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Together for better mental healthcare

Towards accessible and cost-effective primary mental healthcare

The low intensity SLP-model as a model of good practice

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The European MentALLY project

Mental health problems in adults are of great concern as they are highly prevalent and have significant impact on health, social welfare, and the economy. Psychological treatment – whether in combination with medication or otherwise – is effective, but has not been able to nullify the disparities that exist within mental healthcare. Suboptimal access or undertreatment and overtreatment of people seeking services have been reported. MentALLY's strategic aim is to gather the necessary empirical evidence to accelerate the evolution towards a European mental healthcare system that provides effective treatment to all adults who are in need. A carefully designed implementation and dissemination strategy will translate our empirical evidence in ways that will strengthen existing networks and improve practices.

The issue of accessibility and cost-effectiveness

According to the ESEMeD study on mental health in Europe (Alonso, 2002), the majority of people with mental health problems (45-75%) do not get professional help. Patients very often have to deal with long waiting lists, high costs and difficulties in finding the right specialist mental health services. The personal as well as societal consequences of a lack of treatment are high: suicide, absences at work, physical disabilities and criminal activities (Layard, 2015). Hence, the economic cost of mental health problems is enormous.

According to several researchers and policy makers, there is therefore a need for access to mental healthcare to become easier and more cost-effective way. Within the MentALLY project, we sought out examples of evidence-based models to realise this cost-effective accessibility. Within this fact sheet one specific model will be explained later.

How to enable accessibility and cost-effectiveness?

(1) Differentiate between mild and severe mental health problems

According to the study by Alonso (2002), the majority of the people who suffer from mental health problems (65%), deal with mild to moderate symptoms. The other 35% of patients suffer from more severe or very serious symptoms. Mental healthcare should hence have a:

1) Generalist/primary form of care dealing with the high number of people with mild to moderate problems;
2) A more specialised form of care dealing with the lower number of people that suffer from more severe and specialist problems.

(2) Combine targeted specialised care with sufficient primary care services

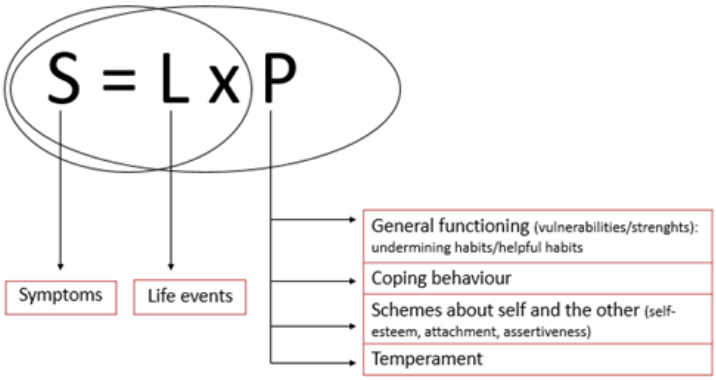
As stated by WHO in their guidelines for better mental healthcare organization (2007), there should be a reasonable quantity of mental health services at a primary care level and only a low number of high-cost long-stay services at a specialist mental healthcare level (such as inpatient beds in psychiatric hospitals). The de-institutionalization of mental healthcare has become a major topic of mental healthcare reform in Europe. Thus, innovative models for evidence-based treatment at a primary care level are needed.

(3) Evolve towards a trans diagnostic approach

According to Macneil, Hasty, Conus & Berk (2012), a diagnosis made solely on the basis of the DSM-5 can tell little about the form of intervention that needs to be undertaken. However, it also provides no information about the person's experience of their condition. Psychodiagnostics should therefore not focus primarily on detecting specific disorders, but rather on clarifying the role and function of a symptom within a person's functioning (Vanheule, 2017). In addition, recent scientific developments suggest that anxiety and mood disorders are more compatible than previously thought. As a result, the need for numerous diagnosis-specific treatments may be outdated and the possibility of more economical applications of evidence-based treatments in clinical practice is created (Ellard, Fairholme, Boisseau, Farchione & Barlow, 2010). Effective treatment of mental health problems should therefore make use of a trans diagnostic yet systematic approach rather than a diagnosis-specific approach.

The SLP-model as a form of good practice that enables accessibility and cost-effectiveness

The SLP-model is, amongst others, one of the evidence-based models that enables accessible and cost-effective primary mental healthcare (Rijnders, Heene & Boone, 2013; Van Orden, Hoffman, Haffman, Spinhoven & Hoencamp, 2009; Van Orden, 2018). The “SLP” is an acronym and refers to

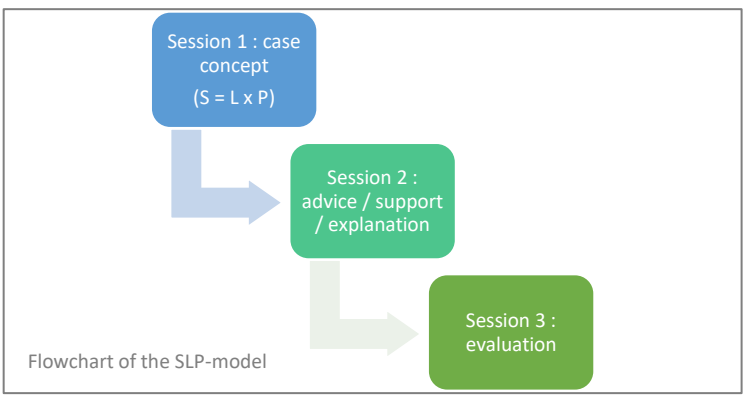


symptoms (S), life events (L) and personal characteristics and general functioning of the person (P). The SLP-model is an innovative solution to mild or moderate problem(s) of clients, general practitioners and employers dissatisfaction with mental healthcare services. Problems with inaccessible, stigmatizing services were reported (Rijnders, Cox & Starmans, 2018). The SLP-model has the aim to achieve maximum treatment results with a less intensive investment by the therapist (Rijnders, De Jongh & Pieters-Korteweg, 1999; Heene, 2015; Van Orden, et al., 2009; Van Orden, 2018).

The basic principles of the SLP-model

A fundamental hypothesis of the SLP-model is based on the assumption that each human being can become a service-user or can convert into being a patient when he or she loses an overview on what is happening in his/her life and how to cope with this in a proper way. This loss of overview is responsible for the loss of a sense of “mastery“ (Frank & Frank, 1991), and the loss of mastery in its turn is responsible for the onset of symptoms. Translating this into tasks for a therapist, this means that the first thing a therapist has to do is to help the patient regain overview or mastery. In addition, the following four aspects are also important basic principles of the SLP-model:

(1) Mental health professionals are part of a multidisciplinary team in general practitioner’s offices.
(2) Individuals with mild issues should be separated from those with severe mental health problems by clinical experts and/or measurement tools, with…
    a. Immediate treatment in cases of mild problems
    b. Referral to specialised care in case of severe problems
(3) Immediate treatment consists of:
    a. Three to six sessions
    b. A focus on general function
(4) Treatment is based on a straightforward and easy to use model: S (symptoms) = L (life events) x P (person)



Flowchart of the SLP-model

The working model of SLP: Five steps from problem to solution

In daily practice, the application of the SLP-model is worked out in the format of a guideline. The guideline covers five steps.

1. A guided exploration of symptoms, life domains and personal functioning

S(ymptoms)	L(ife events) / domains	P(erson)
• For example, panic attacks • Complaints • Disfunctionali elements • Measurement	• For example ,having a son with ADHD • Health • Work • Family • Relationships • Neighbourhood • Other	• For example, being a considerate person • Coping style • Schemes about oneself and others • General functioning/habits • Temperament

2. Shared problem definition

Together with the client, the member of mental healthcare staff works towards a working hypothesis “L x P = S” stating that

- Under the circumstances of L(ife events)
- a P(erson) with certain characteristics will behave as such
- that S(ymptoms) will occur.

3. Defining a target and pathway

The client and mental healthcare provider should think about how to:

- Reduce complaints and dysfunction (S). For example, using a smartphone application that helps the client to relax.
- Adequately use the available resources in the different life-domains (L). For example seeking support from family or friends.
- Optimally regulate habitual patterns (P). For example setting up a behavioural or cognitive experiment.

4. Working towards behavioural change

The goal of therapy is to support individuals in changing their position as a person (P) on a continuum of qualities and habits so that they become more skilful in reflecting upon and reacting reasonably to certain life-events (L), making the symptoms (S) unnecessary. This can be achieved by making use of techniques such as:

- Social learning
- Working with a sociogram
- Behavioural activation
- Solution-focused therapy
- Exposure
- Cognitive training

5. Relapse prevention

At the end of the treatment, the person should be supported in maintaining the behavioural change. This can be done by making use of techniques such as:

- Writing a letter to oneself
- Early sign detection
- Sending reminders to the client

During and after treatment, clients can make use of guided self-help tools. For example, rating themselves on a continuum from less to more rigid. These tools cover the five steps and are integrated in the Dutch book “From Problem to Solution” (Rijnders, Heene & Boone, 2013). This book is also translated in German (Wabnitz, P.), Spanish (De la Rubia-Gomez Moran, M.) and Hebrew (Meyers, J.).

Conclusion: an evidence-based and cost-effective model

Several studies (Rijnders et al., 2016; Van Straten et al, 2007; Van Orden et al., 2009; Van Orden, 2018, Vissers et al., 2017) have demonstrated that working with the SLP-model:

- **Lowers** the degree of emotional, relational and social distress on the OQ-45 (psychological thermometer) in an **average** of 5.9 sessions
- Induces a significant effect in 3 sessions
- **Works for** those with mild to moderate symptoms
- **Does not work for** those who have had a previous failed course of therapy and/or when there are high risks of a lack of safety

- **Requires** reflection and a readiness to try things out from the client, a supportive system around the patient and a reciprocal interaction between the patient and the health care provider
- **Works because** of
    - the focus on the general P(erson) more than the specific S(ymptoms)
    - the approach in which the interaction between P and L is tackled
    - it being combined with continuous evaluation and possibilities for enduring change

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