



THE PSYCHOLOGIST IN PRIMARY CARE: A NECESSARY DEBATE IN THE NATIONAL HEALTH SYSTEM

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The high prevalence of common mental disorders in Spain and other countries, together with the underfunding of public mental health care, constitutes one of the principal problems in the public health context. This paper reviews some of the data in relation to the lack of resources invested in Spain's mental health system, the overuse of psychoactive drugs in primary care and the crucial importance of a professional attention at the primary care level. It also highlights evidence about the potential implication for reducing health costs of incorporating trained professional psychologists in primary health care, and discusses diverse collaborative care models and pathfinder projects developed in other countries. It is argued in favour of providing genuine bio-psycho-social care, as an alternative to the biomedical reductionism currently predominant in health systems.

Keywords: primary care, psychologist, efficiency, effectiveness, cost, medical cost reduction, mental health, health care systems, Spain.

La elevada prevalencia de los trastornos mentales comunes en España y otros países, junto a la infradotación de recursos públicos para la atención a la salud mental constituye uno de los principales problemas de salud pública. En el artículo se revisan algunos datos que apuntan a la precariedad del sistema de salud mental español, la sobreutilización de psicofármacos en atención primaria y la conveniencia de actuar profesionalmente a nivel primario. Se destaca la evidencia existente acerca del potencial de reducción de costes sanitarios que tendría la incorporación de psicólogos adecuadamente formados en atención primaria de salud y algunos modelos organizativos y proyectos desarrollados en otros países. Se argumenta a favor de proporcionar una auténtica asistencia bio-psico-social integrada al ciudadano como alternativa al reduccionismo biomédico que predomina en los sistemas sanitarios.

Palabras clave: atención primaria, psicólogo, eficiencia, efectividad, costes, reducción de costes sanitarios, salud mental, sistemas sanitarios, España.

There would appear to be a general consensus across the scientific-health community on the need to attend adequately to mental health problems within the primary care context, which is the first level of – and entrance to – the health system. Primary care is the resource to which the majority of people initially turn with psychosocial or mental health problems, as well as with physical complaints. It has been claimed that primary care constitutes the *de facto* mental health service for 70% of the population (Regier et al., 1993). However, the inclusion of psychosocial services based at this level of care has been extremely scarce, not to say practically non-existent.

In this regard, since the Spanish legislation of 1986 (*Ley General de Sanidad*), institutional discourse and numerous official documents have made widespread use of the term "bio-psycho-social" to refer to the kind of healthcare deemed appropriate for citizens from an

"integrated perspective". More than twenty years after the announcement of this *desideratum*, which has shown itself to be of a marked politico-decorative nature (Lemos, 2008), and despite the achievement of some important goals in the development of mental health services, such services are still notable for their precariousness and inadequacy, particularly as regards the unequal development and assignment of resources between different regions, with considerable variation in the availability of and access to psychological care services. In the absence of effective psychosocial attention in Primary Care and in the hospital network, minimal community services have been set up, but these fail to cover the real needs (Salvador-Carulla et al., 2003).

The recent Strategy for Mental Health in the National Health System, approved by the Spanish Ministry of Health and Consumer Affairs in February 2007, does not appear to represent a break with the tradition of vague general approaches. This document does not include specific and assessable plans that set out goals with regard to the training of professionals, the provision of resources or psychological attention in primary care, even

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though it does acknowledge the impact on the system of common mental disorders (anxiety, depression and adaptive disorders) and the advantages of increasing the use of psychological strategies for dealing with them.

The current organization and structure of healthcare in Spain is such that citizens lack direct access to psychological care services in the public network. GPs find themselves unequipped to provide a significant, non-pharmacological care response to problems of a psychological nature, due in part to a lack of specific training and a lack of time, but also because their professional responsibility in the psychosocial field is not clearly defined; moreover, there is a chronic lack of availability of and coordination with mental health professionals. This segregation between primary care and mental health services results in an ineffective and inefficient response, which generates, in turn, overloading of the system and leads to situations such as referral to specialists of patients without mental disorders diagnosable according to the psychiatric classifications currently in use (Ortiz, González & Rodríguez, 2006). Such primary care users (as many as 24.4%, according to the same study) are suffering from psychological complaints that fail to fit the diagnostic criteria (IDC-10 psychosocial Z codes), and on referral, half of them already have a drug prescription from their GP.

Apart from the common mental disorders, many of the clinical problems dealt with by GPs cannot be adequately covered from an exclusively biomedical frame of reference. Patients with chronic illnesses or somatisations, overusers of medical services and the elderly, for example, are populations that require psychological and behavioural attention which helps them adapt to their particular difficulties and to comply with medical prescriptions. A large part of such patients are suffering from clinically significant specific psychological problems, but rather than receiving professional psychological attention based on scientific data, they are more likely to be given nothing more than well-meaning support and a prescription for drugs. It is at the primary care stage where these difficulties have to be tackled, with a view to preventing subsequent deterioration that could increase the demand for specialist care.

Recognition of the importance of integrating psychological attention services and primary health care is a relatively recent phenomenon in Spain, while elsewhere it has been a common subject of debate among the scientific community and in policy decisions on health-system reform (e.g., Romanow & Marchildon, 2003). At

an international level there is clear recognition from a range of experts and scientific associations of the need to incorporate mental health professionals into primary care teams (Institute of Medicine, 2005; Kahn, 2004).

The importance of considering a system of integrated care at the primary care level derives also from the high prevalence of the common mental disorders in Spain. Haro et al. (2008) estimate figures of 20% life prevalence and 10% annual prevalence of anxiety-depression disorders in the general population. Other estimates suggest that between 60% and 75% of requests for primary care are associated with behavioural factors, such as unhealthy lifestyles, psychophysiological disorders, somatisation and associated emotional disorders (Fries, Koop & Beadle, 1993, Levant, 2005). All of these needs for help and care generate an enormous social and economic impact that has a negative effect on people, on families and on the social-health system.

Theoretically, the current primary healthcare framework should permit and indeed stimulate the development of psychological care services. The Spanish legislation (Real Decreto 1030/2006) that regulates the provision of services by the national health service makes provision for mental health attention in primary care, with regard to both the detection of psychopathology and the treatment of adaptive disorders, depression and anxiety disorders. Furthermore, the Strategy for Mental Health in the National Health System (*Estrategia en Salud Mental del Sistema Nacional de Salud*; Ministerio de Sanidad, 2007), referred to above, establishes as specific goal 4.4: *To increase the percentage of patients with mental disorders that receive psychotherapy, in accordance with the best practices available*; the term "biopsychosocial" and the invocation of "interdisciplinarity" continue to appear throughout the document. Another publication, *Proyecto AP-21*, a plan for the improvement of primary care in the period 2007-2012, states: *"Primary care is underpinned by teamwork. The different disciplines it combines provide a multidisciplinary and biopsychosocial approach to healthcare for the citizen. Therefore, in many of the services offered at the primary care level there is a need for the joint and complementary participation of various professionals to provide more effective and higher-quality attention"* (Ministerio de Sanidad, 2006, p.81)

DEFICIENCIES IN ATTENTION TO PSYCHOLOGICAL PROBLEMS IN PRIMARY CARE

One of the functions of health professionals in primary



care is to regulate the care burden of specialist mental health services. In theory, it is up to them to detect mental disorders and to attend to psychosocial problems that do not require specialised treatment, determining whether or not it is appropriate to refer the patient to mental health professionals. This model has been shown to have serious limitations, due in large part to the scarcity of resources assigned to primary care, but also to a lack of specific professional competencies in primary healthcare teams.

With regard to the detection of emotional problems, there are solid data suggesting poor capacity for the detection of mental health problems by GPs. For example, around 50% -70% of patients with major depression go undetected in primary care (Coyne, Thompson, Klinkman & Nease, 2002). The study by Aragonés, Piñol and Labad (2006) shows, moreover, that 26.5% of patients were mistakenly diagnosed with depression, insofar as they failed to fulfil the criteria for mood disorder. In the case of anxiety disorders the capacity for detection is even lower: only around 20%-33% are recognised at the primary care level (Wittchen, 1998, Roy-Byrne, Wagner & Scraufnagel, 2005). Of the studies reviewed by Artal, Herrán and Vázquez-Barquero (1996), in the majority, the "no recognition" category accounts for over 50%, a figure which approaches 80% in studies in which a specific diagnosis is required.

A recent study (Fernández et al., 2006) has revealed serious deficiencies in the treatment provision in Spain for problems of anxiety and depression at both the primary care and specialist care levels. Analysing data from the Spanish sample of the ESEMeD epidemiological study (Alonso et al. 2004), these authors conclude that just 31.8% of patients in specialist services and 30.5% of primary care patients receive minimally adequate treatment according to internationally-agreed clinical practice criteria assessed by a panel of experts. It should be stressed that the adequacy of treatment provided by clinical psychologists in this study is 11%, suggesting that the resources invested in psychological care are particularly poor. Indeed, the Spanish data are the poorest in Europe with regard to the quality and appropriateness of treatment for anxiety and depression in public healthcare (Fernández et al., 2007).

COSTS IN MENTAL HEALTH AND ABUSE OF PRESCRIPTION DRUGS

Mental disorders constitute the group of clinical conditions incurring the greatest direct cost to health systems and

overall social burden in Western societies. In the European Union they generate costs estimated at 3-4% of GDP, due particularly to losses in productivity because of work incapacity. Mental disorders are one of the principal reasons for early retirement and for the receipt of invalidity pensions (European Commission, 2005). It has been estimated that mental disorders account for 27% of all years lived with disability, showing greater involvement in the overall burden of illness than cardiovascular disorders and cancer (Schwappach, 2007). Unipolar depression alone is the cause of 12.5% of years lived with disability. In a recent prospective study it was estimated that by 2030 depression will be the second contributory cause to the overall burden of illness worldwide and the first cause in developed countries (Mathers & Loncar, 2006).

The cost of the public health system in Spain is currently around 6% of GDP. Of this health cost, the drugs bill accounts for some 22%. However, it is difficult to obtain objective data on the portion of healthcare spending attributable to mental health; indeed, Salvador-Carulla (2007) pointed out the lack of official data in the national health system on mental health costs. The only information available are partial figures from some regional authorities. Even the recent document "Strategy for Mental Health in the National Health System" (Ministerio de Sanidad, 2007) fails to include official objective data, providing only estimations by a consultant for a pharmaceutical laboratory, which estimated the total annual cost (health and social) of mental disorders in Spain in 1998 at 3000 million euros (Ofisalud, 1998). But regardless of the actual amounts of money assigned, the underprovision of resources for psychosocial treatment compared to the resources invested in medication is striking. Illustrative of this is the fact that in 2006, two of the drugs that generated the highest costs in the national health service, risperidone and paroxetine, accounted for 183 million euros and 153 million euros, respectively (Information Terapéutica del SNS, 2007).

A factor that distorts the rational assignment of resources to mental health care is pressure from the pharmaceuticals industry, which promotes the efficiency of its products in relation to the high costs incurred to society. Economic studies sponsored by the pharmaceuticals industry are abundant in the scientific literature. Such studies generally present data in support of the cost-benefit relation of the agent in question, and are a substantial source of bias in the overall economic analysis of relevant alternative treatments. But methodological distortions and defects



have been detected in the economic analysis of expensive drugs, such as atypical antipsychotics (Basu, 2004) and the latest generation of antidepressants (Baker, Johnsrud, Crismon, Rosenheck & Woods, 2003). It has been observed that the higher the methodological quality of an economic study, the less advantageous the drug, compared to the alternative of reference. This severely restricts the utility of such analyses as relevant information for decision-making about the assignment of resources by healthcare managers (Bell et al., 2006).

In Spain, 16% of the population take some kind of psychoactive drug. Benzodiazepines (11.4%) and antidepressants (4.7%) are the most widely consumed, especially among women. Probability of use increases with age and with comorbidity (Codony et al., 2007). In primary care the use of psychoactive drugs is considerable, and is excessively prolonged due to deficient follow-up of the prescriptions issued. It is estimated that between 20% and 40% of primary care patients use psychoactive drugs (Secades et al., 2003). In this last-mentioned study, 10.5% of the population seeking primary care fulfilled the criteria of dependence on psychoactive drugs. With regard to monitoring, the study by López, Serrano, Valverde, Casabella and Mundet (2006) suggests that psychopharmacological treatment in primary care is in many cases prolonged way beyond what is recommended in guides to clinical practice. Mean time of prescription observed in this study was 5.95 ± 3.28 years, and 14.5% of patients on medication lacked a diagnosis justifying the prescription.

One of the types of medication most widely consumed in primary care are selective serotonin reuptake inhibitors (SSRIs), the use of which has increased by 400% since the early 1990s, despite the fact that they are much more expensive than other drugs of similar efficacy, such as tricyclic antidepressants. SSRIs currently dominate the market, supported by the claim of greater effectiveness and safety than the alternative agents of reference. However, their effectiveness has been widely questioned (e.g., Moncrieff & Kirsch, 2005; Kirsch et al., 2008), and their extensive use has not been accompanied by a reduction in suicides or in working hours lost due to depression (Van Praag, 2002; Ortiz & Lozano, 2005). Moreover, the use of these drugs in mild depression is advised against by various guides to clinical practice. Even so, their prescription is practically automatic, even in the absence of the established clinical indicators (Jureidini & Tonkin, 2006). The enormous increase in expenditure on the prescription of antidepressants has resulted in high

opportunity cost for the health system, given the lack of a parallel increase in investment in psychological treatment resources of proven efficacy and cost-effectiveness. Cognitive-behavioural therapy for depression, though expensive in absolute terms, has shown advantages in the long term with respect to the long-term cost-effectiveness of antidepressants (Hollinghurst, Kessler, Peters & Gunnell, 2005).

COST-EFFECTIVENESS OF PSYCHOLOGICAL TREATMENT IN PRIMARY CARE

The evidence currently available on the efficacy of psychological treatments is robust in view not only of its quantity, but also of the methodological rigour of the studies providing such evidence, and the range of clinical disorders on which they have been applied with clear benefits for the patient (Pérez, Fernández, Fernández & Amigo, 2003). There is an extensive body of research showing that psychological treatments, mainly cognitive-behavioural therapy (Butler, Chapman, Forman & Beck, 2006), are as effective as or more effective than psychopharmacological treatments in the most prevalent disorders, and more effective in the long term (Hollon, Stewart & Strunk, 2006). Psychological treatments applied in "natural" contexts of clinical practice have proved to be as effective as those applied in controlled research settings (Hunsley & Lee, 2007), suggesting that they could be successful if used generally in clinical contexts, both public (Westbrook & Kirk, 2005) and private (Persons, Bostrom & Bertagnolli, 1999). However, claims for the efficacy and clinical utility of treatments are of limited value if there is no sustainable access to them within the healthcare system, not to mention, naturally, a sufficient supply of adequately trained clinicians for applying them in the community.

The economic assessment of psychological treatments is crucial to decisions about the management and assignment of resources, bearing in mind the constantly increasing costs of healthcare and the gap between the needs of the population and the scarcity of available resources. Although there are significant data supporting the cost-effectiveness and reduction of health expenditure associated with the provision of cognitive-behavioural treatments (Myhr & Payne, 2006; Hunsley, 2003), the quantification of efficiency is extraordinarily complex, especially in primary care, where comorbidity of emotional disorders with chronic illnesses and disorders that consume large quantities of resources is the norm (e.g., patients with major depression and diabetes).



Layard, Clark, Knapp and Mayraz (2007) made an incisive economic analysis which convinced the British government of the wisdom of investing considerable resources in the creation of primary care psychological treatment facilities – a total of 173 million pounds sterling for the first 3 years. According to this analysis, the application of the NICE (National Institute for Clinical Excellence) criteria for clinical practice in mental health, which advises cognitive-behavioural treatment for anxiety and depression, will signify a saving for the public purse equivalent to 4.4 times the cost of the project, which was launched in May 2007 (Improving Access to Psychological Therapies; Turpin, Richards, Hope & Duffy, 2008).

Among the principal reasons why psychological intervention in primary care can reduce medical costs, according to Blount et al., (2007), are the following:

1. The majority of visits in primary care are related to needs for psychological attention, even if psychological problems do not constitute the principal complaint

In a retrospective study by Sicras Mainar et al. (2007a) on 64,000 patients attended by 5 primary care teams, 17.4% sought attention for emotional disorder, most frequently anxiety and/or depression. These patients presented greater numbers of health problems – high blood-pressure, dyslipemia, obesity, ischaemic heart disease and cancer – regardless of age and sex. According to Unützer et al. (2006), 75% of patients with depression seek help for somatic complaints, but not for emotional disorder. Indeed, the majority of those who would benefit from psychological attention do not tend to go to the doctor's for psychological reasons, and it more likely that a person with a psychological disorder will visit their GP with a somatic problem than a person without emotional difficulties.

2. Better identification of psychological care needs and integrated care in collaboration with GPs lead to reduced health costs

A person with depression consumes roughly double the quantity of health resources as a chronically ill person without this diagnosis (Kathol et al., 2005). In Spain, the study by Sicras Mainar et al. (2007b) claims that people with depression in primary care generate a cost 58.4% higher. Some 62% of the total cost derives from the consumption of medication. A review of 91 randomised trials revealed that collaborative integration between

psychological care and medical treatment could reduce health costs by around 17% (Chiles, Lambert & Hatch, 1999).

3. The majority of behavioural and psychological needs in primary care can be met without the need for referral to specialist mental health care

Large part of primary care users' needs can be met through behavioural interventions for the treatment of and adaptation to illnesses that are not identified with psychological problems by patients, such as diabetes, hypertension, cardiovascular problems or chronic pain (Friedman, Sobel, Myers, Caudill & Benson, 1995). Mild emotional problems may require, in the first instance, effective, low-intensity brief psychological interventions, such as problem-solving therapies (García Campayo, Hidalgo & Orozco, 2005) or behavioural activation (Dimidjian et al., 2006).

4. Primary care users prefer psychological treatments

The finding that people with psychological difficulties prefer psychological treatment to drugs is a consistent one across a range of studies that have analysed this aspect in the primary care context, but also in that of specialist attention, in which the majority of referred patients expect to be treated by a psychologist (Retolaza & Grandes, 2003). It has also been found that most of those who prefer psychotherapy opt not to have any treatment at all rather than receiving only medication. Therefore, it may be that a large part of those who need help receive none, due to the scarce availability of psychological treatment (cf. Van Schaik et al., 2004; Tylee, 2001; Chilvers et al., 2001).

COLLABORATION BETWEEN PSYCHOLOGY AND MEDICINE IN PRIMARY CARE

Psychological attention services can be integrated in primary care according to different collaborative models along a continuum ranging from total independence of psychological and medical services (referral), to the co-existence of professionals in the same centre but in different services (co-location), and finally to the full collaboration and total integration of professionals in the same service.

One of the models most widely studied and with the most empirical support (Bower, 2002) is that of collaborative care, in which the doctor retains responsibility over the treatment of patients and the psychologist exercises the role of consultant for doctor and patient, contributing skills



to the primary care team and direct attention to the patient through brief psychological interventions.

A model related to the one described above would be that based on the concept of *stepped care*, recommended by the NICE (2004). This model assumes that not all users require intervention of equal intensity and depth, and initially offers less intrusive treatment, since the most effective intervention is not necessarily the same one for all. In practice, this approach implies that some people require "low-intensity" and others more complex, "high-intensity" treatments – formal psychological treatments applied by specialised professionals. The most low-intensity treatments would be principally brief interventions, self-help guided by written or computer-based material, problem-solving techniques or behavioural activation.

It was within the framework of this model that the programme Improving Access to Psychological Therapies (IAPT), (Turpin, Richards, Hope & Duffy, 2008), was launched in the UK, in May 2007, for providing psychological treatment to adults with common mental disorders, especially depression and anxiety. Although in principle no theoretical approach is excluded, cognitive-behavioural treatment is preferred, given the robust evidence of its effectiveness in the treatment of anxiety and depression, according to various NICE reports on behalf of the UK Ministry of Health.

THE CONTRIBUTION OF PRIVATE PSYCHOLOGISTS

The majority of provision and application of psychological treatments occurs outside the public sector (Lawson & Guite, 2005). The psychologists' services available and psychosocial interventions for common mental disorders are provided primarily by private practices and other resources, such as patients' associations, medical insurance societies, foundations and NGOs. Access to such services by citizens is highly unequal because of economic and market factors, but they constitute the principal psychosocial care resource due to their relative simplicity of access, in contrast to the case of psychological attention in the public sector. Private psychologists contribute to containing the demand for public psychosocial care, since they absorb part of the flow of patients dissatisfied with the delays in their first appointment. Goñi, García, Landa and Lizasoain (2008) have estimated the delay for a first ordinary consultation at a mental health unit at 49.09 ± 31.94 days.

The professional community of private clinical psychologists in Spain is numerous, and constitutes 80% of all clinical psychologists (Santolaya, Berdullas &

Fernández, 2002). According to data from a preliminary study by the SEPCyS (Spanish Society for the Advancement of Clinical and Health Psychology; *in press*), the number of psychologists in Spain working in the private sector is close to 8000 professionals distributed across 6400 practices and other facilities offering attention in diverse contexts and from various theoretical models of psychological intervention. A part of this professional body, adequately trained in Health Psychology, constitutes a resource that could be optimized to partially offset the saturation of public services. It is common practice, for example, in Holland, to refer patients with diagnoses of psychosocial or psychosomatic problems from primary care to appropriate resources outside the system, including psychologists in private practices (Verhaak, Lisdonk, Bor & Hutschemaekers, 2000; Smit, 2007).

A good example of collaboration between the public and private sectors can be found in Australia. The Better Outcomes in Mental Health Care (BOiMHC) programme was launched in July 2001 with the aim of extending access to quality treatment for common mental disorders in primary care. This programme permits GPs to refer patients to mental health professionals (basically psychologists) for a limited number of sessions of psychological treatment with empirical support (primarily motivational interview, cognitive-behavioural therapy and interpersonal therapy). Professionals work directly for the centre or clinic, or patients are referred to them through special contracts for the provision of services. This project was developed within the framework of the Access to Allied Psychological Services (ATAPS) programme, whose user demand and GP participation levels have grown steadily since the introduction of this pilot project through 111 projects set up by different health authorities throughout the country.

Between 2001 and 2006 the project received funding equivalent to 164 million euros (Pirkis et al., 2006). The effectiveness of the project up to now has been estimated by means of pre/post-treatment measures, which have indicated a substantial improvement in 65% of users, with a mean effect size of 1.02 for all interventions. Treatment format is individual in 98% of cases, with a mean of five 45 to 60-minute sessions of cognitive-behavioural treatment (cf. Fletcher et al., 2008).

CONCLUSIONS

Although there is currently a consensus on the crucial importance of psychological attention for the quality of



healthcare, access to it is difficult in the public sector. After more than 30 years of clinical trials, meta-analyses and reviews, there is a considerable body of accumulated data demonstrating the efficacy, effectiveness and efficiency of psychological treatments in healthcare settings, both public and private. However, psychological care has been displaced and ignored in the context of strategic planning and development of services, resulting in the under-use, underfunding and underdevelopment of psychological treatments in healthcare.

In primary care there are models of integration and collaboration between biomedical and psychosocial intervention that have been implemented in various countries, with promising results which reveal considerable potential for increased quality of life, satisfaction with services and a long-term contribution to the sustainability of the health system.

The recent evolution of mental health services in Spain and other countries reflects a situation whereby professional attention to these needs is not among the political priorities of parties and governments. As we have seen, mental health care in Spain presents a general picture of precariousness which contrasts with the overall situation of its health system, considered the seventh most efficient in the world, according to the WHO (WHO, 2000). The current scenario of bio-pharmacological hegemony in mental health lacks rational justification on the basis of scientific evidence, the objective situation of the health services, epidemiological data, and the satisfaction levels and preferences of users. The huge discrepancy between the resources invested in biomedical treatment and those devoted to psychosocial attention to emotional illnesses and disorders reflects the reductionist thinking currently prevailing in decisions about health policy (McMurtry & Bultz, 2005).

This situation of deficiency must give rise to rigorous debate and, in turn, a climate of discussion, both scientific and political, that would help initiate a process of change in the current model of mental health attention, towards one which truly incorporates in its strategies all the bio-psychosocial resources of the community available for healthcare provision. The authentic incorporation of mental and behavioural health professionals in primary care teams would represent a step toward psychological care that is actually concerned with people's needs, rather than with their assignment to diagnostic categories (Kinderman, Sellwood & Tai, 2007). This process of change should aim for optimum use of the limited resources of our social-health system from an integrated and cost-effectiveness

perspective, involving the collaboration of all healthcare professionals and managers.

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