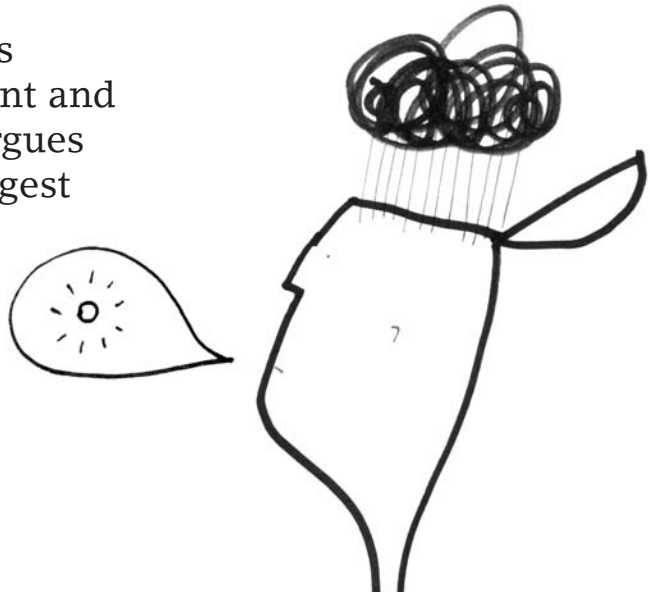
Mental health: the choice of therapy for all

Richard Layard has spent much of his professional life tackling unemployment and inequality. But in his latest work, he argues that mental illness is now Britain's biggest social problem.



Mental health: the choice of therapy for all

As someone looking at mental health in Britain from outside the profession, it is clear that we are doing far too little for those who are mentally ill. I would like to persuade you of four propositions:

- There is a mass of suffering that is untreated and which imposes severe burdens on the economy.
- We have effective means of treating it, enshrined in guidelines from the National Institute for Clinical Excellence (NICE). But the guidelines cannot be implemented with the resources of people and money that are currently available. In particular, evidence-based psychological therapies like cognitive behavioural therapy (CBT), which are in heavy demand, are not adequately available.
- We could meet reasonable demand within five to ten years by a major programme to train more therapists. But this will not be cost-effective unless we maintain the quality of training and of provision. This means that provision should be through psychological treatment centres, working on a 'hub-and-spoke' basis.
- For many people, work is a vital part of therapy and of the recovery process. But at present, there are more mentally ill people on incapacity benefit than the total number of unemployed people. The government's 'Pathways to Work' pilots show that many of these people can be helped back to work, and these programmes should become available throughout the country.

So these are my themes: the scale of suffering and the cost; the existence of known remedies; treatment centres to provide these therapies; and the key importance of work.

Suffering and cost

If you ask who are the unhappiest people in our society, the answer is not the poor but the mentally ill. You can see this from the National Child Development Study, which shows that unhappiness is three times more closely related to mental health (measured ten years earlier) than it is to poverty (measured today). The cost to the economy in terms of lost output is around 2% of GDP and the cost to the Exchequer is similar, including £10 billion spent on incapacity benefit and £8 billion on mental health services.

At present, most public expenditure on mental health goes on the roughly quarter of a million people suffering from psychosis. But at any one time, there are a million people suffering from clinical depression and another four million suffering from clinical anxiety.

For these groups, the depressed and the fearful, there is almost no treatment available except a few minutes with their GP and some pills. Many of these people do not want pills but they do want psychological therapy. According to the Psychiatric Morbidity Survey, under a half of all the people suffering from depression were receiving any kind of treatment, and fewer than 10% were receiving any kind of psychological therapy. For people with anxiety, each of these figures should be halved.

This is totally unsatisfactory. If people have any persistent physical illness like asthma, high blood pressure or skin disease, they automatically see a specialist. But this is not the case if they suffer the torment of mental illness.

There are two reasons for this neglect. One is stigma. The other is an extraordinarily delayed response to the fact that we now have treatments that work, which we did not have 50 years ago.

Treatments that work

We have drugs that will end a depressive episode within four months for 60% of sufferers. And we have therapies (especially CBT) that will do the same as a result of a weekly session. Once the episode is over, relapse is less likely if the sufferer received CBT, unless drug therapy is continued. Thus, cost arguments are not decisive between drugs and psychotherapy – and many people do not want drugs for the best possible reason: they want to feel in conscious control of their mood.

For all these reasons, the NICE guidelines on depression say that 'cognitive-behavioural therapy should be offered, as it is of equal effectiveness to anti-depressants'. The NICE guidelines also cite clear evidence that even in purely economic terms, these treatments would pay for themselves – ignoring altogether the gain in happiness to the patient.

Yet as things are, the NICE guidelines cannot be implemented because the therapists are not available to meet the demand. So the next phase of improving our mental health services has to be based on a simple offer: 'Mentally ill people should have the choice of evidence-based psychological therapy'. The Labour Party's last election manifesto did not say quite that but it said enough for it to be worth discussing in concrete terms how such an expansion could be achieved.

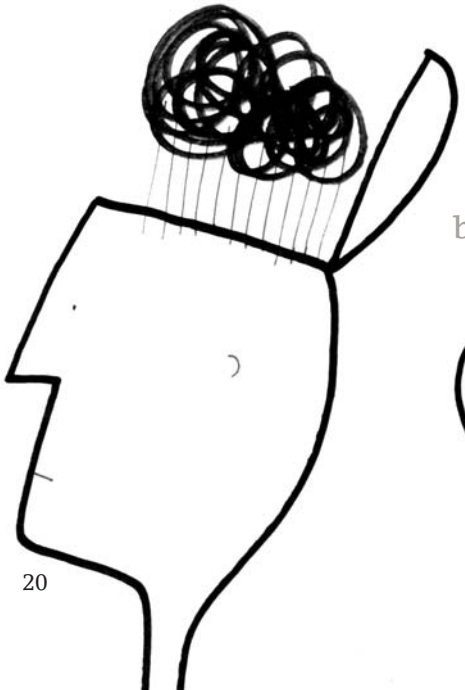
There is a mass of suffering that is untreated and which imposes severe burdens on the economy

Training therapists

First, there is the need for more therapists. A reasonable guess is that eventually in any year, roughly one million people would ask for therapy. If this lasted for ten sessions, that would require roughly 10,000 more therapists.

There should be two main types of therapist: clinical psychologists, who would lead the new effort; and more narrowly trained therapists, who would receive two years of part-time training while working in the NHS. Fortunately, there is huge demand for places in training as clinical psychologists, so it should be possible to produce 5,000 more of them within five to ten years. At the same time, two-year training would be offered to people with suitable experience and credentials – mental health nurses, social workers or occupational therapists – provided that, once trained, they were expected to change their job to become full-time therapists.

It is crucial that these people receive sufficient depth of training to achieve the success rates observed in the clinical trials. There is no point at all in expanding provision via second-rate therapy and it would not be justified on economic grounds – just as there is a major question mark over much of the counselling that GP practices currently provide for lack of any other way to provide talking help to their patients.



We desperately need a better NHS, delivering more help and understanding to the mentally ill

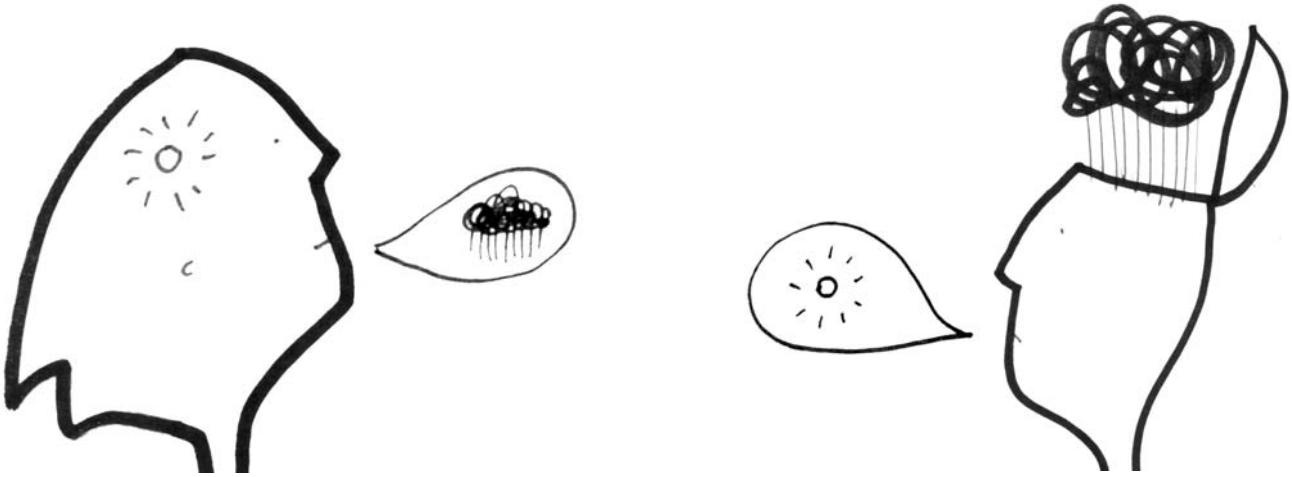
The case for treatment centres

The training must be of good quality and so must the actual treatment that is provided. This raises the crucial question about how treatment should be organised. I suggest that there are five main criteria for a good system of delivering therapy:

- Patients should be able to be treated near where they live.
- Therapists should practise within a system of effective supervision and professional management.
- They should be part of a team of therapists, providing mutual stimulus and support, and offering clear prospects for professional advancement based on recognised excellence.
- There should be a clear funding stream to support the work based on national targets for the availability of services. This should not be left to the discretion of primary care trusts.
- The pattern of expansion should be similar enough in different areas for people to learn about it, for example, in the national media.

These criteria cannot be satisfied within a system of GP-led provision, and I suggest that the new offer of therapy to people with depression and anxiety disorders be delivered through treatment centres. Why?

- They would provide a much better framework for the supervision of casework and for in-service training and professional development than would a service run by GPs.
- They would make it possible to monitor whether therapists were achieving results through standard self-assessment measures where results were made available to the senior staff of the centre.
- They would make it easier to organise the right therapist for each patient, and reduce the chanciness of whether their own GP practice had the therapist they needed. They would make it easier to organise the effective use of human and physical resources, due to economies of scale.
- They could provide a route of self-referral for patients who did not want their GPs to know about their problem.



Treatment will help many people, but work can also be a major route to recovery

The centres would be headed by a psychologist/therapist and would concentrate mainly on CBT. They would be separate from community mental health teams, which deal mainly with more seriously disturbed patients.

There would within the next five years be very roughly one centre per quarter of a million population – or 250 centres in all. A centre would have a central location at which supervision, training and some treatment occurred. But most of the staff would spend at least half their clinical time giving treatment on GP premises: such staff would be jointly appointed by the centre and the relevant GP practices. A typical centre would have about 20-30 staff. The staff would operate under clear NICE guidelines relating to number of sessions, and patient progress would be monitored using a standard national system of recording completed at the beginning of each session.

The treatment centres would be chosen by a system of tendering organised through the Department of Health, and their funding would be protected through the department. Trusts and independent providers would be free to tender. There would in due course be waiting time targets.

In any major expansion, there is always the danger of dumbing down, and this is never a good idea. If it is not possible within the next five years to achieve the extra provision I propose, it is better to expand quantity more slowly while ensuring quality. If this means establishing centres initially in the worst deprived areas, so be it. These can provide valuable experience and lessons for further expansion.

But there must be a clear long-term vision of where we want to be in ten years' time, with a phased path of how we get from here to there. A newly dreamed-up initiative every few years is a certain recipe for dumbing down.

Pathways to work

We desperately need a better NHS, delivering more help and understanding to patients. But for many patients, work is also a major route to recovery. And as taxpayers who pay for incapacity benefits, we can all say amen to this.

There are at least three obstacles to overcome. First, doctors often find it easier to counsel against work: they do not have time to advise on employment problems. Second, the benefit system is a real problem: what if the job doesn't work out? And finally, employers and jobcentres have not wanted to know.

But the government is trying to tackle these problems through its Pathways to Work pilots. When people come on to incapacity benefit, they see an employment adviser once a month in months 3-8 for a work-focused interview. And the NHS has to offer them training in 'condition-management': how they would manage their condition if they were going out to work. Moreover, GPs are lectured on the merits of work.

The results have been astonishing. In the pilot areas, the exit rate of people from incapacity benefit within the first six months of being on it has increased by one half – one of the most successful experiments I know of. On any assessment, the economic benefits exceed the costs. The scheme should clearly go national. And employers everywhere should become more friendly towards the problems of mental illness – keeping people in work as long as possible and giving a second chance to those who have had a break. The Health and Safety Executive has a real role here.

Britain's biggest social problem

I have spent most of my life working on unemployment. It was a national disgrace, and it has still not gone fully away. But mental illness is now our biggest social problem – bigger than unemployment and bigger than poverty.

We need our politicians to see it that way, because that is how it seems to the one third of the families in this country affected in some way by poor mental health. The politicians are now at least beginning to look in the right direction. But the test is how they act.

Richard Layard is director of CEP's research programme on wellbeing. He is also emeritus professor of economics at LSE, a member of the House of Lords and founder director of CEP. This article is an edited version of the inaugural Sainsbury Centre for Mental Health Lecture delivered on 12 September 2005. The lecture draws heavily on two recent publications by Richard Layard: *Mental Health: Britain's Biggest Social Problem?* (http://www.strategy.gov.uk/downloads/files/mh_layard.pdf) and *Happiness: Lessons from a New Science* (Allen Lane, 2005).