A different life is possible

They championed evidence-based therapies for depression and anxiety and showed that these can transform people’s lives. Economist Richard Layard and psychologist David Clark tell Liz Else why their mental health mission has only just begun.

Your book is about the mental health initiative you two fought to start. Who is the book for?

Richard Layard: Everyone. We hope it will be a bestseller.

David Clark: We want people to realise where science has got us to: people whose lives might otherwise be ruined by long-term mental health problems can benefit from the latest psychological treatments, and many can have their lives transformed. If you get treatment in your 20s and 30s, that means you’ve got 50 years of a very different life.

How big a problem is the undertreatment of mental illness?

RL: In rich countries one in five people suffer a mental illness, mostly depression or anxiety disorders. Mental illness accounts for 38 per cent of all illness and even more for people of working age. Yet in most rich countries it gets under 10 per cent of healthcare expenditure.

Coming from outside psychology, as an economist, I was shocked. Throughout the rich world, less than one-third of people with common mental disorders are in treatment; for common physical illnesses like diabetes or cardiovascular problems, it’s over 90 per cent. This difference is an outrage. There are people who have problems, here and now, who could be treated and are not being treated.

Why don’t people get treatment?

DC: Part of it is because health authorities and doctors still do not realise how powerful and cost-effective the treatments are. There’s also a lot of stigma about mental health, which makes people with mental illness less likely to seek treatment. That is probably made even worse because many don’t know that there are effective treatments waiting for them. These are problems we set out to address with the UK initiative we proposed, Improving Access to Psychological Therapies (IAPT). In the last 30 years there have been major advances in psychological treatment, but they largely have not been acted on in clinical practice.

Why has clinical practice lagged behind?

DC: There are lots of reasons. Among them, there’s this very unfortunate term “talking therapies”. Everyone hears that and thinks: “Oh, it’s just like having a chat with someone who’s nice.” People think it would be a nice thing to have, but that it can’t be very effective.

Of course, these therapies aren’t like that. They are based on science, they are tailored to and differ between conditions, and they have evolved enormously on the basis of research about the underlying psychological processes.

What are the consequences of undertreatment?

RL: Among people who are least satisfied with their lives, the biggest cause is poor mental health. These problems affect people in every social class and have huge costs. They also cause low effectiveness at work, family break-up, crime and a host of other problems.

The programme started in England in 2008. Six years on, has it made a difference?

DC: Last year more than 700,000 people were seen through IAPT services, most of whom would not otherwise get any psychological therapy. In services with experienced staff, about two-thirds of people who receive a course of treatment show reliable improvement and close to 50 per cent recover.

What treatment strategies work well?

DC: Initially the focus of the IAPT programme was cognitive behavioural therapy. CBT is recommended for depression and all anxiety disorders by the UK’s National Institute for Health and Care Excellence (NICE). For mild to moderate depression, NICE also recommends treatments such as counselling and couples therapy, so those are offered as well. This is all about evidence-based treatment. CBT is backed by the most evidence, but it’s not the only show in town.

What makes CBT so effective?

DC: There is emphasis on having an empathic, supportive therapist. But it’s called CBT because it focuses on thoughts (cognitions) and behaviours. The key idea is that when people have emotional problems, negative patterns of thinking – and the way these influence behaviour – are what keep the problems going.

How would you use it to treat social anxiety, say?

DC: People with this condition have distorted mental images of how they appear to others. One way CBT might deal with this is to video

PROFILE

Richard Layard (on left in photo) is an economist, a member of the UK House of Lords and author of Happiness (Penguin). David Clark (on right) is a professor of psychology at the University of Oxford and national clinical adviser for the Improving Access to Psychological Therapies (IAPT) initiative. Layard and Clark are co-authors of Thrive: The power of evidence-based psychological therapies (Allen Lane), published this month.
This has never happened anywhere in the world. It is a revolution.

How long does it take to make a difference for one person - and how much does it cost?

RL: For depression and anxiety disorders, NICE guidelines suggest that about half of people will recover within 10 sessions. So far for IAPT, the average cost is about £150 per person. This is not expensive treatment. Moreover, it can prevent public spending on the disability that mental illness can lead to. Our case is that these treatments would actually cost the UK nothing if they were provided more widely.

How much does mental illness cost societies?

RL: For any advanced country, it’s about 8 per cent of GDP. In the UK, the estimate is nearly £30 billion. There are now laws here and in the US that require equal esteem for mental and physical health, but we’re still nowhere near truly equal access to treatment.

In the UK’s National Health Service, treatments are still not provided to NICE guidelines. In the US, health insurers often offer just six sessions of psychological therapy – then you have to reapply if you need more. That’s like saying if a surgical operation takes over an hour, please reapply to continue.

It seems you still have a battle ahead. Why are things moving so slowly?

RL: The problem is that there’s no constituency. It’s less a matter of opposition than not enough people making the proposition, largely because of stigma associated with mental illness. People will fight for more resources for cancer or heart disease. But when it comes to mental illness, there’s no effective lobby.

What could change this?

RL: It requires an uprising by the general public. If ill people themselves are not able to protest by virtue of their illness, we need to hear much more from their relatives, friends and colleagues. Where healthcare is provided in a democracy, politicians respond to the number of letters that make the point.