

Editorial

Equity of access to psychological therapies†

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**Summary**

Improving access to psychological treatments for common mental disorders is a priority in a number of countries worldwide. We consider the evidence presented by Harris *et al* on the Australian Better Access initiative, and discuss the challenges of delivering such initiatives and evaluating their impact.

Declaration of interest

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Evidence-based medicine traditionally focuses on the effectiveness and cost-effectiveness of interventions, but a comprehensive assessment of quality of care also requires consideration of access.¹ In this edition of the *Journal*, Harris *et al* use epidemiological methods to evaluate the performance of the Australian Better Access initiative, designed to improve access to psychological therapies for affective and anxiety disorders.² Their work is highly relevant to other countries, including the UK, as the National Health Service (NHS) tries to assess the value of the UK Improving Access to Psychological Therapies programme, which has similar goals.³

The approach taken by Better Access has been to extend the supply of psychological therapy from the private sector to state-supported provision. What does their analysis tell us about this initiative, and what questions remain unanswered about this ambitious attempt to increase access to non-pharmacological treatments for people with depression and anxiety disorders?

To evaluate Better Access, we should consider questions relating to five core issues: access (who got treatment?), equity (were services targeted appropriately at need?), utilisation (what treatments did people receive?), effectiveness and cost-effectiveness (did they improve outcomes at a sustainable cost?) and patient-centredness (did the service meet patient needs?).⁴

Access and equity

In terms of access, the initiative appears to have been a major success. From the data presented here, there has been a large rise in the use of psychological therapies. Currently, more than one-third of patients receiving services from mental health professionals are using Better Access.

Initiatives such as Better Access and Improving Access to Psychological Therapies face the criticism that the service may be unable to reach those most at need, and are instead used by the literate and the empowered who already enjoy good access. Harris *et al* show that there is no substantial evidence of

socioeconomic inequality in utilisation. Unfortunately, however, data on ethnicity are not presented, an important consideration given that Black and ethnic minority groups experience poorer access compared with their majority White peers; addressing this is a major focus of the Improving Access to Psychological Therapies scheme. Nonetheless, the data provide initial encouraging evidence on access and equity, and the authors are to be commended for their use of rigorous epidemiological methods to provide such clear answers to these complex issues.

The data also raise a number of cautions. Of all those with a 12-month ICD–10 diagnosis of affective or anxiety disorder, 8.4% of people with anxiety and depression used Better Access psychological therapies, and only 39% received services at all. In the UK, approximately one-quarter of people with common mental health problems report receipt of treatment, with 5% receiving counselling and 5% combined counselling and medication.⁵ Of course, not all individuals with mental health problems are appropriate for psychological therapies, but the data demonstrate the gap that remains between provision and potential need, even in the context of an ambitious scheme such as Better Access. There was also considerable disparity in use by diagnosis, as people with anxiety disorders were underrepresented, a finding that echoes the Improving Access to Psychological Therapies programme.⁶ The data also suggest that 7–18% of those who use Better Access services do not have indicators of need (at least in terms of diagnosis or other service needs), and the reasons for their referral requires further research.

Utilisation

Utilisation is another area of doubt for Harris *et al*. The specification document for Better Access assumes that cognitive-behavioural therapy (CBT) will be provided, in line with most clinical guidelines, including those produced by the National Institute for Health and Clinical Excellence in the UK. This assumption may not have been fulfilled in Better Access, with participants more likely to report receiving non-specific ‘counselling’. If guideline recommendations were being followed, one would expect at least as many CBT consultations as counselling in individuals with affective disorder, and we would also expect CBT to predominate in the anxiety disorder group. However, the accuracy of patient self-report is unclear, as ‘counselling’ may have generic meaning rather than reflecting a specific orientation.

An assumption that existing psychological therapists would be both willing and able to provide CBT may have been naive. Those responsible for delivering the Improving Access to Psychological

†See pp. 99–108, this issue

Therapies programme became aware of the fallacy of such an assumption and have consequently embarked upon an ambitious CBT training programme to remedy these deficits. Recent data suggests that this has been largely successful.⁶ Most countries have a deficit in CBT-competent practitioners, and the UK workforce development approach may warrant replication in Australia and elsewhere. Of course, future workforce education and service delivery will also need to keep abreast of developments in the evidence if other psychological therapies (such as interpersonal therapy, problem-solving and counselling) are judged to show comparable effectiveness to CBT.

Effectiveness and cost-effectiveness

Harris *et al* did not set out to explore issues of effectiveness and cost-effectiveness, but these remain vital questions. The UK Improving Access to Psychological Therapies programme is under intense scrutiny to deliver recovery rates at least as good as those seen in comparable clinical trials. Better Access is surely designed to do the same. The rigorous data on access and equity presented here will need to be complemented with equal rigour in the collection of clinical and social outcome data, a signal success of the Improving Access to Psychological Therapies programme.³ The performance of Better Access will be less satisfying if treatments are being delivered that have less evidence of effect. This may be compounded by the lack of incentives within Better Access to provide alternatives, such as low-intensity 'minimal interventions' via guidebooks and the internet. Debates about the proper balance between conventional psychological therapy and these more 'efficient' minimal interventions continue apace.^{3,7} If all that Better Access has done has been to subsidise the private psychotherapy sector in providing therapy of questionable effectiveness at high cost to the taxpayer, then it would not seem to be a model others would want to follow. Harris *et al's* study cannot provide sufficient evidence to reassure us that this is not the case.

Patient-centredness

This brings us on to a final issue. Evidence on effectiveness has long dominated discussions about psychological therapy provision, and only recently have issues of access and equity entered the arena. Patient-centredness (i.e. providing services in line with individuals' choices and needs) is also a relative latecomer, although it remains key to government policy. We know relatively little about patient perceptions and experience of these treatments, particularly the newer types.⁸ This can be overcome in part by 'satisfaction surveys' among people receiving treatment. However, a failure to provide treatments that are perceived as useful and acceptable also affects access and equity, as individuals fail to engage with services that are perceived as unhelpful or insensitive to their needs.

The finding that people not seeking help 'preferred to manage themselves' raises many questions about their decision-making.

Harris *et al* suggest that mental health literacy interventions may help overcome barriers. Although such methods have a role, they are unlikely to be sufficient. The *Journal* has hosted debates about whether psychiatric epidemiology overestimates need and medicalises normal human experience,⁹ and we are only beginning to understand the complexity of patient decision-making about accessing mental healthcare, and how people determine their 'candidacy' for help.¹⁰ Those decisions often reflect the way that services are perceived to respond to distress, rather than a deficit in patient knowledge. Persuading more people with common mental health problems to access psychological therapies is unlikely to be a simple matter of public education. Instead, it will require the design and delivery of services that minimise the material and psychological costs of accessing care, while maximising their potential impact.

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