Overview

Access to therapy is a key issue in mental health policy and practice, and for many suffering from different kinds of distress. This public event considered some of the varieties of therapies on offer in the UK, with a specific focus on Scotland and the opportunities and challenges that might come with policies aimed at improving access.

The event was supported through the ESRC, via its Festival of Social Science. It was well attended, with people from a wide-range of backgrounds and with diverse personal experiences taking part. It featured talks from:

Martyn Pickersgill (The University of Edinburgh)
Chris O’Sullivan (Mental Health Foundation)
Donna Strachan (CAPS – The Consultation & Advocacy Promotion Service)
Linda Irvine (NHS Lothian)

Following the short presentations, event participants were invited to put forward questions and reflections to the panel and each other about their hopes and concerns around access to therapy. This short report summarises the talks and discussion.

Access to What? Access for Who?

Martyn Pickersgill, The University of Edinburgh

Martyn gave a short talk, highlighting what he saw as some of the key questions around ‘access’ in the health and care professions that shaped current initiatives and concerns around access to mental health therapies. These include the prominence and legitimacy of international humanitarian campaigns to support access to pharmaceuticals for individuals who could not otherwise afford them, UK-wide endeavours to increase parity between physical and mental health in the NHS, and economic concerns around sick-days and ‘presenteeism’. Martyn discussed how current initiatives to enhance access to psychological therapies relate to wider concerns about the increasing rates of prescriptions of psychiatric drugs, especially within primary care contexts.

Describing his current Wellcome Trust-supported sociological research on how endeavours to increase access to psychological therapy are playing out in practice, he explored some of the many ways in which the term ‘therapy’ can be interpreted, and ‘access’ both enabled and constrained. Finally, Martyn spoke of some of the difficult questions and concerns that underpinned initiatives to improve access to therapies, including: What therapies should be available? Who should deliver them? In what locations should therapists be based? How do patients come to actually access these? These questions demand engagement between policymakers, health professionals, advocacy organisations, patients, and academics in order to find answers that are clinically, ethically and economically acceptable and durable.
Opportunities and Challenges in Public Mental Health

Chris O’Sullivan, Mental Health Foundation

In his presentation, Chris noted that many people have unaddressed concerns about their mental health. However, traditional services and diagnoses (or perhaps wider conceptions of these) might not always be helpful. Chris spoke of four key ideals that he believed should underpin policy in order to enhance mental health and wellbeing. First, people should be both enabled and allowed to recognise, express and address their distress. Second, service-providers should be responsive to experiences of distress (in all their forms), engaging with people confidently and compassionately – as well as leaving aside their own feelings of unease within that clinical moment (especially in cases of self-harm). Third, individuals should be able to use a blend of services, in order to best fit around the lives they live and the lives they want to live. Fourth, a shift away from the language of ‘service-user’ to an idiom of citizenship is needed to promote choice and empowerment. As Chris showed, stigma is still a real and pressing concern in mental health, and self-stigma – such as feeling undeserving of services, and comparing oneself to people who are ‘really’ ill – can prevent individuals not only from accessing current provisions, but also from demanding more. For Chris, the recovery movement is an important means of broadening out understandings of ‘therapy’ – and, hence, potentially also enhancing means of accessing it.

Barriers to Accessing Therapy

Donna Strachan, CAPS – The Consultation and Advocacy Promotion Service

Donna’s talk was about the barriers people experience when trying to access therapy. Drawing on the reports, research and films CAPS has developed, she described what people had said they found difficult when accessing treatment. The GP as ‘gatekeeper’ is a key issue. GPs have time constraints, may promote a biomedical rather than social model of mental ill-health that might result in prescriptions for drugs but not referrals to psychological therapy, and individuals could previously have had negative encounters with GPs - discouraging them from making appointments. People are also reliant on what information GPs have about community resources. Further, the concept of the ‘referral’ can itself be challenging, especially if presented in a way that disempowers individuals and suggests that others always ‘know best’. Like Chris, Donna stressed the enduring importance of stigma as a barrier to getting help. Stigma can be experienced in a range of ways, including by people who identify (or are identified as) black, gay, or poor. Further, particular diagnostic categories – such as borderline personality disorder – continue to attract stigmatised responses from professionals. The recovery movement is about people being in control of their own recovery; having choice and control about how they get better; and, working in partnership with professionals. A recovery-focused NHS needs to ask how much control people really have about their treatment and how easy it is to access, and whether professionals listen to and respect them.

When is Therapy, Therapy?

Linda Irvine, NHS Lothian

In her presentation, Linda focused on the significance of psychological therapies. She reflected on the continued development of specific kinds of psychological therapies, which had the unfortunate side-effect of proliferating acronyms (for example, ACT, CAT, CBT and DBT) with the result that many non-psychologists (including GPs) were uncertain about what particular therapeutic interventions comprised of, who would be most likely to benefit from them, and what they would involve. Yet, such therapeutic innovation is nevertheless important in order to meet people’s needs and provide for conditions such as anxiety and depression that are increasingly salient in UK society. This is as a consequence of stretched finances for many and a growing recognition of the mental health consequences of physical conditions. Linda argued for the importance of a psychologically informed mental health service, which includes skilled assessment, a formulation of the problem within a context, and a choice of possible interventions. Crucially, this might include no therapy: following assessment, individuals may feel that this isn’t right for them. However, psychologists must likewise take care not to discharge an individual without putting in place alternative and appropriate forms of support. Linda observed that within the NHS there is a growing awareness of the relationship between a professional and a client, stating that this must be founded on respect and compassion. Such an ethic should both pervade and define care and treatment settings.
Discussion

The presentations promoted a wide-ranging discussion of the interests and concerns of the event participants. The core features of the discussion can be broken down into three broad and overlapping themes, explored below: (1) Self-referrals; (2) Community; and (3) Peers and professionals.

1. Self-referral

‘Self-referral’ – as opposed to referral to a therapeutic service by a GP – is one possible mechanism by which access to psychological therapy can be enhanced. Within the voluntary and third sector, self-referral to crisis centres and other kinds of support is common. However, currently, many NHS psychological services do not allow self-referral. Health professionals can find this a challenging concept, and may be daunted by the prospect of demand for therapy that they might not be able to meet. Many actual and potential service-users, however, are not only advocates of self-referral, but are also surprised that this is not already an option that is universally available. It seems clear that more NHS Health Boards and Trusts should experiment with self-referral, even if this policy is not ultimately adopted. Yet, it is also recognised that this is a big shift in work style and the allocation of responsibilities within health systems. Accordingly, Boards and Trusts should work carefully and closely with third-sector organisations and local patient groups in order to implement self-referral trials, and ensure that expectations of all parties with a stake are both realistic and regarded as important for trying to meet.

2. Community

Communities can be both determinants of poor mental health, as well as sources of support and resilience. Key for many of the participants was the placement of NHS mental health services within their local communities, as opposed to expectations of long (and sometimes expensive) commutes to NHS facilities in urban centres that may be unfamiliar. Whilst in more rural parts of Scotland psychologists may spend considerable time ‘on the road’, seeking to make appointments in a range of towns and villages, in highly populated regions the value of localism may be forgotten (as might the demographic and cultural diversity of communities within a city). At the same time, however, services that are not adjacent to one’s home may assist in access to services for an individual who feels stigmatised as a consequence of their thoughts and experiences. ‘Drop-in’ services for individuals to talk with peers in a secure, therapeutic space (that might not include mental health professionals) should also be available, although it was nevertheless recognised that not everyone would find these helpful. When developing community-based services, the specific nature of the community should be born in mind.

3. Peers and Professionals

Related to the above points, much discussion occurred regarding the ‘pros and cons’ of interventions led by peers (as opposed to mental health professionals). Peer-led, and peer-developed and controlled, resources may represent a means of empowerment. Further, it was argued that it is important to acknowledge that people have their own ‘wellbeing indicators’, and that these might be different to outcome measures developed for use in psychology. However, psychologists often exercise considerable discretion regarding their use of screening tools and wellbeing measures, and therapy delivered by a mental health professional is not incompatible with the (co-)development of more personalised indicators. For a variety of reasons (including resource restrictions), NHS services may operate with particular kinds of access criteria for potential patients, which can result in some people being turned away. Peer-led interventions often do not have such formalised entry points, potentially enhancing access. However, peer alternatives may also operate through group work, which may inhibit some individuals from exploring their experiences and feelings in ways that they might with professionals. Perhaps the most fruitful way of moving forward is to better align (and further develop) both peer-led and NHS services.
This report was prepared by Tineke Broer and Martyn Pickersgill (The University of Edinburgh). The authors are very grateful to the speakers for their presentations, and to the diverse audience for their thoughtful questions, reflections and suggestions. The event links with Martyn’s current Wellcome Trust funded sociological research on ‘Access Denied? The Roles of Clinical Knowledge and Moral Discourse in Mediating Access to Psychological Therapies’. For more information, please contact Martyn via the following:

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