

Sainsbury Centre Lecture

THERAPY FOR ALL ON THE NHS

Richard Layard

I am honoured to be asked to give this lecture, especially as I probably know less about mental health than any one here. But, looking from outside, it is clear that we are doing far too little for those who are mentally ill. So tonight I would like to persuade you of 4 propositions.

1. There is a mass of suffering which is untreated and which imposes severe burdens on the economy.
2. We have effective means of treating it, which are enshrined in NICE guidelines. But those guidelines cannot be implemented with the current resources of people and money. In particular evidence-based psychological therapies like CBT which are in heavy demand are not adequately available.
3. We could meet reasonable demand within 5-10 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.
4. 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 Invalidity 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 those are my themes: the scale of suffering and cost; the existence of known remedies; treatment centres to provide these therapies; and the key importance of work. Let me start with the scale of suffering and cost.

SUFFERING AND COST

If you ask who are the most unhappy people in our society, the answer is the mentally ill. It is not the poor. 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 some £10 billion spent on Incapacity Benefits and some £8 billion on mental health services.

At present most of public expenditure on mental health goes on people suffering from psychosis – who are roughly quarter of a million people. But at any one time there are a million people suffering from clinical depression, and another four million suffering from clinical anxiety states. For these groups, the depressed and the fearful, there is almost nothing except a few minutes with the 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 under 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, blood pressure or skin disease they automatically see a specialist. But not so if they suffer the torment of mental illness.

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

TREATMENTS THAT WORK

You do not need to be lectured on that. We have drugs that will end a depressive episode within 4 months for 60% of sufferers. And we have therapies (and especially CBT) which 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 as between drugs and psychotherapy, and as I have said, 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 does not say quite that but it says enough for it to be worth discussing in concrete terms how such an expansion could be achieved.

THE CASE FOR TREATMENT CENTRES

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 some 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 received 2 years part-time training while working in the NHS. Fortunately there is a huge demand for places in training as clinical psychologists, so it should be possible to produce 5,000 more of them within 5-10 years. At the same time 2-year training would be offered to people with suitable experience and credentials: either mental health nurses or social workers or OTs – 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 which GP practices provide for lack of any other way to provide talking help to their patients.

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

1. Patients should be able to be treated **near where they live**.
2. Therapists should practise within a system of **effective supervision and professional management**.
3. 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.
4. 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 PCT discretion.

5. 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 your own GP practise has the therapist you need. 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.

The centres would be headed by a psychologist and would concentrate on CBT. They would be **separate from CMHTs**, which deal mainly with more seriously disturbed patients.

There would within the next five years be very roughly one centre per ¼ 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 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 have suggested, 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 10 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

So 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 Invalidity 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 (at least until recently) has been a real problem: what if the job doesn't work out? And finally, employers and Job Centres have not wanted to know.

But the government, with immense courage, is trying to tackle these problems through its Pathways to Work pilots. When someone comes on to Invalidity Benefit, he sees an employment adviser once a month in months 3-8 for a work-focussed interview. And the NHS has to offer him training in "condition-management": how he would manage his condition if he was going out to work. Moreover GPs are lectured on the merits of work.

The result has been astonishing. In the pilot areas, the exit rate of people for Invalidity Benefit within the first 6 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.

CONCLUSION

So there we are. 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 one third of all the families in the country. The politicians are now at least beginning to look in the right direction. But the test is how they act. There is all the difference in the world between professionalism and dumbing down. That is true in any area but in mental health dumbing down is just so easy, and so disastrous.

Note

This lecture draws heavily on R. Layard *Mental Health: Britain's Biggest Social Problem*, available at http://www.strategy.gov.uk/downloads/files/mh_layard.pdf and on R. Layard *Happiness*. I have had invaluable advice from Molly Meacher, Stefan Priebe, Ben Wright, David Clark and many others