

Improving access to primary mental health care: uncontrolled evaluation of a pilot self-help clinic

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SUMMARY

Psychological therapy is widespread in primary care, but demand often exceeds supply. Innovative self-help approaches may overcome some problems associated with access to therapists. The feasibility, acceptability, efficiency, and effectiveness of a fast-access mental health self-help clinic were examined in a pilot study. The therapist saw 159 patients in 16 months, and on average required only one hour per patient. Generally, patients who used the clinic were satisfied. They reported similar levels of distress at baseline as patients in traditional psychological therapy services, and comparable outcomes. The self-help clinic approach should be evaluated formally within a randomised controlled trial.

Keywords: self-help; mental health; access to care.

Introduction

PROVIDING access to effective mental health treatment is a key goal for primary care,¹ and many practices have deployed psychological therapists to provide on-site services. However, the prevalence of mental health problems means that such services rapidly develop long waiting lists.²

Self-help treatments, such as books, are effective,^{2,3} and an alternative model of mental health provision² proposes that such interventions could be the initial treatment of choice, with traditional therapy reserved for a proportion of patients; for example, those who fail to benefit from self-help or who are at risk. One model of self-help involves clinics in primary care, run by specialist mental health staff, who assess patients, advise on appropriate materials, and monitor progress. Limited face-to-face therapist input means that more patients can be helped compared with traditional therapies. Clinics might usefully complement traditional services.

This paper describes an uncontrolled pilot of a fast-access mental health self-help clinic in primary care.

Method

The aim of the study was to examine the following: acceptability (number of referrals to the clinic, patient attendance, and patient satisfaction); efficiency (therapist input per patient, patient use of other health services); and effectiveness (problem severity at follow-up). Such uncontrolled outcome data has limited validity, but measures can at least ensure that outcome is comparable to that achieved by current mental health services.

The site was a training practice in the southern part of Greater Manchester, which had 10 general practitioners (GPs), with a practice population of 16 000. Patients were referred by primary care staff, or self-referred, between May 2000 and August 2001. Inclusion criteria were age 16 years or over, with a GP diagnosis of depression or anxiety. No standardised diagnostic tool was used. Exclusion criteria were substance misuse, organic brain disease, risk to themselves or to others or psychosis.

The clinic operated one day per week and offered rapid access, i.e. within one to two weeks, to a 30-minute assessment by a nurse therapist, followed by 15-minute follow-ups, usually fortnightly, to monitor progress. Patients received individually tailored programmes of self-help supported by the therapist. The therapist was an academic senior lecturer and mental health nurse with an English National Board of Nursing certificate in adult behavioural psychotherapy, and 16 years' experience of treating patients with cognitive behavioural therapy and of training professionals in these

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HOW THIS FITS IN

What do we know?

Traditional psychological therapy relies on experienced therapists, which means that demand for therapy often exceeds supply. Alternative models of provision, such as those focused on self-help materials, may be one way of overcoming problems with access to services without compromising effectiveness.

What does this paper add?

This study suggests that a clinic providing support with self-help materials is feasible, acceptable to patients, efficient, and should be evaluated formally within a randomised controlled trial.



techniques. Self-help consisted of behavioural, cognitive, and lifestyle advice using previously published manuals and materials.⁴⁻⁶ Patients who were inappropriately referred were returned to the GP or received recommendations on more appropriate help.

The Clinical Outcomes in Routine Evaluation (CORE) 18-item self-report questionnaire⁷ was used to measure wellbeing, symptoms, functioning, and risk at baseline and at follow-ups after three and six months. Five-point scales were used at three months to assess overall satisfaction (rated from 'very satisfied' to 'very unsatisfied'), future use of the clinic, and likelihood of recommending the clinic to others (rated from 'definitely' to 'definitely not'). Patients' notes from the six months before and after referral were examined with regard to GP consultations, psychotropic prescriptions, and mental health referrals.

The CORE data was compared with published data from other primary care psychological therapy providers,⁸ using measures of 'clinically significant' and 'reliable' change based on established statistical procedures.^{7,9} 'Clinically significant' change in CORE scores moves a person from a score typical of a 'clinical' group to a score typical of a 'normal' population (based on normative data). 'Reliable' change is of sufficient magnitude that it is unlikely to be owing to measurement unreliability.

Results

Figure 1 shows patient flow through the clinic.

Acceptability

Of the patients attending the clinic, 112/137 (81.8%) attended multiple appointments. At the three-month follow-up, 83/137 (60.6%) provided satisfaction data, of whom 73/83 (88.0%) patients were 'very satisfied' or 'satisfied' with the clinic, 74/83 (89.2%) would 'definitely' or 'probably' use the clinic again, and 74/83 (89.2%) would 'definitely' or 'probably' recommend the clinic to others.

Efficiency

The therapist saw 159 patients in 16 months. The mean number of sessions per patient was 3.4 (SD [standard deviation] = 2.3, range = 1 to 12, *n* = 137), with an average total

time of 58.3 minutes (SD = 33.1, range = 10 to 184, *n* = 137). There was no significant change in health services utilisation before and after referral to the clinic (data not presented), and 16/137 (11.7%) patients were referred to other mental health services in the six months after referral to the clinic.

Effectiveness

Baseline CORE data was available for 104/137 (75.9%) patients and, of these, 84/104 (80.8%) and 60/104 (57.7%) provided data at three and six months (Table 1). In summary, baseline scores of patients in the clinic, and their outcomes, were broadly comparable to those from the historical data.

Discussion

Acceptability

The high rate of referral suggested that the clinic was acceptable to GPs, and that patient satisfaction was high, and most patients who were offered the clinic attended multiple sessions. Satisfaction data has limitations, and attrition was relatively high. However, the data suggest that a significant proportion of patients in primary care would find the clinic acceptable.

Efficiency

The high rate of patient throughput (159 patients over 16 months) and the minimal therapist input (mean = 1 hour), highlighted the clinic's efficiency. However, controlled evaluation and longer-term follow-up is required to ensure that these benefits are real and that the need for traditional mental health services is not simply delayed.

Effectiveness

Spontaneous remission means that uncontrolled outcome data is difficult to interpret, especially given attrition at baseline and follow-up, and comparisons with published historical data are open to bias. However, counselling services are widely used in primary care and are known to be modestly clinically effective.¹⁰ Demonstrating that the clinic achieves outcomes similar to counselling services does suggest that patients in the clinic are not being offered markedly less effective treatments, although rigorous proof of equivalence will require a controlled trial.

The therapist had extensive experience in self-help treatment, which reduces the external validity of the results. The degree to which the effectiveness of the clinic can be maintained by less experienced clinicians clearly requires further investigation.

Conclusion

The study suggests that clinics might usefully complement traditional psychological therapy services. The intensity of clinic work precludes it being more than a proportion of any worker's clinical time.

However, definitive evaluation of the clinic requires a controlled trial to provide unbiased comparisons of both outcomes and costs in clinics and traditional therapies, and to

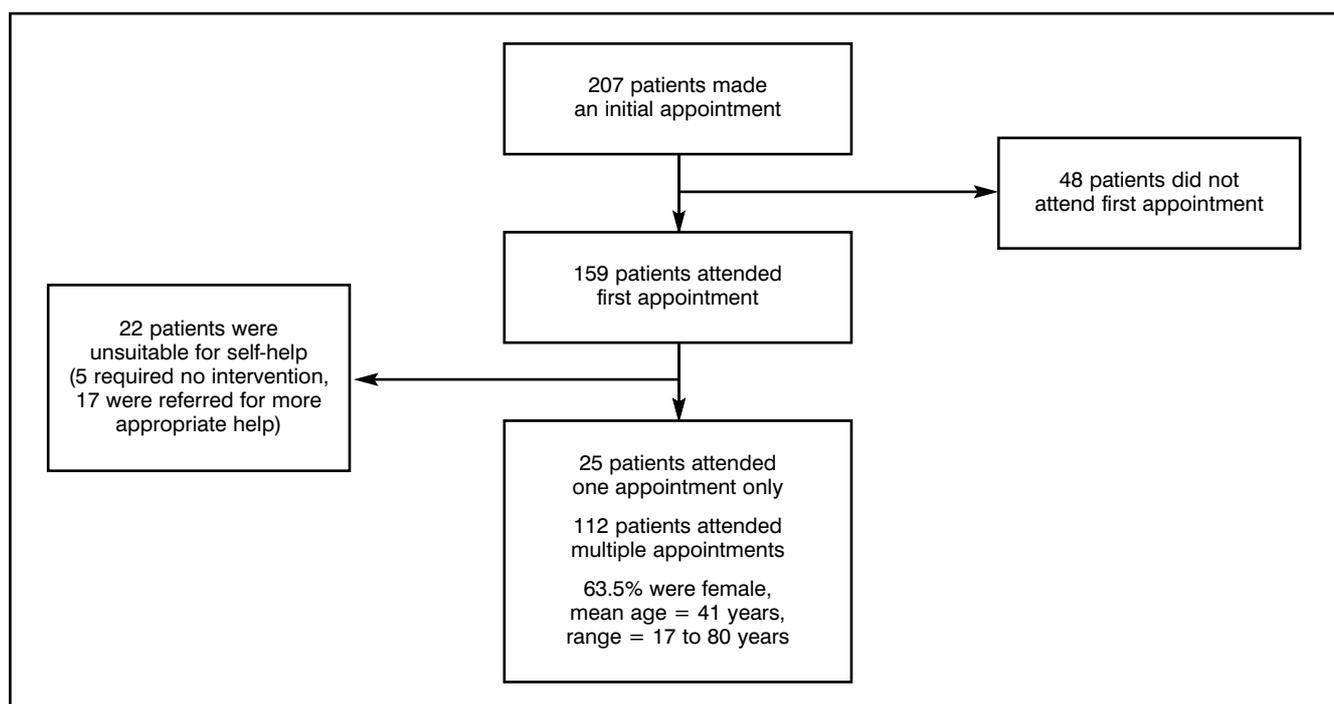


Figure 1. Patient flow through the clinic.

Table 1. Baseline CORE scores, and reliable and clinically significant change in the clinic and in published comparative data.

	Clinic data (n = 104)		Comparative data (n = 1087)
	Three months	Six months	Post therapy
Mean baseline CORE scores (SD)	1.8 (0.7)	1.76 (0.6)	
Follow-up scores (%)			
Clinically significant and reliable change	48	61	59
Reliable change only	15	14	17
Unreliable change	36	22	23
Reliable deterioration	4	3	2

ensure that the present results generalise to other therapists and settings. Evaluation of such an intervention is complex, and may benefit from qualitative methods.

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