A potential model for primary care mental health services in Ireland

Joanne Kierans, Michael Byrne

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Abstract

Objectives: A high demand for the inclusion of psychosocial interventions for primary care mental health presentations has become more apparent in recent years. Current policies have proposed models of care highlighting principles required for a quality service. However, implementation has been slow to date. This article aims to inform the current debate relating to primary care service delivery models for mental health presentations and to contribute towards future planning initiatives.

Method: A narrative review of a range of policies and selected articles relevant to primary care mental health in an Irish context.

Results: The search produced four distinct themes: current service provision in Ireland; stakeholders' views; psychological care options; and potential service structures. Thereafter, a potential service delivery model is proposed. This formulated model employs a combination of elements from the reviewed themes to provide a clinically- and cost-effective, equitable and accessible service driven by service user and carer input.

Conclusions: Although this review was selective in nature, the proposed potential model can complement future research agendas for more favourable primary care practice in Ireland. Recommendations are made for the planning of services including policy implementation procedures, training and communication.

Key words: Primary care; Service delivery model; Mental health presentations; Stepped care.

Introduction

There is a pressing need for further development of robust primary care mental health services in Ireland.[1] While these services have to accommodate mild-to-moderate mental health presentations,[2] they also have to manage, independent of secondary care services, up to 30% of severe and enduring mental health presentations.[3] However, with such a challenging agenda for change,[4] consensus is lacking on the most effective model of primary care mental health service provision.[5]

This article aims to complement current research relating to primary care mental health service delivery by providing a narrative review of a recent range of policies and selected research relevant to the Irish context. The distinct themes that emerged will be discussed in turn. First, the current service provision, related policies, and the perspectives of significant stakeholders in Ireland will be profiled. Following a brief review of three widely used psychological interventions, service structures and models of service delivery are considered. A potential service model is then presented.

Joanne Kierans, BA, Research Assistant, Roscommon PCCC, HSE. ***Michael Byrne**, BA, DPsychSc, Principal Psychology Manager Roscommon PCCC, HSE, Ireland.
Email: michaelj.byrne@hse.ie
*Correspondence

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Methods

For the purpose of this narrative review a search was carried out to find primary studies and selective policy documents relevant to primary care mental health service provision in an Irish context. Search results included studies that investigated current service provision and stakeholders' views in Ireland; randomised controlled trials, systematic reviews and meta-analyses of common psychological interventions; and studies that presented and reviewed service structure systems. Studies carried out in the last 10 years that could potentially suit Irish services were included. For psychological interventions, articles that reviewed studies relevant to the target population or mental health difficulties commonly presented in primary care were included.

For the search of published papers, three databases were used: PsychINFO, Psych ARTICLES, and ScienceDirect. The electronic search of the three databases used the following keywords: 'primary care'/'community care'/'mental health'/'Ireland'/'multidisciplinary'/'early intervention'/'service structure', and 'psychological treatment'/'psychological therap*'/'primary care'/'cognitive behavio* therap*'/'counselling'/'behavio* therapy'/'community care'.

Boolean operators (OR, AND) and synonyms were used as needed. Some articles were found using a manual search, while others were identified from reference lists of already acquired articles.

Current service provision

While Irish policy documents, such as *Planning for the Future*[6] and *A Vision for Change*,[7] proposed models of integrative, multi-disciplinary, and community-oriented care, all the necessary service provision elements have yet to be put in place. This has resulted in variable primary care mental health service provision across and between different administrative areas.[8]

For example, in one service area, one in three GP practice adult attendees were found to have varying degrees of psychological distress and of these, 89% were not receiving treatment for their mental health problems.[9] Additionally, the dearth of non-pharmacological intervention options in primary care can lead to pharmacologically-dominated interventions.[10,11]

Links with secondary and tertiary services are slow to

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improve,[8] and despite the roll-out of many primary care teams (PCTs), there are only a small number of designated primary care mental health posts to date. This poses particular challenges for primary care practitioners.[12] More research into the current provision of services in Ireland is needed for future planning and allocation of services.[7,11]

Stakeholder views on primary care service delivery

The high volume, varied case-mix, and sometimes complex nature of mild-to-moderate mental health presentations continue to stretch the capacity and competence base of most general practitioners (GPs).[9,13] Differences of opinion among GPs,[14] and the limited time available for primary care consultations can add to their work burden.[11] This contrasts with the in-depth information obtainable in (time-protected) secondary care clinical interviews.

Furthermore, GPs may not have enough information on services such as voluntary agencies and self-help groups.[11] Communication with secondary services is also strained, with GPs highlighting lack of notification of admissions and discharges,[15,16] and lack of information about management plans.[8] Similarly, psychiatrists have complained of the lack of information from GPs,[13] suggesting a two-way communication problem between the services.[17]

Our policy document *Primary Care: A New Direction*[18] highlighted that both service users and carers want a range of mental health service options (including psychosocial therapies) to be provided locally so that they can have access to comprehensive care. Being listened to and included in the decision making process can predispose to shared goals and priorities, coordinated care plans and improved clinical outcomes.[4,19]

Psychological intervention options

Transcending a one-model-fits-all approach, care plans also need to integrate biological, psychological, and social elements as appropriate to the complexity of service user presentations.[10] Psychological interventions are effective for a range of common mental health presentations,[20,21] physical illnesses that have psychological components,[22] and for health promotion and prevention in dealing with common presentations such as diabetes and obesity.[23] Hence, informed by individual needs, these approaches need to be routinely considered as an intervention option.[7]

Counselling has demonstrated effectiveness in managing mixed anxiety, depression and generic psychological distress presenting in primary care,[3,24] and its use is evident in both controlled and naturalistic settings.[10] Counselling in the primary care setting tends to be eclectic and practical; this suits the diversity of cases.[24]

Behaviour therapy is effective in addressing a variety of presentations in a primary care setting, such as depression.[25] Less research has been carried out on the efficacy of behavioural therapies in primary care,[23] but it has shown economic benefits[26] and comparability to cognitive-behavioural therapy (CBT).[23,25]

Primary care-based CBT has shown effectiveness in addressing depression[23,27,28] and anxiety disorders.[18] It also compares favourably to counselling,[29] and SSRI-use.[23,30] Similar findings have been shown in the short-term,[31] and for guided self-help using CBT-based techniques.[32,33]

Ideally, primary care services will provide a balance of early intervention for those with the greatest clinical needs and equitable access to the whole population.[12] Regarding the latter, early intervention can prevent exclusion, reduce stigma and help PCTs better understand and detect signs of mental health presentations.[34]

Service structure

In developing a primary care mental health system, it is important not to replicate the organisational culture of secondary or tertiary care services. Primary care services need to prioritise self-determination and empowerment by facilitating equitable relationships.[35]

The 'total population' approach proposed in *A Vision for Change*[7] highlights the various (integrated) support systems that influence mental health presentations. Depending on clinical need, these range from self-help, to support from families, the community, primary care services, and in some cases, from secondary services. Primary care services need to expand to provide (responsive) input at each of these levels.

Stepped care and layered care

'Stepped' care and 'layered' care are models that can potentially improve the quality of primary/specialist care interfacing. Both are comprehensive, flexible, and offer a variety of alternative and community-based services.[36]

The 'Stepped' care approach has two primary features: the recommended intervention is the least intensive intervention that is likely to result in significant improvement; and, if improvement is not realised, service users can 'step up' to more intense forms of intervention.[37] In doing so, the numbers of inappropriate referrals to specialist services may be reduced and more intensive and costly interventions reserved for those who need them most.[37] If the highest level of intervention is not effective, a referral can then be made to specialist services.[31] Service users can then 'step down' to lower intensity interventions as their presentations improve.

'Layered' care is a development of the stepped care approach with the addition of an initial triage assessment, and a single point of entry into a level of intervention through an appointed keyworker[36] or care coordinator.

It is not necessary to start intervention at the most basic level; the clinical assessment determines whether more specialised interventions or access to different layers of intervention are needed in collaboration with the service user. The keyworker appointed for each service user manages primary/secondary care communication, advises service users, directs referrals and ensures that shared care arrangements are effective.[36]

Interface models of service delivery

Bower and Gilbody[38] proposed four conceptual models of primary/specialist care interfacing that can facilitate quality primary care mental health service provision. It would benefit service provision in Ireland to agree on one integrated approach. The models considered below have unique aspects that may contribute to a clinically efficient, cost-effective, equitable and accessible service, driven by service user and carer input.

- *Training primary care staff* involves teaching foundational

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skills to a broad range of staff to help process the high volume of presentations. Staff are thus empowered to manage cases and provide psychosocial interventions and self-help skills that are effective in addressing low intensity mental health presentations. Doing so facilitates continuity of care via maintenance of primary care practitioner-service user relationships but with a more process-oriented approach. This may be more beneficial for mild-to-moderate mental health presentations.[17] However, the existing evidence base for the clinical effectiveness of this model is disappointing and studies have not shown substantial improvements.[39] Additionally, expanding the roles of primary care staff may not be practical given existing heavy workloads.

- *Consultation-liaison* involves (secondary care) mental health specialists educating and supporting primary care staff. Regular on-site liaisons allow cases to be discussed without formal (onward) referral that potentially reduces the number of inappropriate referrals to secondary care. This recommended model also facilitates effective inter-service communication.[7,17] Since cases are managed entirely within primary care, for some service users it can reduce the stigma of attending secondary care services. However, this partially integrative model may also be an impractical approach due to time constraints and heavy workloads.
- *Collaborative care* is a fully integrative approach with the addition of new quasi-specialist staff to work directly with service users and consult with PCTs and specialists. This model involves aspects of the training and consultation-liaison models. Co-locating mental health specialists with primary care staff can improve primary/secondary care communication.[40] Some service users may better engage if they can discuss their mental health concerns with a different (in-house) and accessible staff member. However, this model may be impractical given current resource constraints.
- *Replacement/referral* passes the responsibility of the management of cases to secondary care staff for the duration of their (episodic) care. This model is clinically effective at least in the short term for either one of, or a combination of, one-to-one work, self-help techniques and bibliotherapy.[31] However, no consistent methodological quality has been found to be effective.[38,41] Furthermore, since this model may not reach a large number of service users, access and equity to services may be restricted.

Towards a potential model of service delivery

A combination of elements from these models may provide a composite model of service delivery *(see Figure 1)* that maintains the 'total population' approach outlined in *A Vision for Change*.[7] By adopting a stepped care approach to service delivery, services would be capable of accommodating a high volume of service users and be easily accessible, providing early intervention, mental health promotion, person-centred community-based interventions and self-help techniques, as well as one-to-one CBT services and referrals to secondary care if needed.

As part of Primary Care Networks (PCNs), mental health professionals could provide on-site liaisons, and training and support to PCT staff. If extra staff were resourced (eg. via reconfiguration) and specially trained as primary care practitioners, they could also potentially enhance access and equity to cost-effective services.

Proper integration of these primary care practitioners with the PCT would be essential and their workload would need to be reviewed on a regular basis to ensure guidelines relating to the service delivery were appropriate and effective.[42] These practitioners could manage low intensity cases in primary care, act as keyworkers for individual cases, and liaise between PCTs, the PCN, and secondary care services. What level of care is needed or whether an onward referral to secondary care is more appropriate could be decided in a collaborative manner at liaison meetings for all referral types (including self-referrals).

Experienced PCN clinicians could provide adequate supervision and support for the primary care practitioners' caseload; such as risk management, signs and symptoms of relapse, and ethical conduct. They could also act as line managers to the primary care practitioners in all the PCTs (from the network area) and be accountable for decisions relating to mental health issues.

This service model is an alternative option for service users to pharmacological-only interventions for addressing their mild-to-moderate mental health problems. However, if deemed more appropriate, pharmacological interventions could be provided in combination with psychological interventions.

Although the Irish policy literature recommends a consultation-liaison approach with a (secondary care) mental health professional working as part of the PCT or PCN,[7,17] there is little evidence to date that this model has been applied widely in Ireland. Ideally PCTs would have some available offices for the PCN in primary care centres, and PCNs would be co-terminus with community mental health teams (CMHTs). The latter, already evident in some service areas,[8] would facilitate robust liaisons with secondary services and improve interface networking. Co-located mental health services would also allow service users to differentially access these services.

Implementation of this model would be no easy task. Reconfiguration and considerable resourcing of extra staff in the form of primary care practitioners would be necessary to adequately address clinical need within each catchment area. For example, a similar programme in Australia worked in collaboration with academic departments of psychology and general practices to provide 2.5-4 full-time positions per regional grouping of GPs.[43]

A similar number of primary care practitioners for every PCT within a PCN may be required to realise the potential benefits of such posts. If such posts were funded, these primary care practitioners could work in collaboration with each other as well as the PCN and secondary services to enhance communication and liaison within and between the services. Controlled evaluation studies are required to show the costs and benefits of this system to all participants involved and through these further issues that may arise can be addressed.

Conclusion

This narrative review suggests that the shift towards primary care mental health services creates new ways of working with potential to show positive changes in practice. This was a selective review of studies mostly conducted in Ireland, the

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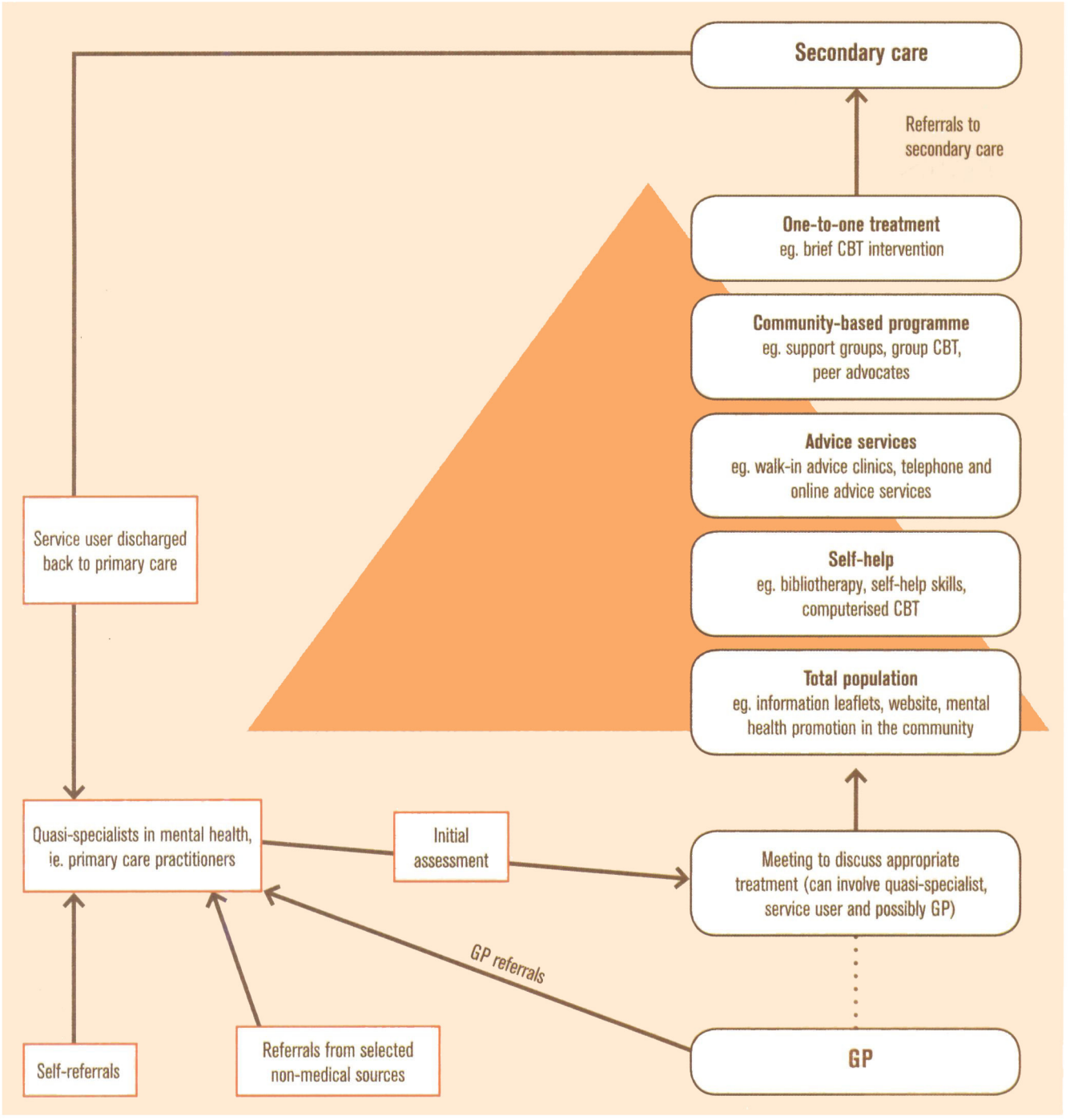
Figure 1: Overview of a potential model of service delivery



UK and the United States, and this choice automatically excluded literature reported in non-English language journals. However, the resulting formulation of a service model potentially suited to an Irish context can contribute to future research on identifying factors beneficial to best primary care practice.[1] To ultimately decide on the best approach, further research is needed on the relative efficacy of potential models compared to intervention-as-usual conditions, staff and service users' preferences on integrated services, and staff availability.[21]

The proposed model is currently being piloted as a Primary Care Adult Mental Health Service in the Roscommon Local Health Office Area, HSE West. Under the supervision of the principal psychology manager, four primary care practitioners are providing a variety of services based on the proposed model to adults with mild-to-moderate mental health problems. All service elements of this pilot project are currently being evaluated.

Additionally, further research is warranted on the prevalence of mental health presentations and how current services are meeting this need. Doing so would inform service planning. A national training strategy is required, that will accommodate the education and training needs of various professional groups to help overcome confusion over clinician roles and responsibilities. Improved primary-specialist care services communication will also clarify roles, responsibilities and referral protocols.[15] As mentioned above, a liaison person could engineer high levels of communication both

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within and between teams.

A limited budget for mental health services is a considerable obstacle to providing appropriate intervention and quality care.[2] Implementation of a new policy will mean substantial organisational change, increased capacity, and realignment of professional roles.[11] Despite the current financial crisis, development of services still needs to progress as, in the long term, pervasive mental health presentations will have considerable economic and social costs. Regardless of the variable progress and setbacks, the right ideology is in place[7,8] and things are moving in the right direction. We have one foot on the ladder – let's keep climbing.

Declaration of Interest: None.

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