



MENTAL HEALTH IN PRIMARY CARE: WHAT WE HAVE, WHAT WE NEED AND WHERE TO FIND IT

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A recent issue of Papeles del Psicólogo dealt with the subject of mental health in Primary Care. The present text sets out to respond to the papers that described the current state of mental health in Primary Care in Spain and the proposals derived from those analyses. This response concerns issues related to the work of clinical psychologists in Primary Care and their professional reputation. The Spanish Clinical Psychology internship is defended as an essential training requisite in this field. Finally, considering the existing literature and the current state of professional Psychology in Spain, it is argued that the clinical psychologist is the "new" figure that we are looking for to improve mental health in the Primary Care context. The necessary work of non-clinical psychologists in universal and selective prevention in school, work and social environments is also considered.

Keywords: Primary care professionals, mental health, psychological intervention, training, organizational models.

En un reciente número de Papeles del Psicólogo se abordaba el tema de salud mental en Atención Primaria. En este texto pretendemos responder a los trabajos que describían la situación actual de la salud mental en Atención Primaria en España y las propuestas que se derivaban de esos análisis. Se responde a aspectos relacionados con la labor de los psicólogos clínicos en Atención Primaria y su reputación profesional. Se defiende la consideración del sistema de Residencia como un requisito esencial para la formación en este campo. Finalmente, dada la literatura existente y la situación actual de la Psicología profesional en España, se sostiene que el psicólogo clínico es esa "nueva" figura que se está buscando para mejorar la salud mental en Atención Primaria. Se valora igualmente la necesaria labor de los psicólogos con especialidades no-clínicas para la prevención universal y selectiva desde ambientes escolares, laborales y sociales.

Palabras clave: profesionales de atención primaria, salud mental, intervención psicológica, formación, modelos organizativos.

A recent issue of this journal dealt, in a special section, with the question of Mental Health in Primary Care. Leaving to one side the article describing the British experience (Turpin, Richards, Hope & Duffy, 2008), I should like to address these comments to the content of the other two articles (Pastor Sirera, 2008; Pérez Álvarez & Fernández Hermida, 2008), referring to the situation in Spain, with a view to proposing an alternative view to that held by these authors.

The authors remind us about some general aspects such as the great prevalence of psychological problems (to use the most general of terms) and the high associated costs, the excessive medicalization of such problems, and the need, backed up by the data, to employ psychological treatments as the first option, especially for the most common disorders. Pérez Álvarez and Fernández Hermida (2008) make a radical (in Ortega's sense) reappraisal of the conception of mental disorders, aligning themselves with those who call into question both mental "illness" and the biopsychosocial model that supports it... While we must be

accepting of fair criticism, the validity of the points made is greatly limited by some of the errors involved, and which I shall deal with in the different sections that follow.

CLINICAL PSYCHOLOGISTS IN PRIMARY CARE IN THE NATIONAL HEALTH SYSTEM

It is too common to be put down to mere carelessness that on talking about Primary Care, and even almost about public health in general, the work of clinical psychologists is overlooked. The fact is that a substantial portion of clinical psychologists work in the Primary Care, rather than the Specialist Care context. Indeed, until a few years ago it was the norm. The creation of the speciality and the granting to clinical psychologists of the status of health specialists, together with a disenchantment with the failed community attention model, are among the factors that led to the reclassification and relocation of a large percentage of primary care psychologists' positions. However, the functions, appropriately carried out or not, are still the same, and this includes – particularly in the case of Mental Health Centres (MHC), teams or units – relations with other Primary Care professionals via a "Referral" model, which does not exclude regular meetings or other forms of consultation and communication. There are other, less well



developed models, such as the “Replacement” model, in which mental health professionals are stationed in Health Centres (HS) to attend to people with mental disorders; or the “Link” model, in which they provide support as consultants or supervisors for GPs’ cases (Williams & Clare, 1981). The advantages of some over others have yet to be clarified (Bower, 2002). As regards the results of the principal systematic review on the effects of situating mental health professionals in health centres, they are no more than modest. Neither the “Replacement” nor the “Link” model has been responsible for great changes in the practices of GPs (Bower & Sibbald, 2000), while in the “Referral” model, the most widely found in our context, there is most certainly room for improvement. But claiming that this work does not exist, or that it is totally useless is, not to put too fine a point on it, simply disrespectful. It is a curious philosophy that promotes the contextual by ignoring the context in which it pretends to implant itself.

ON THE REPUTATION OF CLINICAL PSYCHOLOGISTS

I do not feel I am in any way distorting the issue if I say that clinical psychologists in the public health system have a certain capacity to take criticism and to criticize ourselves. Work overload, difficulties related to promotion and influence in institutions, lack of training and resources, the abuse of eclecticism, a tendency to be out of touch with treatment protocols as endorsed by research, and problems with supervision (and with supervisors) are just some of the possible criticisms. None of this is new (Hernangómez Criado & Suárez Blázquez, 2003; Palacios Ruiz, 2004). It is the responsibility of us all to acknowledge and try to improve the current state of things. Even so, it is important to respond to some of the criticisms received by clinical psychologists in the public health system from the articles we have mentioned. For example, the passive acceptance of biological reductionism of which Pérez Álvarez and Fernández Hermida (2008) complain at length. While recognizing that the problem is a serious one, this does not mean that the activity of clinical psychologists takes place always (or even usually) under the assumptions of this approach. For certain disorders the use of this perspective may be appreciable, but I know few clinical psychologists who in their approach to a case of depression place the emphasis on genetics or neurotransmitters. The most widely used treatment model is based on psychosocial antecedents, on cognitive style, on behaviour, and so on. It is certainly the case that, more often than we would like, we receive people already on medication (given the, as it were, “passion for antidepressants”), but why do these authors

assume that we clinical psychologists are so unfamiliar with the academic literature that we are totally uncritical of these practices in our medical colleagues?

There are fields, such as those of schizophrenia or bipolar disorder, in which things are different. There is undoubtedly a predominance of biology-based explanations, for better or worse (a debate which I shall not enter here). But it would be fair to acknowledge that the situation has improved somewhat. When I was doing my internship, some ten years ago, only a few clinical psychologists – some of whom I was lucky enough to meet – had the courage to use psychological treatments (other than occupational rehabilitation activities) with people suffering from schizophrenia or bipolar disorder. In the majority of mental health centres it was assumed that clinical psychologists did not treat such cases because they involved biological, serious matters, medication... in sum, due to a kind of stigma. One can perhaps still appreciate in the approaches a predominance of biology-based psychoeducation over more life-experience-based and integrative conceptions, but the current situation (once again: improvable) is not like that of the “brain decade.” Rare is the conference or science meeting attended by psychology interns in which there is no presentation of some experience of the psychological treatment of such patients.

I should also like to make another clarification under this heading. Pastor Sirera (2008) cites a work by Fernández et al. (2006) to highlight the claim that clinical psychologists provide suitable treatment in only 11% of cases “suggesting that the resources invested in psychological care are particularly poor” (p.283). Indeed, several criticisms could be made in relation to the method and interpretation of results in the article by Fernández et al. (as of them all), but this is not the place. On the other hand, it does seem appropriate to make some clarifications about Pastor Sirera’s interpretation. At no point in the article by Fernández et al. (2006) do the authors refer to clinical psychologists, but rather to psychologists in general (it is curious that when talking about inadequate treatment they specify, and unduly, that those concerned are clinical psychologists); and on the other hand, nor is the study restricted to people attended to by the public health service. We can assume that a substantial portion of those seen by psychologists for emotional problems over the previous year were actually treated in the private sector, which has more professionals working in it – as indeed Pastor Sirera subsequently reminds us. Therefore, this figure of 11%, which we insist is criticizable for other, methodological reasons, reflects not a deficiency of psychological attention



in the public system that supposedly needs rectifying through the inclusion of psychologists (clinical psychologists?), but rather a discrepancy between clinical practice (public and private) and the recommendations of clinical guidelines (what should be done in theory). Although this deficiency is undoubtedly greater than it ought to be, it is to some extent reasonable to find it. There may be various reasons why psychological treatment is not applied within ideal parameters, some of these reasons having nothing to do with the professional resources available (e.g., spontaneous remission).

Unfortunately, data on the work of mental health professionals in the public sector are scarce, rather heterogeneous between institutions or units, and of questionable reliability. But the situation in the private system is even worse (see Bas Ramallo & Bas Maestre, 1998). Thus, following a basic contextual principle, before proposing referral to the private sector as the solution to the ills of the public healthcare system (Pastor Sirera [2008] proposes it openly; Pérez Álvarez and Fernández Hermida [2008] also do so, but with less conviction), it would be advisable to have greater knowledge of how mental disorders are dealt with in the 6400 (!) private practices to which Pastor Sirera refers (and I admit that having counted them represents a significant advance). For a start, in the private sector in Spain it is still possible for a graduate fresh out of university to offer services as a psychologist to people with mental disorders, of varying degrees of severity, without any period of previous clinical supervision. We are confident that the Spanish Psychological Association's efforts to ensure the application of the current legislation will help correct such irregularities in the private sector.

SPECIALIST IN CLINICAL PSYCHOLOGY AS A MINIMUM, NOT A MAXIMUM REQUIREMENT

In the article by Pérez Álvarez and Fernández Hermida (2008) the authors ask whether the psychologist in Primary Care should be a clinical psychologist. Their response is: "Nothing would preclude this, but the profile of Primary Care psychologist would be not that of a clinical psychologist as specialist, oriented to mental health" (p.262)... to go on, with calculated periphrasis, to say that the profile of the psychological consultant is "an unsurprising figure in relation to the tradition of Clinical Psychology." And they go on to list the objectives, functions and skills of this "new" figure. It would be a case of providing psychological therapies that are characteristically brief and oriented to "the utilization of resources the client already has for solving their problem" (p.263), and which would involve

brief psychodynamic psychotherapy, the "client as active self-healing" model, logotherapy, "new wave" behavioural-contextual therapies, solution-centred therapy, and so on – though "it is not surprising that cognitive-behavioural techniques have some advantages for use in this context" (p. 265) (nor does Pastor Sirera [2008] exclude any theoretical approach, though he acknowledges a preference for cognitive-behavioural treatment). As regards assessment, as well as being rapid, it should "focus on the basic determinants of behaviour, according to an ABC model, which relates current behaviour to antecedents and consequences" (p.264) – in truth, not at all surprising in relation to the tradition of Clinical Psychology. An initial session could take 25-30 minutes (successive ones taking 5-25 minutes), of which the assessment of the psychological aspects involved would take 5-10 minutes (the proverbial brevity of the contextual approach). Among the other skills of psychological consultants, they should "learn to make decisions" (p.265), "have skills for bringing about motivation to change" (p.265), "be capable of working in the field of prevention" (p.265), and "have a capacity for working as a member of a team" (p.265); moreover, "an adequate understanding of medical terminology, common illnesses and their treatments, and the effects of medication, is essential." (p.265).

Returning to everyday reality, some questions arise: What would be the speciality of this figure with such lustrous professional attributes? How would one gain access to this (health) speciality? What would be the relationship between this figure and the clinical psychologists functionally dependent on Specialist Care? What would their status be within the health system? Would they be medical professionals like GPs, or senior technicians as psychologists were before the recognition of their speciality? Can we imagine them working as mental health supervisors/consultants for Primary Care specialists without being mental health specialists themselves? How would they avoid falling victim to the *extremely reductionist biomedical model* in which the clinical psychologist is (supposedly) absorbed? In order to apply brief treatments, would *brief* training be sufficient?

The Psychology Internship system (*Psicólogo Interno Residente*, PIR), the only legally recognized route to qualification as a clinical psychologist in Spain, does not include training in all the fields of mental health, nor the title of specialist in Clinical Psychology accredited as an expert in any of them. What the PIR offers is basic training, under direct clinical supervision at officially appointed institutions, in what mental health problems are (including differential



diagnosis) and how to approach them, together with some grounding in the healthcare context in which they present themselves (including interconsultation). It would be absurd to think that on completion of the internship a psychologist is equally specialized in the treatment of auditory hallucinations and tinnitus, in assessing cognitive deficits and the emotional distress associated with cancer or fibromyalgia. Sub-specialization (formally defined in the relevant legislation – *Ley de Ordenación de la Profesiones Sanitarias*, or LOPS – as Area of Specialized Training) is essential. But sub-specialization – so underdeveloped – should be situated *after* specialization (as occurs in the case of first degrees), and in no case prior to it. The opposite is what appears to be argued by those who propose that one can be a specialist in a given clinical area (of psychology) without the need for the specialization (in Clinical Psychology). This perverts the logic of the accumulation of knowledge and skills on which the educational system is based. Who would dare propose access to doctoral courses for those not already holding a degree? The proposal to incorporate non-clinical psychologists without the need for them to do an internship would not only imply making an exception within the LOPS legislation: if it were to be accepted, it would end up blowing apart the law itself, which stipulates that all health professionals must be trained through the internship system (art. 20 of the LOPS).

THE PREVENTION OF MENTAL DISORDERS: THE CLINICAL CONTEXT AND BEYOND

According to the most favourable reading of the diverse (in all senses) dual-phase epidemiological studies carried out in Spain, one in five people will suffer from a mental disorder in the course of their life (life prevalence) (Haro et al., 2006), while the least positive reading says that one in five are suffering from such a disorder at the present time (point prevalence) (Roca et al., 1999; Vazquez Barquero, Muñoz & Madoz Jauregui, 1982). Dual-phase studies involve screening by means of a general questionnaire, followed by a structured interview to determine, among the possible cases, whether there is a disorder, and which disorder. Generally, epidemiological studies on the prevalence of mental disorders are limited to the study of those most widely found. Pérez Álvarez and Fernández Hermida (2008) cite the psychiatrist Derek Summerfield (Summerfield & Veale, 2008), who opposes the expansion in the UK of psychological treatments for anxiety and depression, to call into question, as he does, whether such studies contribute data on “true” cases. Without entering into the debate on the reliability and validity of the

diagnostic instruments, it is worth pointing out that the numerous studies on minor and subclinical depression suggest that functional impairment (Cuijpers, de Graaf & van Dorsselaer, 2004; Jaffe, Froom & Galambos, 1994) and especially work-related impairment (Backenstrass et al., 2006), costs (Cuijpers et al., 2007), socio-economic burden (Judd, Paulus, Wells & Rapaport, 1996; Judd, Schettler & Akiskal, 2002), quality of life (Rapaport & Judd, 1998; Wells, Burnam, Rogers, Hays & Camp, 1992) and risks of transition to major depression (Cuijpers & Smit, 2004) can be appreciated from the first symptom, and progressively increase up to the syndrome in its most severe forms. Risk of suicide is increased for all mental disorders with respect to the general population, and while it is well known that in the case of major depression it is 20 times greater, it is perhaps less well known that for adaptive disorders – the quintessential mild complaint in mental health – it is still 14 times greater (Harris & Barraclough, 1997). In sum, the consequences of mental problems can be appreciated from the mildest or initial forms. Their identification and swift resolution, essential tasks of Primary Care, are complicated not only by the intensity of the symptoms, but also by high comorbidity of both a physical (Roca-Bennasar, Gili-Planas, Ferrer-Perez & Bernardo-Arroyo, 2001) and mental (Autonell et al., 2007) nature.

Although the terms may blur the objectives somewhat, not all primary prevention is the task of Primary Care, and not all attention in Primary Care is primary prevention. Within primary prevention, in addition to indicated prevention (addressing those identified as high-risk, with minimal but detectable signs or symptoms of a mental disorder, but who do not meet the diagnostic criteria for a specific disorder at that point), we can distinguish universal prevention (interventions aimed at the population in general or at an entire group) and selective prevention (interventions aimed at individuals or groups at greater risk of developing a mental disorder) (Mrazek & Haggerty, 1994). Psychology in this context need not be confined to clinical (face-to-face) attention – in many cases it may be too late for that anyway, and from a primary prevention point of view it is an incomplete approach. Universal and selective prevention clearly do not require the direct participation of a clinical specialist. Interventions in schools, in the workplace and in society in general are contexts in which Psychology, through its non-clinical specialities, can/should make preventive contributions in the area of mental health – or indeed, in which it can and should boost the initiatives already in place and develop new and more effective ones. If we assume that a large part of what reaches GPs’



surgeries and health centres may not be “true” cases (of mental disorders), and that there is a risk of the psychopathologization of everyday problems, the solution lies not in creating (and regulating) new, low-profile “clinical” or “healthcare” figures, but rather in providing interventions outside the healthcare context by the agents already available. A greater presence and recognition of psychologists in educational and work environments and in the context of the socially disadvantaged offers us an unmissable opportunity to prevent mental disorders, contextualizing them within the general field of Psychology. Leaving clinical interventions (identification, diagnosis, treatment, etc.) provided in healthcare units to mental health specialists, in this case, clinical psychologists.

CONCLUSIONS

Bearing in mind the recommendations of clinical manuals about the use of psychological treatments and the current resources of the Spanish public health system, clinical psychologists themselves would seem to emerge as these “new” figures that provide the key to tackling mental health problems in Primary Care. Given the deficiencies acknowledged, the current “Referral” model should be reviewed, with a view to homogenizing and delimiting the responsibilities of clinical psychologists. Such a review, which might involve trials with complementary forms of integration in health centre contexts, should render the public health system capable of offering effective psychological treatments with different levels of intensity (see Turpin et al., 2008) as an alternative to medicalization. The indicated prevention system in relation to mental health should also be improved at this first care level. All of this is especially relevant to the most common forms of mental health problem, those related to anxiety and depression, but not to them alone.

It is to be hoped that the progression of Clinical Psychology will force the recognition of new healthcare (sub-) specialities, be they Health Psychology, Clinical Neuropsychology or Child and Adolescent Clinical Psychology, to mention just the most popular. But looking to make progress by returning to situations prior to the legislation that created and regulated the speciality in Clinical Psychology involves a clear risk of devaluing the figure of the clinical psychologist in public health, and by extension, the Psychology professional in society. In a context of superabundance of qualified psychologists there is no justification whatsoever for short-cuts in the acquisition of the health professional’s basic skills – and even less if we consider the implications of mental health for individuals and for society as a whole. Internship should be recognized, as in the rest of the medical and healthcare

professions and in accordance with the relevant legislation, as a minimum training requirement for the treatment and prevention of mental disorders in the public and private health systems.

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