WHITE PAPER

HOW TO SITUATE PSYCHOLOGICAL SERVICES THROUGHOUT A STEPPED CARE PUBLIC HEALTH SYSTEM

White Paper

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White paper: How to situate psychological services throughout a stepped care public health system

1. Background

1.1 Psychology can play an important role in the improvement of people's health and wellbeing. The European Federation of Psychologists' Association (EFPA)'s Standing Committee on Psychology and Health has situated psychology and the roles that psychologists hold in the broad domain of health (EFPA Standing Committee Psychology and Health, under submission). Psychological interventions range in breadth, scope and purpose from disease prevention, health and wellbeing promotion, treatment, supporting those with severe mental and physical health conditions to reintegrate into the community after (residential) treatment, among others.

1.2 This wide range of interventions is implemented in a wide range of psychological services. This range spans from group to individual, from face-to-face to self-help, from in-person to digital. To maximally benefit individuals, these services need to be organised in an effective and efficient way. The World Health Organisation[1] proposed a model through which mental health services could be effectively organised. It consists of a stepped-care approach with a great emphasis on prevention of mental illness and community - oriented interventions. A stepped-care approach to service delivery represents one attempt to maximise efficiency of resource allocation of evidence-based interventions[2]. Stepped-care refers to a delivery model whereby intervention or service provision depends on type and /or intensity, based on need. Such a model is beneficial to health care systems and particularly those with limited resources. Lower cost interventions are offered as a first line of service delivery whereas more expensive and intensive interventions are provided for individuals who are in need of them.

1.3 An added benefit to a stepped-care approach is that it provides a framework via which treatment efficacy can be improved through the standardisation of systems and procedures of a health care system. A stepped-care approach is often displayed as a pyramid where less intensive interventions (typically prevention) are provided for a larger number of individuals at the bottom of the pyramid, while fewer individuals are served with progressively more intensive interventions. Progressing through steps typically serves fewer individuals with particular circumstances and needs via providing more expensive, intrusive and intensive intervention (e.g., from mere provision of information to intensive one-to-one psychotherapy). Adopting such a stepped-care model presents the potential to maximise the effectiveness and efficiency of allocation of resources[2].

1.4 In several countries (for example Belgium, UK, Portugal) initiatives are under way to organise (mental) health services in a different way. Traditionally, most health systems are organised to deal with acute situations with the bulk of investments going to specialised and often residential (hospital) services[1,3]. In response to that, some countries are trying to implement a public health approach[4]. Such an approach takes a broader perspective rather than focusing on treating acute health problems, as in the upper levels of the WHO pyramid. The main focus is less on "how to treat a sick individual" but "how can we keep our population as healthy and satisfied (with life/care) as possible".

1.5 In this white paper we aim to situate psychological services within a public health and population-oriented framework[4]. We acknowledge work done by colleagues, and some of the same authors of this paper, on the Global Psychology Alliance's paper 'How does psychology fit within a

population health framework?'[5] which approaches these questions from an international, rather than European-focused perspective.

1.6 We use the WHO stepped care model (and definitions) to propose for the effective organisation of mental health services and situate the broad range of psychological services in the different layers of the model. Although the initial model was meant for mental health service delivery[1], we feel that the stepped care approach can easily be transferred to the whole of the health domain, including public health. Thus, this paper can be used by EFPA's Full Members who want to support their members in the field to broaden their range of service delivery and to show the added value of psychology within a public health system.

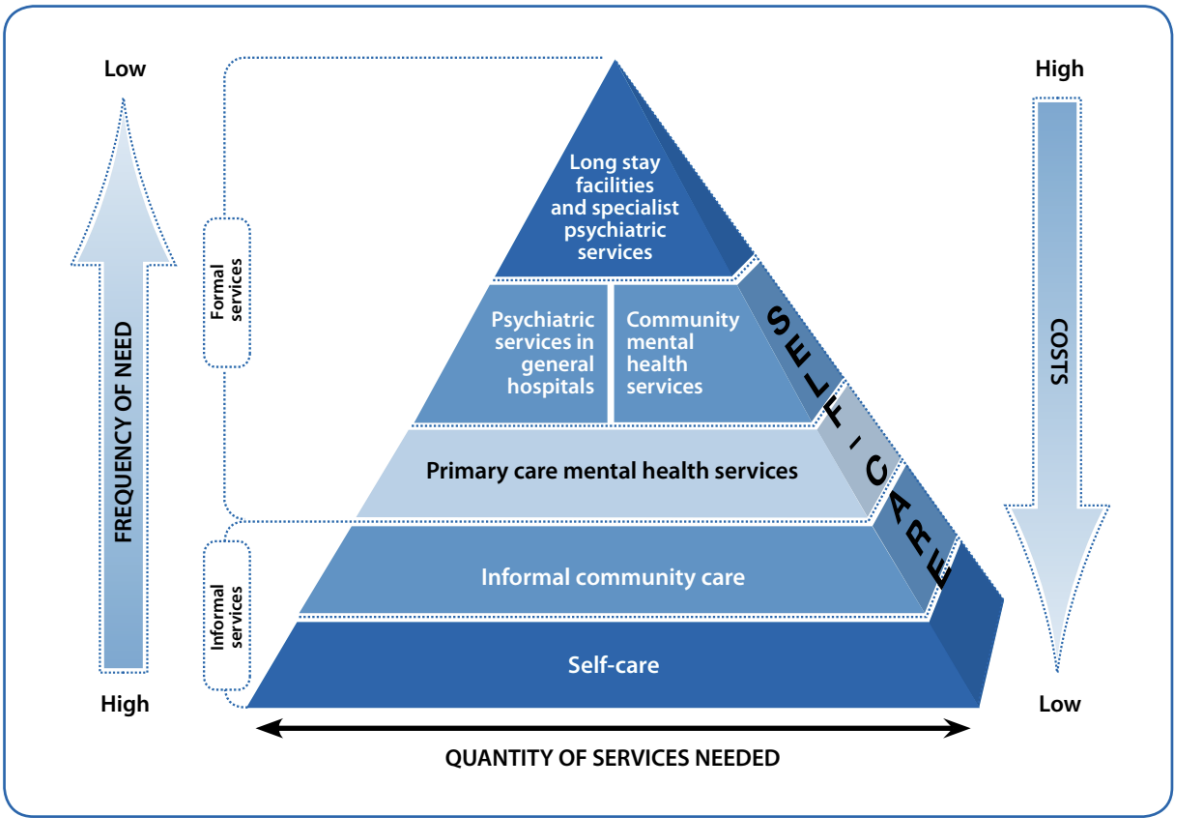

Figure 1: WHO Service Organisation Pyramid for an Optimal Mix of Service for Mental health[1].

2. Psychological services for supporting and promoting self – care

2.1 According to WHO, self-care is defined as the ability of individuals, families, and communities to promote and maintain health, prevent disease, and cope with illness and disability with or without the support of a healthcare professional[1]. In the context of health services provision, people who do not demonstrate improvement following guided self-care are then 'stepped up' to receive higher intensity services from qualified experts[6]. Self-care interventions emphasise the important roles that individuals and communities have in their own healthcare, shifting away from health centres as sole providers of care.

2.2 Self-care promotion requires the public having adequate awareness of physical and mental health issues and at the same time health systems that promote individual responsibility and resources for self-care. In addition, self-care requires people who seek help when needed, and governments who prioritise access to quality health care services for all.

2.3 Couched within a stepped-care model, self-care can range from self-guided interventions using self-help type approaches (e.g., bibliotherapy, self-help digital interventions or apps etc.) to engaging with support groups (e.g., alcoholics anonymous) led by individuals who face a particular difficulty, to group therapies led by trained therapists, to more specific one-to-one therapeutic encounters. Whilst this focus is mostly on patients and the public; additionally, self-care also applies to health workers. Health providers including emergency health workers, community providers and family caregivers, are themselves exposed to significant stressors. Training for these groups should also focus on strengthening competencies in self-care for them to support themselves and to enable them to better support patients and the public.

2.4 Self-care interventions encompass use of tools that can support and empower individuals to focus on caring for themselves. Research in self-care should be rigorous to provide a strong evidence base to promote the introduction, use and scaleup of these interventions. This research needs to include community engagement, through participatory and qualitative research methodologies to ensure that self-care interventions are tailored to user needs and that the evidence base captures lived realities. In addition, robust evidence of implementation research is also needed to ensure that self-care interventions are implemented in safe and supportive enabling environments to facilitate access and uptake and ensure that improvements in health outcomes reach underserved and marginalised populations.

2.5 Self-care interventions have the potential to increase self-efficacy and autonomy especially when they are accessible, acceptable, and affordable. They can improve access and coverage, reduce health disparities when carefully implemented, increase service quality, improve health and social outcomes and reduce costs. Benefits have also been reported for different health priorities; for example in sexual and reproductive health they can improve adoption of preventive behaviours, treatment adherence, and reduce the need for healthcare services[7], whilst in epilepsy care they can improve knowledge and self-confidence in self-management including the psychosocial stressors, improvement in seizure control, and improvement of quality of life[8].

2.6 There is also another reason self-care support is urgently needed. It is expected that by 2030 there will be a global shortage of an estimated 18 million healthcare workers, with an additional 130 million people in need of humanitarian assistance, and at least 400 million people lacking access to basic healthcare[9]. In Europe, the European Commission highlights that almost 5% of the population reporting that they have unmet needs for a medical examination or treatment mainly because of high healthcare costs and waiting lists[10]. Therefore, investing in self-care and prevention programmes offered widely to the public, can aid in being able to provide more costly and targeted interventions to those who need more support and are not helped only by self-help type interventions.

3. Psychological services for supporting informal (non-professional) community care

3.1 Informal community care is important in integrating communities and towards the rehabilitation of people with mental illness. This also includes prevention which is not covered in detail in this section. Informal carers are fundamental to any health and social care system and therefore

supporting these caregivers and identifying potential risk factors for their mental health and preventing burnout is essential.

3.2 Work has shown detrimental mental health effects of being a carer. The EUFAMI's Caring for Carers Survey[11] which included 1,000 carers in 22 countries revealed that whilst carers face positive experiences, more than one in three experience high levels of anxiety with detrimental effects on their health, with an additional 15% feeling stigmatised. A further study based on 700 informal carers in Europe and Canada recommended investment in supportive measures in order to provide carers supporting someone with mental health problems a break from the 'caring week'. They also suggested that carers have a right to an assessment of their mental health needs[12]. Furthermore, they highlighted the need to invest in and evaluate measures aimed at reducing levels of loneliness and increasing access to emotional support, including helplines and peer-support groups.

3.3 Psychological services for informal carers need to identify those who are vulnerable and need support. One such group are carers who are living with the person they are supporting. They are at greater risk of loneliness and worse mental health outcomes[13]. A neglected population of carers are young carers who are estimated worldwide to represent 2%-8% of informal carers, with their percentage expected to increase in the coming years[14]. ''Young carers' are children and young adults under the age of 25 providing unpaid support to a family member living for example with a mental health condition, or other disability[15]. This population has specific unmet needs and their journey through the health systems has thus far been understudied[16]. Depending on the needs, many carers may be effectively supported by fostering self-care services, others may need more extensive care.

3.4 Providing psychological services in the community however also extends beyond the traditional remit of caring for and empowering the individual. Psychologists can do so by looking at the issues in a specific community (e.g., school, police department, indigenous community, individuals with a stigmatised disease) through an ecological perspective, in recognition of the fact that the majority of the determinants of health and mental health in particular, are socially and not individually determined[17]. When doing so it can support the mental health of community members by engaging a broad spectrum of the community and stakeholders involved, fostering collaboration, and sharing of information, resources, risks, and rewards for mutual benefit of community members. To achieve these outcomes, it is inevitable that practice of a democratic approach towards social change is needed, based on the promotion of active citizenship and empowerment, which in turn leads towards an approach that builds on a community's strengths[18].

3.5 When dealing with the issue of school violence for example, a community-focused approach to mental health, even when practiced in public health systems, recognises that working with offenders and victims is not enough. Rather, working with all students, teachers and other stakeholders to address bullying, foster an egalitarian climate among students and an active approach towards violence prevention by bystanders, as well as ensuring a culturally responsive environment is vital[19]. Greater professional as well as peer-to-peer mental health support to teachers, parents and student bystanders is also effective, as well as efforts to change the school climate and attitudes towards discipline and violence in the local community[20].

3.6 Among the myriad of other community interventions, sometimes lead by psychologists from the public health care system, are peer-support programmes for medical staff[21] or police officers[22], programmes to improve the mental health of stigmatized communities[23] and interventions to improve workplace mental health[24]. They all strive towards empowering different non-professionals to support the mental health of their community members, thereby increasing the sustainability and reach of psychological mental health interventions.

4. Psychological services in primary care

4.1 Within a stepped care model such as the pyramid model of the WHO, the importance of primary care cannot be overestimated. Primary care is often the first contact for a patient with a professional presenting with any kind of health issue (formal care). It is important for health professionals to be able to recognise mental health issues and their impact on physical health problem presentation.

The characteristics of mental health services within primary care are:

- Firstly, services need to be accessible both in location and capacity. Waiting lists in primary care are to be avoided.
- Interventions need to be limited in time (brief interventions) and focused on indication (i.e., can this question be answered through means of a short intervention or is referral necessary?) so as to avoid waiting lists.
- Adoption of a generalist approach as psychologists will be confronted with a very broad range of mental health issues. This means they cannot afford to select patients based on their questions or the preferred model of treatment of the professional.
- Integration within the local health network and good cooperation and communication with other health personnel, acting as members of a multidisciplinary team. Referrals for mental health services may result from colleagues in primary care (e.g., general practitioner) or from more specialised layers in the health system.
- Flexibility in working hours and availability for emergencies.
- Understanding of medical functions, procedures, habits, and medical interventions as well as the emotional and psychological barriers that interfere with medical procedures and services (e.g., adherence problems).
- Specific tasks for a primary care psychologist would include: to provide for brief, easy - access and generalistic psychological care for non-complex (mental) health issues, to work closely together with other professionals in primary care in a network model, prevention via interventions targeting health compromising habits and aiding in the adoption of healthy habits and functional coping with difficulties, early detection and intervention in mental health problems, screening and indication for possible referral towards more specialised care, low-intensity follow-up of stable chronic health conditions.

4.2 Psychological services offered in a primary care context need to be attuned to these specific characteristics. This has implications both for the interventions that can be used as well as for the training and competencies of psychologists working in primary care. It will be important to make use of the competencies psychologists have to: identify social needs and vulnerabilities; orient other professionals; and promote preventative interventions suitable for community contexts.

4.3 There is also reflection on how to integrate mental health services into existing primary care services such as a general practice. According to Gatchel & Oordt[25] and their model of co-located clinics, mental health providers can be co-located within general primary care clinics. Mental health professionals need to be available for consultation and triage, as well as educating other health care

professionals on how to deal with individuals seeking services and their families. The psychologists in such a model are an integral part of the health care team. Mental health professionals within primary care assess everyone, conduct a functional analysis and case formulation and proceed to offer services ranging from encouraging self-care interventions to providing group interventions, to more targeted individual therapeutic services as needed.

4.4 Most of the (recent) mental health reforms in the EU focus very strongly on the reinforcement of primary care. In the United Kingdom, a large programme was funded to render psychological services more accessible in primary care, the Improving Access to Psychological Therapies (IAPT) programme[26].

5. Psychological services within community mental health services

5.1 Community-level mental health services happen in many structures depending on the national organisation of services. They can happen in specialised mental health units at a primary care level, provision of mental health care in a general hospital (i.e., non-psychiatric), social sector (e.g., NGO) or private entities focused on the community. Unlike the interventions at a primary care level, the focus at this level is not on prevention or early intervention but rather treatment. It is important to highlight that there is a continuum in service delivery from primary care, community care and mental health specialised services (discussed further on).

5.2 The provision of psychological services at this level comprises of several traditional psychology and psychotherapy interventions for common affective disorders. Such interventions can be highly effective[27]. The study of these interventions has not only been conducted through randomised controlled trials but also in real-world settings focusing on effectiveness and implementation issues. Finally, process research (i.e., research into the mechanisms through which these interventions result in change) has reinforced the theoretical underpinning of psychotherapy and psychological interventions.

5.3 Besides having different interventions for specific conditions or problems, several interventions have been developed focused on particular groups (e.g., children and adolescents). These interventions and the comparison across groups (including culturally defined groups) suggest a universality in the usefulness of psychological interventions. Psychological interventions and psychotherapy have been developed for individuals, couples, families, and groups (i.e., group therapy).

5.4 Finally, despite not being the sole focus, community interventions developed within psychology have an essential role in addressing community mental health. These interventions can be broad or focused on specific groups, like homeless individuals or migrants.

5.5 Psychological interventions can also target physical illnesses not addressed in primary care[28]. In these instances, often, the focus includes psychological adaptation and dealing with the mental health consequences of physical illness. Among more conceptual contexts, studied examples can be found in cancer treatment, palliative care, dementia and AIDS. The intervention on psychological dimensions, besides preventing and dealing with mental health issues, also have implications for health outcomes.

5.6 Overall, psychological services at the community level tend to be more targeted and intensive and can last for numerous sessions. Community level psychologists are also tasked with identifying those individuals who may need additional and more intensive services, maybe in specialised

psychiatric hospitals. Early identification of these cases is important to provide a better level of care, more targeted to the needs of the individual, decrease costs and aid the person manage their condition in a timely and effective way.

6. Psychological services within highly specialised psychiatric hospitals

6.1 Psychological care within specialised mental health or psychiatric hospital facilities is needed in cases where all other levels of care have failed or are not sufficient to help a person overcome difficulties. In these cases, specialised psychological care that is more intensive and highly individualised is required. It is important through the pyramid of care to identify individuals who may warrant more specialised care since if left unidentified and untreated there are increased risks for suicide, longer treatment course and higher overall costs to the person, their families, the health care system and society more generally[29,30]. Early possible indicators that can alert psychologists to the need for more specialised care include: depressive mood characterised by suicidal thoughts and rumination, earlier age of onset of problems and symptomatology and older age at present, absence of remission or only partial remission following other forms of treatment (including pharmacology), presence of other (psychological and medical) comorbid conditions and especially Post-Traumatic Stress Disorder (PTSD), bipolar conditions, major depression, personality disorder traits, substance abuse, and severe chronic pain[31]. Additional individual difference characteristics associated with need for more specialised care include: experiential avoidance and psychological inflexibility[32], low self-directedness, reward dependence and extraversion[33], high disconnection and rejection[34], overvigilance and neuroticism[35], external locus of control[36], low physical functioning and physical quality of life[37], and multiple childhood traumas[38]. Socioeconomic variables are also associated with need for more specialised care, such as low or absence of social support[39] and being socioeconomically disadvantaged[40].

6.2 One problem that often arises in care settings that tends to be largely ignored and contributes to delayed or inadequate response by the system is treatment non-response at all previous levels of care and even in specialised settings[32]. Treatment non-responders tend to be characterised by comorbidities, chronicity of difficulties and persistence of symptoms. Estimates suggest that more than a third of psychiatric patients do not respond to their first line of therapy[40]. Newer approaches to therapy (e.g., Acceptance and Commitment Therapy) have been proposed as interventions that can aid this group of individuals in need of services[41]. Interventions for this population of individuals may need to be more intensive, continuous, and focused on patients' wellbeing and functioning while reducing suffering and maintaining any treatment gains over time. To aid in integration, these specialised residential treatments should where possible be delivered in close collaboration with local mental health services, family doctors / general medical practitioners and other services involved in care such as social care.

6.3 Other important examples for consideration as part of psychological services in highly specialised psychiatric hospitals are psychological programmes in psychiatric hospitals or using medication programmes through nurses.

7. Special issues

7.1 Code of ethics

Across Europe, psychologists are (often) considered as healthcare professionals. However, in practice, they (are required to) uphold their own professionals standards which sometimes differ from those of other healthcare professionals. An overarching ethical and deontological code, which has guided and often inspired national ethical and deontological codes, is EFPA's Meta Code of Ethics[42], which is built on a number of key principles: respect for a person's rights and dignity, competence, responsibility, and integrity. Adherence to this code is essential to uphold the professional standards of psychologists. Sometimes, these principles may conflict with existing practices within healthcare (e.g., professional confidentiality when working in multidisciplinary teams). While the far-reaching framework might feel restrictive, it nevertheless puts clients and their interests centre-stage.

7.2 Psychology and E–health

7.2.1 When it comes to eHealth, psychologists have an important role to play, both in the delivery, as well as in the conceptualisation of digital tools and services. Digital mental health (DMH) interventions can be found across the whole continuum of services from mental health promotion and mental disorder prevention to full treatment of mental disorders, as well as interventions for relapse prevention or for the recurrence and the management of chronic conditions. These also encompass a wide range of technologies: from basic websites and apps, over wearables to immersive technologies and even digital phenotyping[43].

7.2.2 Considering the capacity of DMH interventions to offer high-quality care, the most established and researched are internet-based interventions which have proven to be effective for a wide range of (mental) health disorders[44]. These are often developed as self-help interventions which makes them highly scalable and an interesting opportunity to increase access to mental healthcare services. In more recent years, research has however shown that these interventions, often developed by psychologists in collaboration with IT professionals, tend to underperform in real-life compared to controlled studies. High drop-out seems to be one of the main challenges. Although self-help interventions have merits in specific contexts and for a niche of the population, most interventions are increasingly being offered in a guided or blended format. In these types of interventions, minimal support is provided by a mental healthcare professional such as a psychologist for users to adhere to the programme and to push through. In a blended format, online interventions are combined with more conventional practices.

7.2.3 When focusing on the development of DMH interventions, psychologists have a twofold role to play. On the one hand, they offer insights into theoretical frameworks and existing evidence-base for (behaviour) change that aid the conceptualisation of these interventions. On the other hand, they also increasingly play a role in the actual development of these interventions. In this capacity, they aid developers to improve engagement and increase adherence, by involving end-users in the conceptualisation process, for example through co-creation.

7.2.4 DMH is also starting to advance psychological assessment at both an individual and population level. Methods such as ecological momentary assessment (EMA)[45,46] and assessment of free text using machine learning and text-based transformer model[47] promise to provide a more ecologically valid and rich assessment of psychological dynamics and function in daily life. During the COVID-19 pandemic such machine learning methods have also been used to estimate the prevalence and changes in the

mental health of populations[48]. However, as a recent review indicates, there is much methodological knowhow that needs to be integrated with psychological knowledge to make such DMH methods reliable, unbiased and clinically actionable[49].

8. Contextualisation

8.1 Implementing a strategy of reorganising service delivery is hard to do in a universal manner. Such implementation is bound to meet local resistance from objective limitations and/or cultural dimensions. With respect to objective limitations, several factors should be considered. Firstly, the global level of spending in health care, associated with the richness of a country is important. Health systems with more resources can provide more specialised care, invest in new programmes and address less urgent needs of citizens. Rich countries have higher degrees of freedom in the choices that can be made. Secondly, the demographic characterisation of the context of application is important. More populous countries or those with a higher density can have a greater provider mass with more specialisation than sparsely populated regions. The way the services are organised will determine how to implement such changes. Some European countries have public-based centralised systems while others have private-based decentralised provision of care. These differences mean that any reorganisation of services will have to be fundamentally different across countries. Finally, each country has different targets according to societal demands. Some countries are particularly faced with the issues of an aging population; several problems (e.g., addictive behaviors such as alcohol use) are more relevant in some countries rather than others.

8.2 A second type of challenge comes from more transient factors. A tradition of differentiating interventions may not be familiar to mental health professionals, including psychologists. Low intensity interventions, provided to a greater number of individuals with corresponding needs, are often seen as half-a-treatment, irrespective of their effectiveness or suitability to clients. Professionals may also not be trained in the specific intervention level in which they are integrated. Secondly, tensions between levels of provision of care may also arise when citizens are referred prematurely to higher levels. This is much more relevant in an environment of scarcity of health provision resources. Finally, it is important to consider that such a specialised organisation of services is based on a particular worldview in which evidence-based, pragmatic specialisation and need-dose matching are central components. Such a global view in the provision of care may collide with existing cultural values and traditions and hence lead to resistances.

8.3 The need to contextually adapt the provision of services is hardly incompatible with the differentiation of interventions. This means that the pyramid will have different sizes, slopes and even levels according to each national reality. Furthermore, the targets for interventions will vary across countries based on societal needs and demands. Finally, any change should be negotiated with the relevant stakeholders. It is better to have an imperfect compromise that is applied than a perfect solution that is resisted. In any case such reorganisation of services should follow two main goals. Firstly, greater attention should be given to prevention and early intervention rather than treatment. This is a cost-effective principle in the sense that early intervention and prevention tend to be less costly and the consequences of chronicisation are very burdening. Secondly, the differentiation of interventions allows for a greater access to the health system of a greater number of individuals. This is an essential gain of such a reorganisation, irrespective of the context in which it is implemented and its extension.

8.4 Overall, according to the European Commission[50] mental health care presently has not yet adequately addressed the complex challenges of mental health problems, which continue to afflict humans and contribute majorly (1 in 6 of the EU adult population) to disability globally. This calls for a radical change and shift in the paradigm of mental health care. Adopting a public health stepped-care approach as proposed by WHO is one step in this direction. Encompassed in these efforts should also be the improvement of standards of psychology training and competence, developing new research methods and re-envisioning current models of mental health care and its delivery[51]. Specialised competencies for community and preventative interventions should also be widely used. Collaborative care, prevention efforts and encouragement of self-care, grounded in science and evidence-based approaches should not be understated as the way forward with emphasis and resources placed to provide services at the lower levels of the WHO pyramid.

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