

Development and policy

Commissioning psychological therapies: a new world?

Joan Foster

Chair, Counsellors and Psychotherapists in Primary Care (CPC), Bognor Regis, UK

As Chair of Counsellors and Psychotherapists in Primary Care (CPC) I have been involved with numerous primary care trusts (PCTs) reviewing and evaluating current provision, designing and setting up services. A great deal of work has gone into service design and delivery, particularly the most appropriate area to site the management of psychological therapy services.^{1,2}

Where are we now?

Psychological therapy services in primary care are principally made up of primary care counselling services, sometimes joined by graduate mental health workers, but very rarely by clinical psychologists and cognitive-behavioural therapists

What has emerged in those PCTs with managed primary care counselling services (approximately 85%) is that roughly 40% are sited in PCTs, another 40% in mental health trusts, and independent providers deliver the remaining 20%. However, the result of *Commissioning a Patient-led NHS* is that PCT provision has effectively gone out of the window.³ When we add the implications of 'practice-based commissioning' to the mix, it is clear that new thinking is required.

Stepping back to look at the totality of mental health provision, there have traditionally been three areas: primary, secondary and tertiary. Funding has concentrated on tertiary and secondary, with primary being the poor relation. This is despite the fact that 91% of patients with a mental health problem are *only* seen in primary care.⁴ General practitioners (GPs) continually express concern about long waiting lists for both primary and secondary mental health services.

Generally speaking, the current structures for NHS psychological therapy services are as described in Table 1.

The problem is how do the three levels relate to each other, and is there joined-up thinking and strategic planning? Certainly my own experience working with counselling services, GPs and mental health commissioners around the country is that it is rare. We all know the strengths of multidisciplinary working but equally we are also aware of professional rivalries and the pressure of being the Cinderella service in terms of funding. The most pressing issue for GPs is always waiting lists – and they are always particularly worried about waiting times for psychological therapies in secondary services.

Where are we going?

However there does seem to be an indication of a shift of direction, hopefully to a better deal for psychological therapies. Anything that raises the profile and increases funding is to be welcomed with open arms, but there is also the danger of the baby being thrown out with the bath water and the flavour of the month becoming concrete policy. So what do all these mixed metaphors mean in actuality?

Flavour of the month is certainly cognitive-behavioural therapy (CBT); especially following Lord Layard's paper, identifying the major impact mental health problems have on the workforce.⁵ The solution he proffered was the employment of 5000 extra psychological therapists trained in CBT, with 250 new centres being opened. Unfortunately, he seemed unaware, and uninformed of what could be described as a hidden resource – practice-based counsellors already integrated into the primary health care team. This is because up until recently they did not 'exist' on Department of Health pay scales and therefore could not be counted. With the new Department of Health pay scales (Agenda for Change) this resource can be identified and built

Table 1 Current structures for NHS psychological therapy services

Level	Talking therapy provision	Psychiatric provision
Primary care	Practice-based counsellors (brief, focused interventions) Graduate mental health workers (guided self-help) Primary care mental health practitioners (triage and liaison secondary care – SEMIs)	Some CPNs
Secondary care	Clinical and counselling psychology/CBT Psychotherapy Art/drama therapy Elderly Specialist services e.g. – Eating disorders – Substance abuse – Child and adolescent mental health services	Community mental health teams Crisis intervention Assertive outreach Home treatment services Learning disabilities
Tertiary care	Minimal psychological therapy provision	Inpatient wards Outpatient – long-term care

upon. Estimates of the number of primary care counsellors vary from 3000 to 5000.

Primary care counsellors see patients with mild to moderate mental health problems. Many offer solution-focused, problem-solving treatment interventions, using CBT skills. Counselling has been found to be as effective as CBT for patients with depression; so perhaps as part of joined-up, strategic planning, account will now be taken of this existing resource.⁶ Effective planning needs to promote an understanding of the complexities of psychological interventions and the dangers of pursuing a prescribed model such as CBT to the exclusion of other therapeutic interventions which are equally effective and sometimes more so, but most importantly are the right intervention for the patient.

It is going to be a highly demanding process for PCTs being amalgamated into much larger PCTs to commission effectively in this NHS. Perhaps approaching commissioning from the perspective of the patients' needs rather than the dictates of economists would be a more constructive approach. Patients suffering from serious mental illness want to be seen and supported in primary care.⁷ At 12 months, patients who chose counselling were more satisfied with treatment than those who chose CBT,⁶ and:

Surveys clearly show that patients prefer a psychotherapeutic approach (counselling or talking about their problems) or at least expect such an approach in combination with their medication. Evidence indicates that certain specific forms of psychotherapy are useful for patients with mild, moderate and severe depression. Their usefulness is

most obvious in the milder forms and in the prevention of further episodes of depression. Men are less likely to ask for this form of treatment.⁸

How do we get there?

So people like talking therapies and they like being seen in primary care – nothing really new here. Not only that but talking therapies are effective too. This fits neatly into practice-based commissioning and of course a patient-led NHS. However, new commissioning structures mean that the nuts and bolts of meeting these needs are becoming more complex rather than less. New issues are beginning to emerge as to how services will be delivered.

In addition, differing structures are emerging round the country. Many PCTs are employing primary care mental health workers (PCMHWs), however no clear patterns have emerged as to their roles. In some PCTs they provide a triage service for all mental health referrals from the GP, in others they provide a liaison function between primary and secondary care. In some cases they will offer brief psychological interventions. It is my view that little strategic thinking has taken place as to how the PCMHWs link in with the existing primary care counselling services, and in some PCTs there has been confusion as to who should be seeing whom.

Graduate mental health workers have also been introduced nationally but not quite reached the

number (1000) that the government had promised. Again, around the country the workers have developed differing roles. In some areas, the training provided has been strong and effective; in others the input of supervision from existing practitioners, often primary care counsellors has been the key factor. Sadly in some PCTs, graduate workers have sat twiddling their thumbs with no meaningful direction to speak of. Again, the lack of strategic thinking and understanding of existing provision of primary care psychological services resulted in misunderstandings and confusion as to the role that these workers could play. It has been a pleasure to meet with some who have created an effective role for themselves. Graduate workers flourish when they have clear direction, clear management and are integrated into the wider primary care mental health team. They are able to provide an effective service in terms of identification of local resources, Computerised CBT (CCBT), possible input into audit and evaluation, and offering brief behavioural interventions. They are not qualified to assess patients.

The issue for the future is the level of understanding of commissioners as to the strengths and limitations of the new roles being introduced into primary care. Nurses, occupational therapists, primary care mental health workers, community psychiatric nurses (CPNs) and graduate mental health workers may have counselling 'skills', but are not normally trained as counsellors. Without wishing this to be seen as a defensive position, it is critical that commissioners understand that counsellors, psychotherapists and counselling/clinical psychologists have been trained to offer in-depth psychological therapies (talking therapies), which are highly skilled, very tricky treatment processes. There may be different theoretical approaches among the psychological therapy professionals, e.g. person-centred counselling, psychodynamic psychotherapy or CBT. The key point is that all such psychological therapists have undertaken specialist training to post-graduate level and beyond.

Effective commissioning requires that commissioners understand the complexities of the current variation in provision and the skills and training of potential practitioners, and have an overall vision as to how they should be integrated to provide effective primary care psychological therapy services.

Mega-PCTs will have a variety of providers of psychological therapy services in primary care with varying levels of funding. It has been enough of a task to move to equity of access in existing PCTs, and it has not yet been achieved nationwide. So we can only wonder whether equity in terms of funding and provision is going to stay on the agenda and be regarded as an imperative by the new merged PCTs.

Practice-based commissioning will result in local initiatives to meet local needs, and we need to ensure that a baseline of equitable provision is established across all the new PCTs. If that is in place, then the opportunity for new developments is to be welcomed. We know that there are practices and PCTs where mental health service provision is very low on the agenda. Nationally we must ensure that there is adequate, equitable provision in place for all patients.

However, there are some risks to be aware of in the development of new local initiatives:

- unregulated providers, using trainees and under-trained voluntary counsellors, could undercut NHS psychological services and provide a poor-quality service
- audit, evaluation and outcome measurement need to be tightly monitored with clear guidelines from the PCT, and preferably nationally. Otherwise clinical governance requirements may not be met
- the benefits of a co-ordinated, managed service may be lost with small, individual initiatives being put in place without awareness of the bigger picture
- economies of scale may be lost with duplication across the new PCT.

On the other hand, potentially, there are also huge benefits. Assuming services will operate from an equitable baseline of provision; then localities/clusters or practices will be able to develop specific services to meet the needs of their areas. The differing needs of a rural area from a deprived urban area could result in new local thinking – moving away from one-size fits all. For example: the rural area could introduce travelling centres, the urban area could introduce drop-in sessions. Integration with social care could become firmer, with social workers and counsellors working together. Much closer links with secondary care could be established with psychiatrist and counsellor working together to provide a counselling intervention for a long-term patient facing a life crisis. Where this has been possible in the past this has been a recipe for very effective care

For developments such as these to be rolled out where appropriate requires clear strategic thinking on behalf of commissioners. Up to now, the commissioning of mental health in primary care has mainly been that of a primary care counselling service. Commissioners now have the opportunity to think much bigger and to look at how primary, secondary and tertiary services interface, and to clearly identify the referral patterns and needs. To take this forward, recognition must be given to the complexities of mental health provision. From first-hand experience, I know that those charged with

commissioning a primary care counselling service learn very rapidly how complex a task it is. I fear that too often services under-perform because the management requirement is not recognised or adequately funded. There seems to be some illusion (not in all services I hasten to say!) that service managers are something of a luxury. I know that it is traditional to knock management and the NHS for having too many managers. In terms of psychological therapies it is a fallacy – good managers produce good services. Good managers are needed in order to understand and provide the complex thinking required in the provision of psychological services. They need training and support and proper remuneration.⁹ Only then will all services produce the high results currently achieved by some and be fit for purpose in a patient-led NHS. For example, CORE (Clinical Outcomes Routine Evaluation) benchmarking data show that 72% of patients achieve a successful outcome following a primary care counselling intervention, but the range is from 40% to over 95%.

AUTHOR BIOGRAPHY

Joan Foster is Chair of the national association of Counsellors and Psychotherapists in Primary Care (CPC). She has worked as a Primary Care Counsellor since 1992. She has worked as a trainer in time-limited counselling and supervision and runs a number of training courses for CPC. She has been a provider of a primary care counselling service.

Joan acts as consultant to a number of PCTs in the establishment and running of primary care counselling services and is involved in interview panels and in evaluation of services. As Chair of CPC, Joan was a member of the Department of Health Workforce Action Team, Primary Care Sub-Group addressing the Workforce Planning, Education and Training Issues for Adult Mental Health Services.

She has published a paper on 'Counselling in primary care and the new NHS' in the *British Journal of Guidance and Counselling*.¹⁰ She is joint author of *Quality in Counselling in Primary Care A Guide for Effective Commissioning and Clinical Governance*. She has co-authored *Psychological Therapies in Primary Care – setting up a managed service*.²

REFERENCES

- 1 CPC. *Guidance and Frameworks for a Managed Primary Care Counselling Service*. Bognor Regis: CPC, 2005.
- 2 Foster J and Murphy A. *Psychological Therapies in Primary Care – setting up a managed service*. London: Karnac, 2005.
- 3 Department of Health. *Commissioning a Patient-led NHS*. London: Department of Health, 2005.
- 4 Department of Health. *National Service Framework for Mental Health, Modern Standards and Service Models*. London: HMSO, 1999.
- 5 Layard 2004: *Mental Health, Britain's Biggest Social Problem?* London, 2004.
- 6 King M, Sibbald B, Ward E *et al*. Randomised controlled trial of non-directive counselling, cognitive-behaviour therapy and usual general practitioner care in the management of depression as well as mixed anxiety and depression in primary care. *Health Technology Assessment* 2000;4:1–83.
- 7 Lester H, Tritter J and Sorohan H. Patients' and health professionals' views on primary care for people with serious mental illness; focus group study – 20 April 2005. *British Medical Journal* 2005;330:1122.
- 8 Mulholland C. *Depression and Suicide in Men*. www.netdoctor.co.uk/menshealth/facts/depression-suicide.htm (accessed 19 February 2006).
- 9 CPC. *Management of Counselling Services*. Four one-day workshops: Introduction to Managing Counselling Services, The Context of Counselling Services, Managing Money, Managing People Bognor Regis: CPC, 2006.
- 10 Foster J. Counselling in primary care and the new NHS. *British Journal of Guidance and Counselling*

ADDRESS FOR CORRESPONDENCE

J Foster, Queensway House, Queensway, Bognor Regis, West Sussex PO21 1QT, UK. Tel: +44 (0)1243 870701; fax: +44 (0)1243 870702; email: joanfoster@cpconline.co.uk

Received ?????

Accepted ?????