Symposium on Clinical Psychology in Primary Health Care
November 19th 2012

Experience and research in psychological intervention in primary health care in Europe

UNITED KINGDOM
Dr Rebecca Johnson
Outline

- Primary Care Psychology in the UK
  - IAPT programme
  - Stepped Care

- Walsall Primary Care and Talking Therapies Service (PMH&TTS)
  - A description of an IAPT service
  - Clinical Psychology within the PMH&TTS

- Some of the good and bad about IAPT for Clinical Psychologists
Improving Access to Psychological Therapies (IAPT)

• Layard report 2005 made strong case for investment by central government in psychological therapies

• Implementation of National Institute of Clinical Excellence (NICE 2004) guidelines for anxiety and depression

• A national programme aimed to rapidly train and increase the number of therapists available to deliver talking therapies to people with mild to moderate common mental health disorders
  • 3600 new psychological therapists between 2008-2011 (8000 over 6 years)
  • Enable access to treatment for 900,000 more people
  • 25,000 fewer on benefits/sick pay by 2015
## Stepped Care Model

<table>
<thead>
<tr>
<th>Referral Guidance</th>
<th>Symptoms</th>
<th>Functioning</th>
<th>Level of Risk</th>
<th>Interventions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Step 4 &amp; 5 Severe</strong></td>
<td>Constant distress/No control Strong feelings of hopelessness. At least two interventions steps 2 and 3 tried but no improvement after 12 weeks. Presenting with severe risk or psychosis.</td>
<td>Persistent problems with functioning independently and maintaining daily activities and social support. Self care severely affected</td>
<td>Definite indication of risk with intent and means. Previous attempts to self or others. Clear signs of vulnerability and inability to protect self.</td>
<td>Definite indication of risk with intent and means. Previous attempts to harm self or others. Clear signs of vulnerability and inability to protect self.</td>
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<tr>
<td><strong>Step 3 Moderate / Severe</strong></td>
<td>Constant distress /preoccupied. Little or no control Some feelings of hopelessness about the future Interventions at step 2 tried but did not help.</td>
<td>Social support and occupational functioning are showing signs of disruption or breakdown. Self care and daily living affected, showing signs of self neglect</td>
<td>Definite indication of risk. Some intent but has deterrents and support</td>
<td>High Intensity interventions CBT/IPT (16-20 sessions) Mindfulness-Based CBT Group based CBT Medication</td>
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<tr>
<td><strong>Step 2 Mild</strong></td>
<td>Constant distress for at least two weeks, but appears to have a degree of control</td>
<td>Able to maintain most activities but minimal disruption in personal, social or work pattern is beginning to show.</td>
<td>Low risk: some thoughts but no intent or plan</td>
<td>Low intensity intervention / signposting/cCBT / Guided self-help /Telephone support Psycho-education/ Counselling</td>
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<tr>
<td><strong>Step 1 Early Signs</strong></td>
<td>Short-term / mild or recent distress Occasional distress but feels and appears in control</td>
<td>Able to maintain daily living activities and social support and occupational activities</td>
<td>No concerns or risk of deliberate self harm/suicidal intent/ neglect/risk to others</td>
<td>Watchful waiting / Self help / cCBT/ Books on Prescription Support Groups / CAB/ Education / Job Centre Exercise Prescription</td>
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Results so far for IAPT

Richards & Borglin (2011)
- Two year empirical assessment of IAPT (n=7859)
- 53% received two or more treatment sessions (n=4183)
- 47% of referrals DNA
- Over half met reliable improvement or reliable and clinically significant change criteria (55.4% for depression; 54.7% for anxiety)
- Of those that complete treatment, 40% show no improvement even after High Intensity (HI) CBT

Clark (2011)
- “progress is generally in line with expectation”
- Currently 310,000 patients p/a (by 2015 goal is 900,000)
- 13,962 moved off benefits (target was 11,000)
Walsall

Walsall
Primary Mental Health & Talking Therapies Service

Staff:
- 1 x Service manager (Band 8a)
- 1 x Clinical Lead & CBT Practitioner (Band 8a)
- 5.8 x Enhanced Primary Mental Health Care Practitioner (HI CBT) (Band 7)
- 11 x Primary Mental Health Care Nurse (Band 6)
- 3 x Primary Mental Health Care Worker (Band 5)
- 1 x Consultant Clinical Psychologist (Band 8d)
- 3 x Clinical Psychologist (Band 8a)
- 0.5 x Group Trainer (Band 7)
- 1 x Lead Counsellor (Band 7)
- 1 x Assistant Psychologist (Band 5)
# EPC KPIs, Quarter 1 2012-13

<table>
<thead>
<tr>
<th>KPI Description</th>
<th>KPI</th>
<th>WAL</th>
<th>DUD</th>
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<tbody>
<tr>
<td><strong>No. Referrals In</strong></td>
<td>3a</td>
<td>685</td>
<td>507</td>
<td>874</td>
<td>682</td>
<td>660</td>
<td>578</td>
<td>2219</td>
<td>1767</td>
<td></td>
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<tr>
<td><strong>No. &gt;28 Day Wait</strong></td>
<td>3b</td>
<td>147</td>
<td>129</td>
<td>185</td>
<td>143</td>
<td>185</td>
<td>141</td>
<td>264</td>
<td>228</td>
<td>264</td>
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<tr>
<td><strong>No. People entered Psych. Services</strong></td>
<td>4</td>
<td>439</td>
<td>300</td>
<td>514</td>
<td>422</td>
<td>417</td>
<td>345</td>
<td>1370</td>
<td>1067</td>
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<tr>
<td><strong>No. Completed Treatment</strong></td>
<td>5</td>
<td>118</td>
<td>122</td>
<td>124</td>
<td>129</td>
<td>104</td>
<td>97</td>
<td>346</td>
<td>348</td>
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<tr>
<td><strong>No. Moving to Recovery</strong></td>
<td>6a</td>
<td>56</td>
<td>56</td>
<td>54</td>
<td>58</td>
<td>49</td>
<td>35</td>
<td>159</td>
<td>149</td>
<td></td>
<td></td>
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</tr>
<tr>
<td><strong>No. Completed Treatment - No caseness</strong></td>
<td>6b</td>
<td>12</td>
<td>28</td>
<td>9</td>
<td>22</td>
<td>8</td>
<td>19</td>
<td>29</td>
<td>69</td>
<td></td>
<td></td>
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<tr>
<td><strong>No. Moving off sick pay and benefits</strong></td>
<td>7</td>
<td>15</td>
<td>5</td>
<td>11</td>
<td>10</td>
<td>12</td>
<td>6</td>
<td>38</td>
<td>21</td>
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<tr>
<td><strong>Recovery Percentage 6a/(5-6b)</strong></td>
<td>KPI 15</td>
<td>52.83%</td>
<td>59.57%</td>
<td>46.96%</td>
<td>54.21%</td>
<td>51.04%</td>
<td>44.87%</td>
<td>50.16%</td>
<td>53.41%</td>
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* Year to Date figure
Clinical Psychology

• Step 3 of model – moderate to severe mental health problems some risk issues but can be managed in Primary Care

• Care clusters 3 (non-psychotic moderate severity), 4 (non-psychotic severe) and 6 (non-psychotic disorders of over valued ideas) with some 8 (non-psychotic chaotic and challenging disorders)

• Summary of Interventions:
  – Psychodynamic therapy,
  – Schema Therapy
  – Attachment Based Psychoanalytic Psychotherapy
  – Systemic / Narrative Therapy
  – CBT / REBT
  – CAT
  – EMDR/Trauma Focused CBT
Clinical Psychology

- Capacity model (no waiting list)
- 2000 contacts (3.6 WTE)
- Up to 26 sessions = 80 referrals / average 15 sessions = 133 referrals

• Complex Cases...
  - Complex co-morbid conditions (e.g., depression and anxiety in the context of a history of sexual abuse, trauma or neglect)
  - Risk issues - including sub-clinical eating disorders, substance abuse, self-harm, Borderline Personality Disorder, attachment disorders
  - Medically Unexplained Symptoms (MUS)
  - Complicated grief
  - Asperger’s syndrome
Is IAPT bad for Clinical Psychology? Yes….

- Caseloads become saturated with severe / intractable cases
- Might divert potential Clinical Psychologists into career as IAPT therapist
  - Reduce diversity within profession
- Short term / ‘superficial’ interventions will look successful even if this is only temporary
  - Provide perspective to policy makers that short and cheap interventions are as powerful as more individualised interventions
  - Clinical psychologists might appear expensive compared to other workers on a per referral basis
- Increased demand for Clinical Psychologists to provide supervision for IAPT workers allowing less clinical time
- Large number of new job titles that are confusing and ambiguous
  - Public might find it difficult to discriminate between new ‘low level psychologists’ and Clinical Psychologists
- Blanket use of CBT in IAPT reduces the importance of assessment and formulation in Clinical Psychology to a “one size fits all” approach
  - as IAPT grows so will the popularity of CBT which will leave little room for eclecticism
Is IAPT bad for Clinical Psychology? No….

- IAPT has not replaced existing services but has added a new layer of service
- IAPT is diverting potential Clinical Psychologists away from the profession but competition for this work is very high and IAPT offers another career choice
- Clinical psychologists are not alone in needing to demonstrate their cost effectiveness and as a profession we have the skills and knowledge to do this
- It’s new, there are bound to be teething problems; overall IAPT is a positive development in mental health service provision
Any questions......
References


Primary Care and Family Service, South Birmingham

- 1996, popn 400,000
- 1000 referrals per year / 5 WTE (+ trainees)
- Operated as a GP practice but for psychological intervention with direct access and self-referral
- “A systemic approach when each session might be the only / last session”
- Single session consultation
  - Way of responding quickly to everyone
  - Individual or family
  - Not assessment, opportunity for therapeutic conversation
- Weekly drop-in session for Family support
Consultation Appt
Self Help Clinic
Client can ring in at any time to arrange a suitable appointment or Drop-in at specified times

Family Support

Brief Therapy
Series of appointments (average 4)
Discussed in consultation and agreed as likely to be useful.

Families Team and Couples Work
When relational issues seem to be main focus, best worked in relational system

‘Safe’ Referral on
For individual family members to use if appropriate

Referral (Professional or Self)

As way of ending with ‘the door still open’
References