Editorials

Psychological therapies in primary care:

a progress report

In the February 2013 issue of the *BJGP*, we gave an overview of the use of cognitive behavioural therapy (CBT) in primary care, arguing that access to CBT and other psychological services such as mindfulness-based cognitive therapy (MBCT) could be improved.[1] We also suggested that further research into what works, for whom, and in what circumstances would be invaluable in order to make optimum use of available resources. Eighteen months on, we offer a progress report on the provision of psychological therapies in primary care in the UK.

In January 2014, the Department of Health (DoH) in England produced the document *Closing the Gap*, which outlined its 25 key priorities in mental health.[2] The document aims to bridge the gap between the long-term ambitions set out in the government's mental health strategy[3] and shorter-term action, such as how changes in local service planning and delivery will make a difference to people with mental health problems in the next 2 or 3 years. The priorities are laudable and include a pledge by the DoH to 'lead an information revolution around mental health and wellbeing' and to 'tackle inequalities around access to mental health services'.

IMPROVING ACCESS

In relation to psychological therapies, there is a commitment to increase the number of people accessing psychological therapies each year from 600 000 to 900 000, as a result of a further £450 million investment into the Improving Access to Psychological Therapies (IAPT) programme. Clinical Commissioning Groups (CCGs) are now being actively incentivised to increase access to psychological therapies through the Quality Premium scheme, which provides additional funding to those who meet key goals. In addition, there is a pledge to extend Children and Young People's IAPT across the whole of England by 2018.

As highlighted in our original editorial, potential indications for the use of psychological therapies reach well beyond 'simple' anxiety and depression. Patients with long-term conditions are at high risk of 'complex multimorbidity' consisting of both multiple physical and mental health conditions.[4] Such complex multimorbidity is socially patterned, occurring more frequently and at a younger age in areas of high socioeconomic deprivation.[5] Indeed, the IAPT action plan in 2011 extended the scope of services to include people with long-term physical conditions (LTCs), those with medically unexplained symptoms (MUS), and those with severe mental illness.[6] Services are still evolving to meet these increased demands, so it is no surprise that early results are mixed. For those with LTCs, for instance, referral to IAPT was associated in one study with the issue of a greater number of prescriptions for antidepressant medicines and less use of emergency services.[7] For those with MUS, however, referrals into IAPT remain low and many IAPT therapists lack training and experience in working with MUS.[8] It may be that low-intensity, short manualised approaches provide one effective option for MUS treatment.[9]

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NATIONAL AUDIT

The National Audit of Psychological Therapies (NAPT), which is concerned with psychological therapies solely for adults with anxiety and depression, showed wide variation in the availability, access, and uptake of psychological services across the country and between different groups.[10] It found, for example, that only 6% of those using services were over 65 years old, despite this group making up over 20% of the total population with these common mental health problems. Waiting times had improved since the initial audit in 2010, but 9% of people still had to wait more than 18 weeks from initial referral to receiving treatment. There were concerns, too, that fewer than a third of patients referred for high-intensity therapy received the minimum number of sessions recommended by the National Institute for Health and Care Excellence (NICE). Access to psychological services for the large number of people with physical and mental health conditions other than anxiety and depression is likely to be even more patchy and inconsistent.

DEVOLVED NATIONS

NAPT covers both IAPT and non-IAPT sites in England and Wales, but the approaches to increasing psychological services taken by the two nations, and those of Scotland and Northern Ireland, are quite different, with implications for the availability of those services.

In Wales, the Health Minister, Mark Drakeford, recently announced an additional £650 000 to improve access to psychological therapies. This may go some way to allay concerns about the availability of psychological services (and the relatively low number of trained therapists in particular), detailed in a 2013 Welsh Government-commissioned review of services.[11]

The strategy in Scotland has been to redesign existing services, rather than introduce a new service like IAPT. Unlike the Welsh Government, which has largely devolved responsibility for the implementation of policy to local health boards, the Scottish Government has produced detailed guidance in the form of the Matrix, which sets clear performance targets, with centralised planning for training through NHS Education for Scotland (NES).[12]

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In Northern Ireland, the 2010 Strategy for the Development of Psychological Therapy Services made recommendations for the commissioning and provision of psychological services, using a stepped-care approach.[13] It acknowledges that, until relatively recently, there were no formal therapy services directly available to general practice. From 2009, however, funding has been provided to introduce computerised CBT to every practice, albeit primarily designed to treat mild to moderate depression. We could not find any up-to-date information on the availability of psychological therapies in Northern Ireland, but it is likely that, as in the other home nations, the service is highly variable.

GP COMMISSIONING

England has taken a different trajectory from the other three countries of the UK by implementing GP commissioning for psychological services. The Joint Commissioning Panel for Mental Health (JCPMH), co-chaired by the Royal College of Psychiatrists and the Royal College of General Practitioners (RCGP), has developed practical guidance for commissioning of mental health services, but the full impact of this has yet to be seen.

Alongside this, the RCGP is committed to an enhanced and extended GP training programme, such that future GPs will receive specialist-led mental health training. However, it is the training of psychological therapists (for both low-intensity and high-intensity therapies) that is most needed.

In summary, it is clear that there is a firm commitment across all four home nations to increase access to psychological services. However, it remains unclear to what extent improved access has been achieved in relation to need in the populations served. A flat distribution of access and uptake in the face of the known steep social gradient in mental illness would likely worsen the inverse care law and widen rather than narrow health inequalities.[14,15] The pace of change and the distribution of additional resources will determine the progress each service can make in improving the mental health of their populations and, in so doing, achieving such aims as tackling 'inequalities around access to mental health services'.

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Competing interests
Chris Williams is author of a range of CBT-based resources that address anxiety, depression, and other disorders. These are available commercially as books, computerised CBT products, and classes. He receives royalties, and is shareholder and director of a company that commercialises these resources. Stewart Mercer and Alistair Wilson are trustees of the charity Mindfulness Scotland. David Blane and Jill Morrison declare no conflicts of interest.

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