment-resistant, recurrent, atypical and psychotic depression, and those at significant risk	Medication, complex psychological interventions, combined treatments
Step 3: Primary care team, primary care mental health worker	Moderate or severe depression	Medication, psychological interventions, social support
Step 2: Primary care team, primary care mental health worker	Mild depression	Watchful waiting, guided self-help, computerised CBT, exercise, brief psychological interventions
Step 1: GP, practice nurse	Recognition	Assessment

IAPT programme, UK

Improved Access to psychological therapies.

- ◆ Bringing talk therapies to the masses.
Began in 2006 by NHS
- ◆ Implementing NICE guidelines for people suffering from depression and anxiety disorders.
- ◆ Offers patients a realistic and routine first-line treatment, combined where appropriate with medication which traditionally had been the only treatment available.

- ◆ By March 2011: 142 of the 151 Primary Care Trusts in England had a service from this programme in their area and 50% of the adult population had access.
- ◆ 3,660 new cognitive behavioural therapy workers had been trained, Over 600,000 people started treatment, over 350,000 completed it, over 120,000 moved to recovery and over 23,000 came off sick pay or benefits (between October 2008 and 31 March 2011).

Impact of IAPT

- ◆ **An increase in employment of 5%.**
Glover web and Evison, 2010
- ◆ **Across 32 IAPT sites the overall proportion in work and not claiming benefit rose by 2%.**
Gilbody, Bower and Whitty, 2006.

IAPT - concerns

- ◆ Must not be limited to CBT.
Now incl. interpersonal therapies.
- ◆ May distract from the importance of and funding for more extensive treatments required, that can also be provided at primary care.
- ◆ 1 yr training programme, indicates the minimal level of expertise involved. Typically are trained to do one thing: Self-guided Help.

IAPT has relegated psychologists to the sidelines. Perhaps we have to stand up and shout a bit more loudly about the skill of a psychologist – not putting down our colleagues but emphasising the unique contribution psychology can make to the rapidly developing mental health scene.'

White, 2008

New position of G.P. Psychologist / Psychotherapist

- ◆ Psychology in primary care is a new hybrid paradigm requiring a broad generalist approach to a wide variety of presentations as well as the ability to focus in depth on complex issues across the developmental life span.
- ◆ Suggests the need for experienced practitioners with a variety of skills and competencies.
- ◆ (Martin, Hawkins, Hicks and OFlynn)

The psychologist in primary care is a general practitioner who has skills in the psychological assessment of and intervention with common health problem of clients and families throughout the lifespan (Acklin, 2004).

The fact that primary care involves an unselected patient population with a tremendous diversity of problems means that pragmatism and efficiency become crucial (Searight, Price & Gafford, 2004).

- ◆ Given the range and diversity of presentations in primary care there is a requirement for highly skilled and adaptive psychologists and psychotherapists from both assessment and therapeutic intervention perspectives.
- ◆ Competency in the use of several modalities and short term interventions is imperative.

PMHC initiatives in Ireland

1. Dublin/ North Wicklow/ North East
(Martin, Hawkins, Hicks and OFlynn)
2. RIAN (Ward)
3. Roscommon (Byrne)
4. Primary Care Centres

- ◆ The HSE National Service Plan (2012) provides for the roll out nationally of a primary care service based on the model developed by RIAN to be managed by the national counselling service. This is an excellent development and needs to be comprehensively resourced and supported, even if to the detriment of other PMHC services.

Ideal Model of Primary Mental Health Stepped Care

- ◆ Non-stigmatised and normalised
- ◆ Ease of access.
- ◆ Integrated and embedded in the community.
- ◆ Access to broad range of resources.
- ◆ Quality screening and assessment.
- ◆ Back up of medical professionals when required.
- ◆ Cost effective.
- ◆ Early intervention.
- ◆ Non-medicalised.

This stepped care model of service delivery is already in existence and working very effectively for 10,000 young people in Ireland

- ◆ Student counselling provides the largest single dedicated PMHC service to young people in Ireland.
- ◆ Student counselling, embedded in the heart of the student community is ideally situated to deliver effective and efficient- services to those in need, when they need it.

Student counselling as stepped care

'The right service delivered by the right people in the right place at the right time'

Model of stepped care at U.L.



Comparing counselling in HE with NHS, in U.K.

Patti Wallace, BACP, 2012.

- ◆ Caseness – of similar severity.
- ◆ Clients slightly more improved in HE compared with NHS.
- ◆ Average waiting period between referral and assessment in HE was 9 days, 63 days in NHS.
- ◆ Average waiting time between referral and first appointment in HE was 16 days in NHS was 84 days.

Suicide rates

Suicide rate for 15 – 25 year
old age group in Ireland: 1.6 per 10,000

Student Population of U.L.: 12,000

Expected rate of suicide/annum: 2

No. of high risk students
with suicidal intent attending student
counselling, 2012: 17

No. of U.L. student suicides 2012 : 0

No. of U.L. student suicides 2013_(todate) : 0

No. of suicides of U.L. student
counselling attendees in 28 years: 0

Stop 'passing the buck' on mental health.

e.g. some would argue that
Counselling services in HE should
not try to deliver a service that
should be provided by the NHS.

- ◆ Student counselling ought to be seen as a provider of an educational service and not an adjunct to primary care.

(Cowley, 2007)

- ◆ As resources are being constantly stretched, third level institutions will be seeking to limit, charge for, outsource, and refer these services elsewhere, which will lead to increased waiting lists within the HSE sector.

Collaboration Necessary

- ◆ Recommendations from Royal College of Psychiatrists report on mental health of students in higher education, 2011 :
- ◆ The departments of health should provide special funding for student health services.
- ◆ Higher education institutions and NHS services who provide care to students should establish some form of co-ordinated working relationship.

- ◆ **The student counselling model can be replicated in the wider community.**

Proposal 1

Examining psychological morbidity and treatment outcomes at medical and non-medical PMHC facilities such as Student Medical and Counselling services

Proposal 2

Community pilot project

- ◆ Identifying a primary care sector in which a non-medical primary care mental health facility can be rolled out over a five year period.
- ◆ Evaluate its effectiveness.

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Thank you