

Debate & Analysis

Cognitive behavioural therapy:

why primary care should have it all

Cognitive behavioural therapy (CBT) is a short-term treatment that aims to change unhelpful patterns of thinking or behaviour that can contribute to maintaining or worsening various mental or physical health problems. Its potential applications are widespread. In the UK, the National Institute for Health and Clinical Excellence (NICE) recommends CBT as an option for treatment of a wide range of mental health conditions, including depression, anxiety, post-traumatic stress disorder (PTSD), obsessive-compulsive disorder (OCD), and bulimia nervosa. CBT can also be used in sleeping disorders, to cope with a range of physical health problems such as pain and fatigue, as well as for phobias, substance misuse disorders (including smoking cessation), and functional disorders/medically unexplained symptoms.

The traditional model of CBT (1 hour sessions for 12–20 weeks) can be used across age groups (including children, young people, and older adults) and can be delivered using a variety of methods (face-to-face, in groups/classes, by telephone). Although originally the preserve of secondary care psychiatry and psychology services, CBT has increasingly been applied in primary care settings as a first step in care.

USES OF CBT IN PRIMARY CARE

The majority of published research on the use of CBT in primary care has been in individuals with depression, with improved outcomes demonstrated for both mild-to-moderate¹ and major depression,² when compared to usual care. CBT is ideally suited to breaking the unhelpful 'thoughts-feelings-behaviours' cycles associated with depression, anxiety, and related disorders such as PTSD and OCD. However, there is growing evidence for the use of CBT in the treatment of other conditions seen frequently in the primary care setting. For instance, there have been a number of randomised controlled trials in primary care of CBT versus usual care for conditions ranging from irritable bowel syndrome³ to low back pain⁴ and sleep problems,⁵ with promising results. Yet there remains a considerable gap between the potential applications of CBT and its availability in primary care.

ACCESS TO CBT IN PRIMARY CARE

Access to CBT is generally sub-optimal in

primary care worldwide. In England, access to CBT has increased since the Improving Access to Psychological Treatments (IAPT) programme was introduced in 2006, representing the largest investment ever made in primary care mental health. An early evaluation of the programme at two pilot sites found reduced emergency department attendances, sickness certification, and improved adherence to drug treatment.⁶ Service changes to increase access to psychological therapies have also been made elsewhere in the UK and in several other countries.

One of the biggest barriers to more widespread use of CBT has been a shortage of specialist staff. Clinical psychologists are few in number and relatively expensive, so models of service delivery using staff whose main role is not necessarily in mental health care show real promise to increase availability of CBT. Such staff can deliver key elements of the CBT approach using either focused interventions such as low-intensity behavioural activation, CBT self-help resources (bibliotherapy), or computerised CBT (CCBT). Here, the resources themselves communicate key elements of the CBT intervention. The structure and format of the CBT resources ensures treatment fidelity.

However, such approaches are not a simple solution for primary care. Gellatly *et al*⁷ have shown that when CBT resources are offered for depression, results are poorer if they are offered without support. But who should provide this support? In the UK, self-help coaches and psychology assistants have effectively supported the delivery of depression resources in primary care with less than 2 hours of support.⁸ This recently published study showed significant improvements in outcomes for patients with depression with a mean benefit of 5.3 points on the Beck Depression Inventory-II at 4 months, and significant benefits maintained at 12 months.⁸ National

telephone support has also been offered for book-based CBT in Scotland through the NHS24 Living Life Project, and telephone support for a CCBT package for depression is currently being evaluated in England as part of the Healthlines project (www.bris.ac.uk/social-community-medicine/people/project/1668).

Such low-intensity interventions (less practitioner time involved) provide the opportunity for large numbers of patients to be seen and supported. These approaches could be offered alongside, or instead of, antidepressant medication for mild-to-moderate depression, as recommended currently by NICE.⁹ Guided CBT resources give the same short- and longer-term outcomes as high-intensity specialist CBT for mild-to-moderate depression and anxiety,¹⁰ thus freeing up specialist psychotherapists to focus on those with complex presentations. These longer specialist inputs can also be delivered in primary care.

INDIVIDUALS WITH MORE COMPLEX PROBLEMS

The recent CoBaT trial found that high-intensity CBT plus usual treatment with antidepressants for treatment-resistant depression led to significant clinical benefits over the treatment as usual group.¹¹ This is the largest UK-based trial of primary care-based CBT and confirms the need for both high- and low-intensity CBT to be available within primary care settings.

Another intervention for individuals with more complex problems is mindfulness-based cognitive therapy (MBCT). MBCT combines mindfulness techniques that promote meta-cognition (decentring from recurrent negative thoughts and feelings) with elements from cognitive therapy.¹² It has been researched and applied particularly in the context of relapse prevention in recurrent depression and is recommended for this by NICE. As with CBT in general,

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there is a need to develop and evaluate low-intensity formats of MBCT to supplement the standard MBCT programme of 8 weeks of 2.5-hour sessions.¹³ Such developments, if shown to be effective, would help to embed MBCT into routine primary care delivery.

IMPLICATIONS FOR RESEARCH AND HEALTH SERVICE ORGANISATION

It is clear that CBT and variants such as MBCT hold much promise. Over the last 10 years low-intensity delivery of CBT has allowed such approaches to be increasingly accessed by primary care patients. However more needs to be done, and research is needed to enhance delivery. In primary care, many patients have multimorbidity of mental and physical conditions and, hence, complex care needs.¹⁴ Low-intensity interventions can be effective for more than depression and anxiety, but can complex disorders (including mixed physical and mental comorbidity) be treated using such interventions? If so, this would move low-intensity delivery well beyond conditions labelled as being only 'mild-to-moderately severe'. Crucially, it is not known who does well with low or high-intensity therapies. NICE recommends that the choice is based on complexity of presentation, rather than on severity of symptoms.

A central theme here is that such resources need to be supported so that patients engage and are encouraged to apply what is being learned. It is not yet clear who can best do this, where the staff members can be sited, or how much support needs to be given. It is also unknown to what extent such support can be offered using automated emails or text based prompts. Access to support will otherwise remain a key problem slowing the adoption of such approaches.

Finally, research into access, usage, and outcomes of psychological therapies within and between countries, by age, sex, ethnicity, deprivation, and rurality is needed. This is particularly important in the area of CCBT, where those with the lowest incomes, such as unemployed and older people, are least likely to have

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access to smartphones and broadband at home. It would be unacceptable if efforts to widen access to psychological therapies contributed to widening inequalities in health.

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Provenance

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Competing interests

Chris Williams is author of a number of written and computerised CBT self-help resources and training packages. 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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