Layered care: a proposal to develop better primary care mental health services

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ABSTRACT

There is increasing pressure on primary care mental health services to meet more needs in the community, provide new and different methods of delivering services, and redesign care pathways and models of care. Layered care is a response to these requirements; it is a development of the stepped care approach that could provide a quicker, more accessible and user-involved experience for patients. The model provides patients with easy access to a variety of mental health responses that build up into an individual programme through one initial contact with a mental health worker. It provides access to a range of services from minimal interventions (e.g. support, advice, information) to more specialist mental health treatments (e.g. counselling, cognitive–behavioural therapy (CBT), psychotherapy). Following the general practitioner’s initial triage assessment there is a single point entry into layered care through a new role, the key worker, who may be a primary care mental health worker. This person meets with the patient, and discusses and selects from a variety of treatment or non-treatment options for their individual care plan. The model therefore enables service users to construct their own individual treatment package. Integral to the layered care model is the belief that greater collaboration, shared care, user involvement and integration between primary and secondary mental health services are required to modernise primary care mental health services and simplify care pathways. This paper presents the layered care model and the thinking behind it for criticism, discussion and consideration of its suitability in primary care settings.

Keywords: ??????????

Introduction

One in four general practitioner (GP) consultations are for mental health problems and managed in primary care; it is the first point of contact for over 90% of patients experiencing mental health problems, often because GPs are viewed as less stigmatising.¹

Providers and commissioners are encouraged to develop more flexible models of delivery of treatment in order to meet these high levels of need in primary care [through] facilitated self-help, group work, and stepped care.² At present counselling is the main treatment and provided in the majority of GP surgeries.³ Nevertheless, reliance on traditional counselling as the main psychological treatment in primary care often precludes patients from benefiting from a variety of other mental health interventions that could help more immediately and cost-effectively. When providing mental health services in primary care it is suggested that instead of asking what counselling resources we need, it is better to ask how we can help people in the community to...
help themselves. What is required is a comprehensive and flexible system of primary care mental health delivery that allows a variety of community-based interventions to be available, while also preserving access to counselling, psychotherapy and other specialist mental health services. Layered care is a proposed system that could meet these new challenges and provide better mental health services.

Mental healthcare systems

At present there is encouragement to think about reconfiguring primary care mental health services along the lines of primary care mental health systems or systems of primary mental healthcare. One example is the primary care mental health team (PCMHT), which provides a single point of access, liaises with secondary care, runs clinics in local practices and provides link working, but the PCMHT requires major reorganisation and reconfiguration of staff and services.

Layered care is a comprehensive mental health system that could meet these requirements without large-scale service redesign. It is developed from the stepped care models found in the USA. Layered care provides:

- a single and simple point of entry
- minimum wait
- an individualised programme for each patient
- access to multiple treatments and professionals
- a key person responsible for each patient
- user-led treatment planning
- evaluation
- integration with secondary care services.

Stepped care

Stepped care employs a set of predetermined guidelines to determine the initial least intrusive intervention that is efficient in use of treatment resources and has the best chance of being effective. Failing success at the first level, stepped care provides for an escalation to more extensive and costly treatments with the proportion of patients requiring them becoming relatively smaller. The stepped care model is shown in Figure 1.

Stepped care has long been the basis for medical treatment; after symptoms have been evaluated an individualised treatment plan that is the least intensive and congruent with having a successful outcome is provided. For example, aspirin is the first treatment of choice for headache; expensive and intrusive investigations and treatments would only occur later if symptoms worsened. Stepped care proceeds in a systematic approach to move a patient through a hierarchy of treatments to find the ‘best’ one. In mental health it has been suggested that cognitive–behavioural therapy (CBT) might be delivered using a stepped care approach instead of traditional service models which ‘disenfranchise the majority of people who would benefit from CBT’. Other applications include:

- nicotine and alcohol dependence
- eating disorders
- anxiety
- and particularly depression.

However, there is a paucity of research on its application in mental health, partly due to the ‘methodological challenges facing the implementation and analysis of sequential experimental design’ which
are required to assess the effectiveness of stepped care type approaches.\textsuperscript{21} There are more general concerns about the model; when should therapist switch from one step to the next, what are the criteria, does failure at a lower level of treatment discourage the patient from subsequent treatment, and does repeatedly changing treatment lead to patients ‘demoralized by treatment failure’ and ‘getting worse from ineffective treatments’?\textsuperscript{21,22} It seems pointless to require patients with complex mental health problems to pass through one stepped care treatment at a time if specialised treatment is required. Furthermore, in stepped care different treatments cannot be intermixed at the same time – for example providing support and information combined with referral for specialised psychotherapy and attendance at a self-help group.

**Layered care**

Layered care is a modified stepped care model that responds to these problems. Patients are not required to have an initial treatment that is the most basic, they could have more specialised interventions without moving through the stepped treatments, and access other layers of treatment is be determined by clinical assessment not the rigid stepped hierarchy.\textsuperscript{21}

Layered care makes available multiple layers of treatment for each patient. Many of these layers will already be in place (e.g. counselling, psychotherapy, clinical psychology), and others will need to be created; for example people with mental health problems have been found to derive considerable assistance from self-help support groups and the use of self-help books.\textsuperscript{23–25} An individualised treatment programme is devised which will contain a mixture of these different treatment layers (see Figure 2). It is an example of a multiple access system; most patients will receive the less intensive interventions, the principle of selecting the least intrusive and costly ones first is maintained but there is also access to the higher layers.\textsuperscript{4,13} This flexibility enables patients with more complex disorders to be referred for specialist assessment and treatment interventions, but also to receive input at the lower levels while waiting.

As the example in Figure 2 illustrates, patients can start with immediate participation in mental health support groups, stress management, and contact with the voluntary sector while waiting for specialised treatment. Because early intervention can reduce disturbance there is the possibility this may be no longer required, but if it is, the containment may allow greater benefit from specialised treatment by preventing deterioration during the wait.

**Figure 2** Example of a patient’s layered care programme. The bold lines indicate the layers of the treatment plant. This patient with complex personality and mental health problems requires input from the voluntary sector, an ongoing mental health group, and anxiety management, while waiting for specialist psychotherapy and psychology assessment.
The literature relating to management for depression supports the principles layered care is based upon. These principles include: employing collaborative partnerships, co-ordinating care, using collaborative stepped care models, providing multifaceted integrated approaches and psychosocial treatments (Howell, 2004), responding to patient’s request for quick access to services ‘that do more to reach out to them’ (Kadam, Croft, McLeod, and Hutchinson, 2001, p. 379), and using self-administered treatments (Scogin et al., 2003).18,19,26–30

Following assessment, the GP refers the patient to a keyworker for further evaluation and, if appropriate, a treatment plan. Keyworkers would be mental health professionals who co-ordinate and review the delivery of multicomponent interventions, commonly described as ‘behavioral health professionals’ in the USA.18 They have been used for many years in residential, and other social and mental health care settings, for example learning disabilities and the collaborative stepped care treatment of depression.18,31

Keyworkers

Keyworkers are central to the layered care model and provide the following:

- linking and co-ordinating with other services
- support, advice and information
- designing individual therapeutic programmes
- a named person for the patient
- monitoring, review and discharge.

A consensus is emerging about the need for a named key or link person to co-ordinate primary mental health interventions for service users. The National Service Framework describes the role of the link worker; this person maintains communication between primary and secondary care, advises patients, directs referrals and ensures that shared care arrangements actually work.6 Also the Sainsbury Centre for Mental Health Report Primary Solutions discusses a primary care worker who assesses, makes referrals, supports other care staff, monitors progress and adherence to treatment, gives self-help advice, and facilitates primary/secondary care liaison.7

The keyworker role in layered care is particularly suited to the new UK primary care mental health workers (PCMHW). Their recommended functions include support, delivery of brief evidence-based therapeutic interventions and self-help techniques, and strengthening the information available to patients with common mental health problems.32,33 They are described as having a role in case management in collaborative care models (e.g. stepped care), referral facilitation, mental health assessment, and linking services (e.g. voluntary sector and secondary mental health).4,8 It could be argued that PCMHWs are unsuitable for this role because considerable assessment skills might be required to direct a patient to the appropriate level of care. This may be true for the higher levels of specialist psychological therapies, but for most patients what will be required is in-depth knowledge of self-help materials, brief intervention techniques, the local voluntary and statutory services, signposting and information. Training and supervision would enable PCMHWs to make appropriate referrals for specialist assessment. It would be self-defeating to restrict access to layered care to those patients who have received a prior in-depth specialist assessment.

Keyworkers would rotate between GP surgeries so that they are readily available to patients and primary care staff. However, the role is not restricted to any one group; members of other mental health professions may take on the keyworker function from time to time for particular patients. Colleagues in secondary mental healthcare could also access primary care mental health services by linking the patient with a keyworker for a particular piece of therapeutic work, for example a self-help support group, while maintaining their overall case responsibility in secondary care. It is unlikely though that the new gateway workers and support time and recovery workers (STAR) could perform the keyworker function. The prime responsibility of gateway workers is to strengthen access and provide community triage for people who need urgent contact with specialist mental health services, and STARs are meant to provide support to service users by giving time and aiding recovery.34,35

Examples

To illustrate how layered care would operate in practice, two hypothetical examples are presented; they are based on typical mental health problems that present in primary care.

Case 1

An older aged woman with a chronic health problem referred by her GP for moderate depression. She had suffered for some time but her problems are exacerbated by a move to a new area where she is isolated, spends days at home alone, and has developed negative thought patterns. Lack of social support and severe financial problems contribute to her low mood and self-esteem. Her layers of care would involve:

- referral to a local ‘fun, friendship and fitness group’ for the over 50s
Layers of expertise

A final point: less experienced and trained colleagues often find themselves struggling to help patients who require specialist input, and likewise highly trained and experienced professionals spend time giving basic support, advice and information. Layered care provides a range of responses requiring different levels of skills and knowledge. As Figure 3 shows, triage, specialist assessment and treatment functions require higher levels of expertise than providing support and information. The model therefore allows specialised professionals and those with specific specialist skills to retain those functions, and encourages those with generic mental health knowledge and skills to provide early intervention work that may produce earlier recovery.

Conclusions

To meet increasing demands in primary care mental health it is necessary to review existing methods of service delivery to ensure they provide a good quality service that meets service user needs, and employs staff resources wisely. Layered care is put forward as an attempt to respond to these requirements by developing stepped care into a more flexible and responsive primary care mental health system. It enables a broader range of interventions to be quickly and efficiently made available to service users with mental health problems in primary care. It allows a named person to be responsible for their treatment programme, is more efficient, and better co-ordinates the use of scarce expert resources. Particularly it also provides a role for the new primary care mental health workers. It could provide an alternative to traditional counselling ‘one size fits all’ services and be acceptable to primary care trusts, mental health commissioners, service providers and users.

ACKNOWLEDGEMENTS

Thanks to Sean McCoy, Mental Health Commissioner, Dartford Gravesham and Swanley Primary Care Mental Health Trust for supporting this project.

REFERENCES


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Accepted May 2005