What is primary mental health care?

Linda Gask

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‘Primary care’

- There is enormous international variation in what is meant by the term.
- The Alma-Ata Declaration (World Health Organization, 1978) defined primary care as:

‘Primary care’

‘the role of primary health care as the local, universally available, essential, first point of contact with the health system, based on practical, scientifically sound and socially acceptable methods and technology at a cost the community and country can afford.’

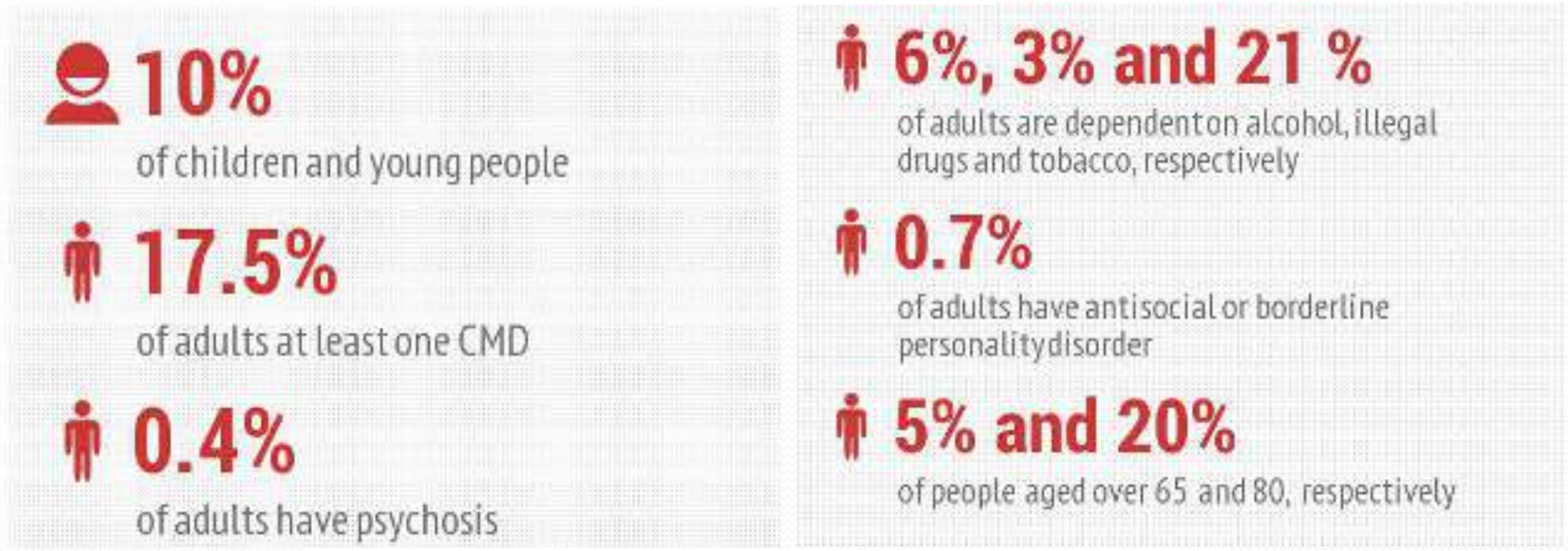
Pathways to care model.

What is primary mental health care?

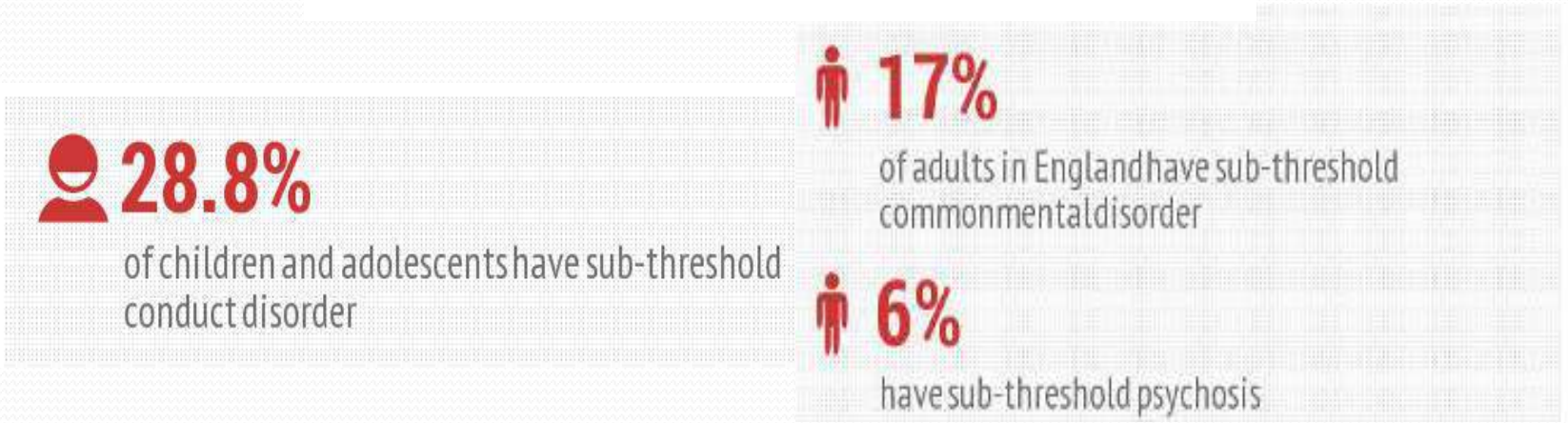
- First line interventions provided as an integral part of general health care
- Mental health care provided by practitioners who have expertise and skills and who are supported to provide mental health services
  - (WHO & WONCA 2008)

Common Mental Health Disorders are common

National rates of mental disorders



National rates of sub-threshold mental disorder



Source: McManus et al, 2009; Knapp et al, 2007

Severity of common mental health disorders: definitions

- **Mild** relatively few core symptoms, a limited duration and little impact on day-to-day functioning
- **Moderate** all core symptoms of the disorder plus other related symptoms, duration beyond that required by minimum diagnostic criteria, and a clear impact on functioning
- **Severe** most or all symptoms of the disorder, often of long duration and with very marked impact on functioning
- **Persistent subthreshold** symptoms and associated functional impairment that do not meet full diagnostic criteria but have a substantial impact on a person's life, and which are present for a significant period of time

Classification and guidelines: How many disorders can you have?

- Guidelines don't fit with reality of primary care
- Mixed anxiety and depression commonest presentation in primary care
- Anxious symptoms cut across all common mental disorders (CMDs)- tend to make the outlook worse and suicide more likely
- Somatic symptoms overlap with anxiety and depression
- Substance use may complicate the picture
- Long term physical health conditions – COPD, diabetes, CVD, arthritis…

So why focus on Common Mental Health Disorders?

- Suffering
- Suicide
- Impact on future generations
- Managing increasing demand

Most lifetime mental disorder arises before adulthood

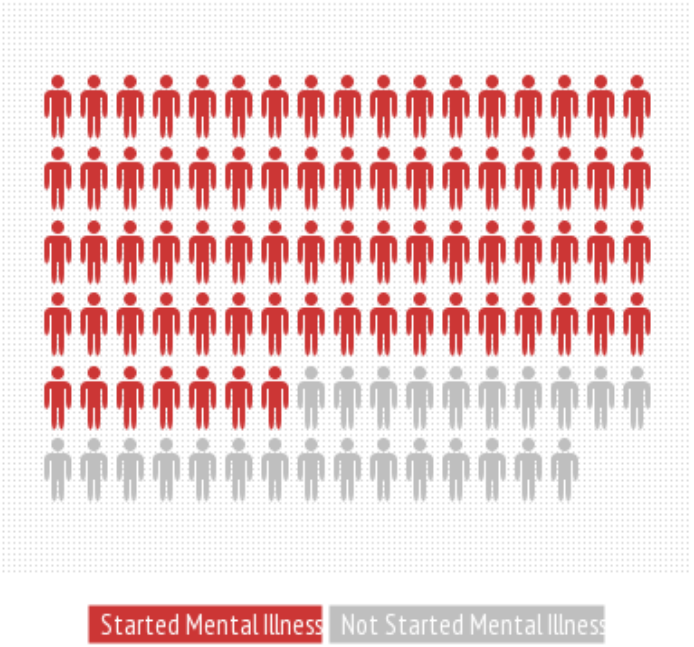
Age of onset of lifetime mental illness – predates subsequent physical illness by several decades

At Age 14

50% OF LIFETIME MENTAL ILLNESS (EXCLUDING DEMENTIA) STARTS BY AGE 14

By Mid Twenties

75% OF LIFETIME MENTAL ILLNESS (EXCLUDING DEMENTIA) STARTS BY MID TWENTIES



Source: Kim-Cohen et al, 2003; Kessler et al, 2005; Kessler et al, 2007

Long Term Conditions

- 15.4 million (about 1 in 3) people live with a long-term condition (LTC) in England, and set to increase

- Patients with LTCs are intensive users of healthcare
  - Use 52% of all family doctor appointments
  - And 65% of all outpatient appointments
- Depression and anxiety is under-recognised and untreated
- Majority are managed in primary care with structured treatment pathways and referral to specialists only when required

Multimorbidity and goal-oriented care

Professor Jan De Maeseneer
Ghent University

Suicide

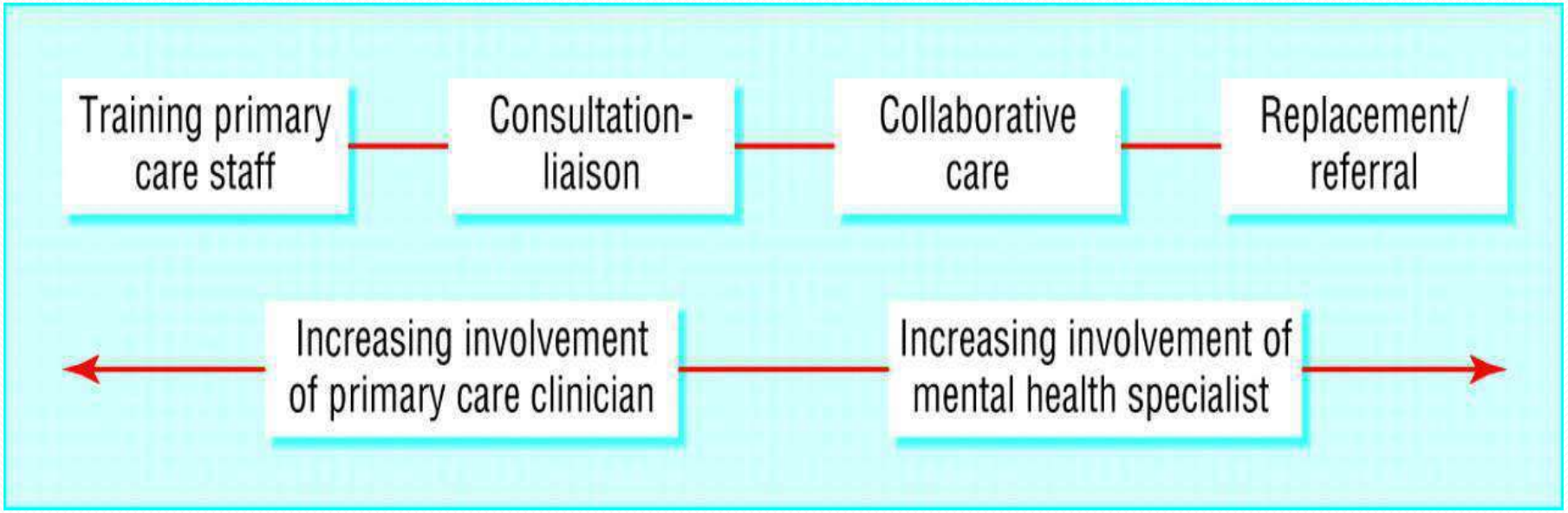
- **Three-quarters of all people who end their own lives are not in contact with mental health services.**

7 Good reasons for integrating mental health into primary care

- 1. The burden of mental disorders is great.
- 2. Mental and physical health problems are interwoven.
- 3. The treatment gap for mental disorders is enormous.
- 4. Primary care for mental health enhances access.
- 5. Primary care for mental health promotes respect of human rights.
- 6. Primary care for mental health is affordable and cost-effective.
- 7. Primary care for mental health generates good health outcomes.

(WHO and WONCA (2008))

Models of mental health care in primary care.

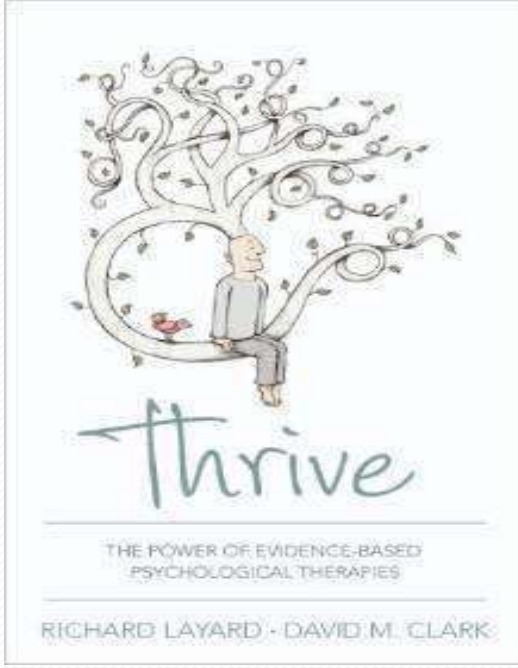


Peter Bower, and Simon Gilbody BMJ 2005;330:839-842

A World Class Programme

"The IAPT programme represents a world beating standard, thanks to the scale of its implementation and the validation of its treatments"

Nature editorial 27th Sept 2012



'Professors Layard and Clark (the Dream Team of British Social Science) make a compelling case for a massive injection of resources into the treatment and prevention of mental illness. **This is simply the best book on public policy and mental health ever written**'

Martin Seligman

IAPT – a groundbreaking initiative

- Original aim – to provide a universal primary care psychological therapy service for people with depression and anxiety disorders
- Use of NICE approved and evidence based therapies within a stepped care model
- Collection of outcome data at every session
- Therapy provided by trained and supervised workforce
- Focus on employment

Stepped care

- Use of least intensive or intrusive intervention likely to produce health gain
- Identifies primary care as a site of delivery of treatment for mild to moderate mental health problems
- Self correcting through regular structured review of patient progress
- Provides mechanisms to audit the effectiveness of treatments and support implementation of Nice Guidelines

The stepped-care model for depression (NICE CG 23)

Focus of the intervention	Nature of the intervention
STEP 4: Severe and complex[1] depression; risk to life; severe self-neglect	Medication, high-intensity psychological interventions, electroconvulsive therapy, crisis service, combined treatments, multiprofessional and inpatient care
STEP 3: Persistent subthreshold depressive symptoms or mild to moderate depression with inadequate response to initial interventions; moderate and severe depression	Medication, high-intensity psychological interventions, combined treatments, collaborative care[2], and referral for further assessment and interventions
STEP 2: Persistent subthreshold depressive symptoms; mild to moderate depression	Low-intensity psychosocial interventions, psychological interventions, medication and referral for further assessment and interventions
STEP 1: All known and suspected presentations of depression	Assessment, support, psycho-education, active monitoring and referral for further assessment and interventions

[1,2] see slide notes

iapt

Improving Access to Psychological Therapies

NHS

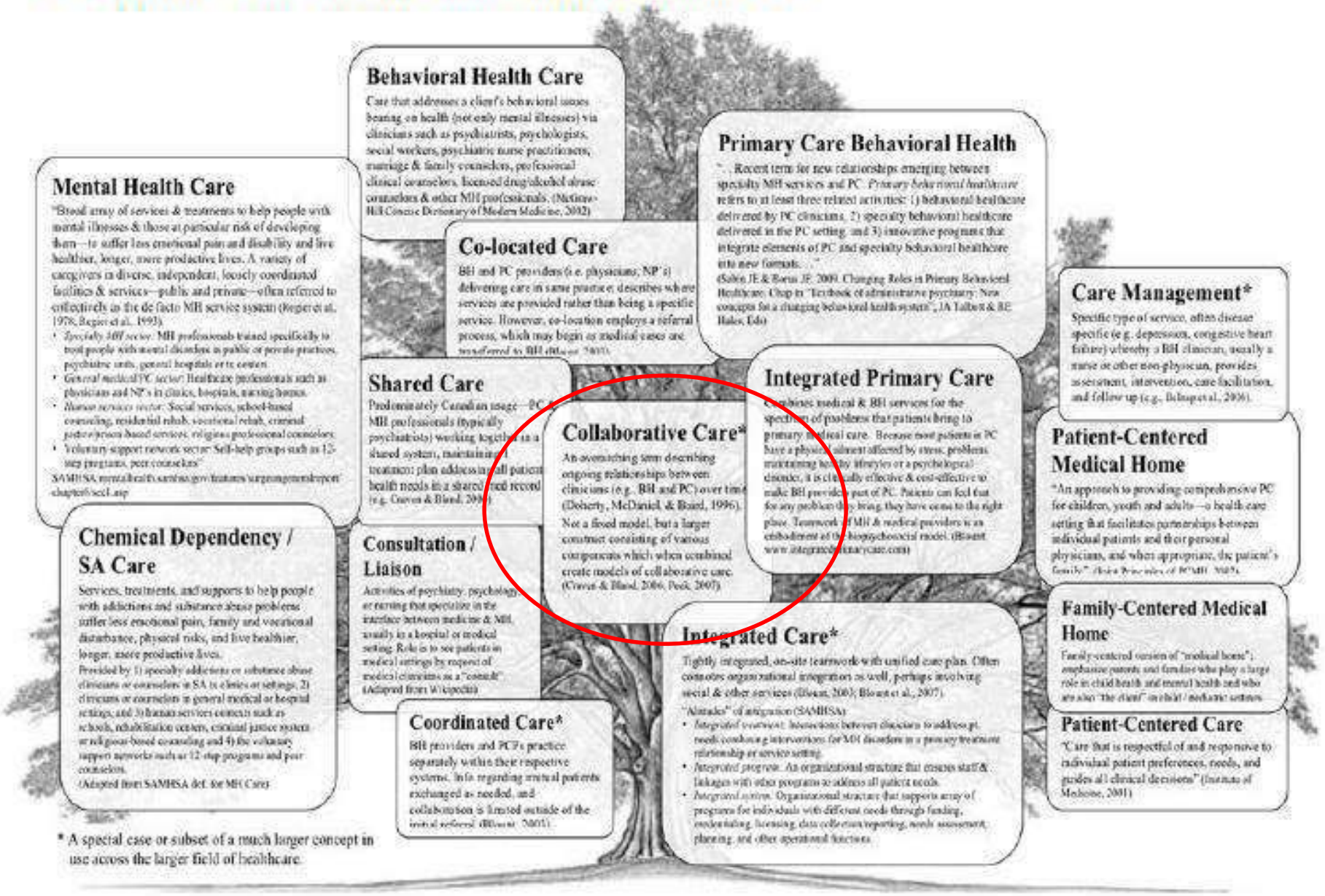
Treatment

- Recovery Focus
- Psychological therapies to treat people with depression and anxiety disorders – NICE
- Guidance, which now includes a range of interventions
- Stepped Care
- High and low intensity therapy

Consultation-Liaison

- Regular face to face contact between psychiatrist and primary health care team (PHCT)
- Referral only after a discussion at a face to face meeting
- Some cases are managed by the PHCT only
- When referral does take place there is feedback to, and management by, the PHCT

Figure 1. Family tree of terms in use in the field of collaborative care



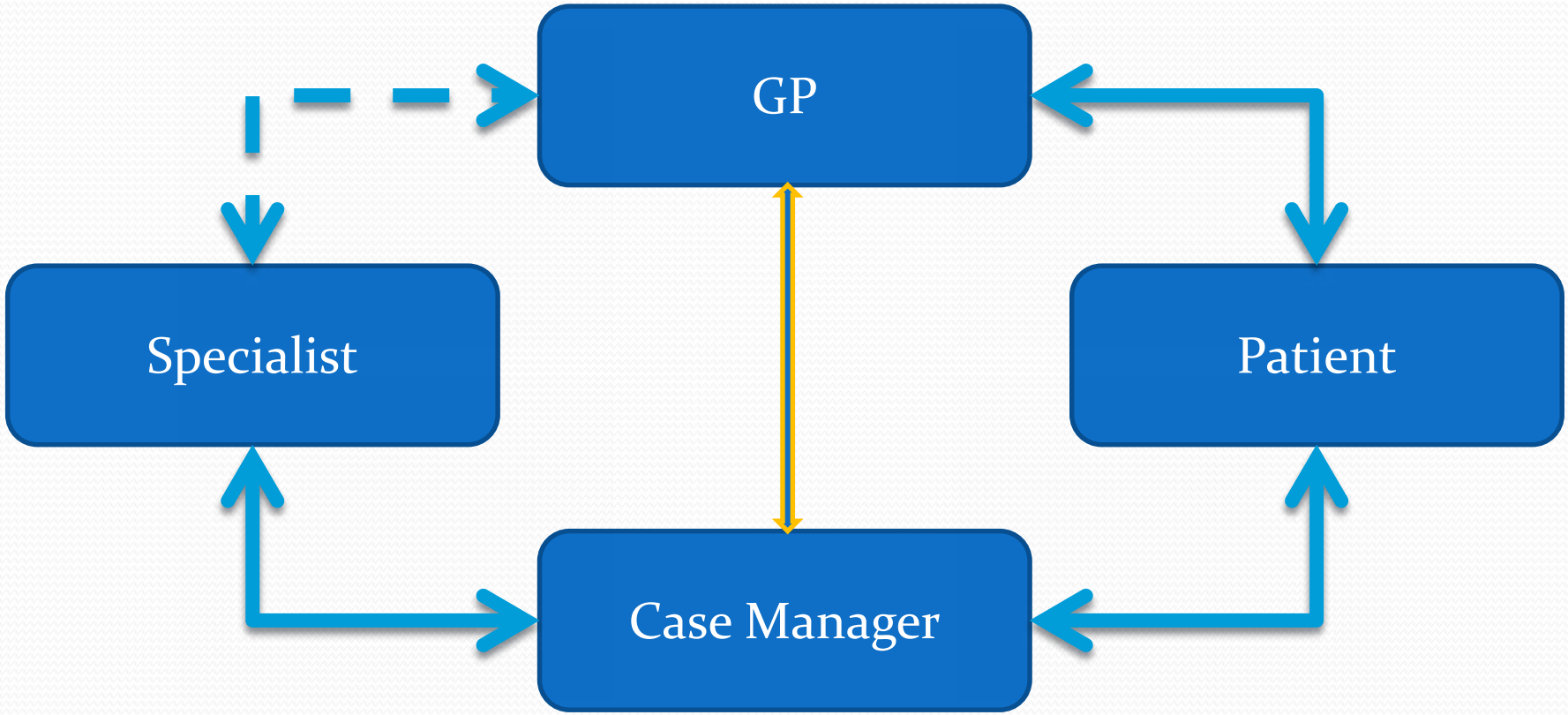
US Agency for Healthcare Research and Quality (AHRQ) 2011

Collaborative care

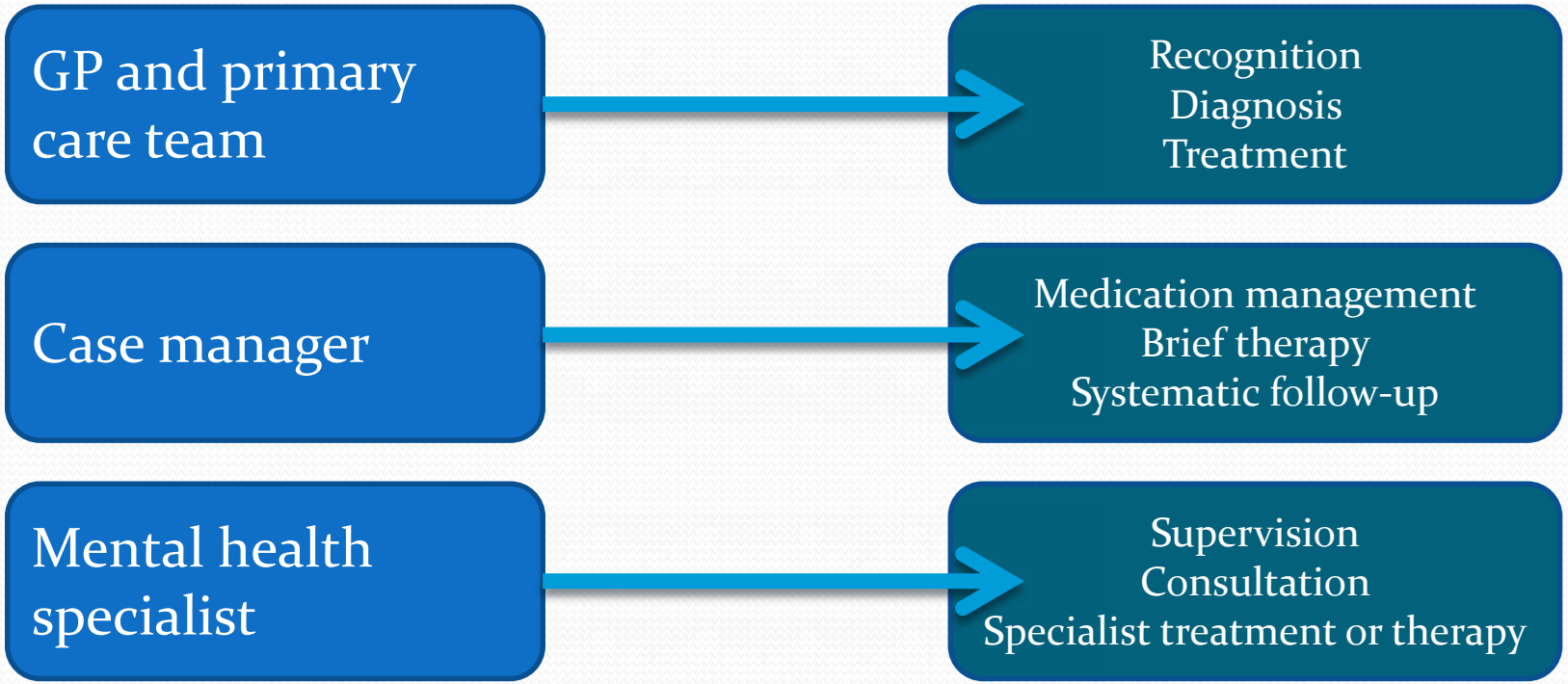
Collaborative care

- **Multi-professional approach to patient care** provided by a case manager working with the GP under regular supervision from specialist mental health clinician(s)
- **A structured management plan** of medication support and brief psychological therapy
- **Scheduled patient follow-ups**
- **Enhanced inter-professional communication** patient-specific written feedback to GPs via electronic records and personal contact
  - *for UK example see CADET study: Richards et al. BMJ 2012*

Collaborative care relationships



Collaborative care interventions



BMJ

BMJ 2013;347:f4913 doi: 10.1136/bmj.f4913 (Published 19 August 2013)

RESEARCH

Clinical effectiveness of collaborative care for depression in UK primary care (CADET): cluster randomised controlled trial

David A Richards *professor*[1], Jacqueline J Hill *PhD student*[2], Linda Gask *professor*[3], Karina Lovell *professor*[4], Carolyn Chew-Graham *professor*[5], Peter Bower *professor*[6], John Cape *head of psychology*[7], Stephen Pilling *professor*[7], Ricardo Araya *professor*[8], David Kessler *consultant senior lecturer*[8], J Martin Bland *professor*[9], Colin Green *professor*[10], Simon Gilbody *professor*[11], Glyn

STUDY PROTOCOL Open Access

Collaborative Interventions for Circulation and Depression (COINCIDE): study protocol for a cluster randomized controlled trial of collaborative care for depression in people with diabetes and/or coronary heart disease

Peter A Coventry[1*], Karina Lovell[2], Chris Dickens[3], Peter Bower[1], Carolyn Chew-Graham[1], Andrea Cherrington[1], Charlotte Garrett[1], Chris J Gibbons[1], Clare Baguley[4], Kate Roughley[1], Isabel Adeyemi[1], Chris Keyworth[1], Waquas Waheed[5], Mark Hann[1], Linda Davies[1], Farheen Jeeva[1], Chris Roberts[1], Sarah Knowles[1] and Linda Gask[1]

What do patients want?

- **Access**
  - **Fast** access to **effective care** delivered with **adequate expertise**
- **Stigma**- remains a major barrier
- **Psychological therapies** preferred for common mental health disorders

Working together effectively

- People (especially MH staff) need to be clear what their roles are and be trained to do them and properly supervised to carry them out..
- Flexibility and tolerance are key attributes
- Senior managerial support essential
- Opportunities to meet/co-location
- Joint problem-solving, agreeing of protocols and referral guidelines- need to work together
- Ensure that outcomes are properly evaluated, discussed and acted upon.

Improving access

Collaborate to develop local care pathways that:

- support integrated delivery across primary and secondary care
- have clear and explicit entry criteria
- focus on **entry** and not exclusion criteria
- have multiple means and points of access, including self-referral
- have a designated lead to oversee care
- promote access for people from socially excluded groups

Thank you!

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