Campaign for psychological therapy

SUMMARY

- Mental health problems affect a third of all British families. They are a major source of suffering and they also impose major economic and social costs on the rest of society.

- Effective treatments exist but only a quarter of all the individuals affected are in any form of treatment – compared with over 90% of people suffering from physical illness.

- This reflects a scandalous disregard of NICE Guidelines for people with mental health problems. The Guidelines require the offer of evidence-based psychological therapy to all who need it. Under the new NHS constitution people are entitled to the treatments required in the Guidelines. But in most parts of the country access to such treatment is heavily rationed for children; and for adults it has often barely existed. The situation for adults is now improving rapidly. But it will require major political leadership if all mentally ill people are to receive the treatment they need and are entitled to.

- The Campaign asks that each political party include in its Manifesto the following simple commitment: **that within 5 years the NHS will offer evidence-based psychological therapy to all children and adults who need it.**

THE SCALE OF THE PROBLEM

Mental illness is the single biggest source of misery in our society. For example, prior mental illness (ten years earlier) explains more of the misery in our society than is explained by current levels of poverty.[1] So everyone who cares about fairness and helping the most disadvantaged should give high priority to the care of people with mental problems. **There are few forms of deprivation worse than chronic mental illness.**

The scale of the problem is massive. **One in ten children** has a diagnosable problem requiring professional help – about half of these have emotional problems (mainly extreme anxiety) and half have problems of behaviour These children are five times more likely than others to smoke, to take drugs, to self-harm and to avoid school.[2] And when they become adults (if they had conduct problems in youth) they are three times more likely to be arrested for a crime or to become teenage parents; and they are twice as likely to get divorced or to live off benefits.[3] These are big costs to society. These children are also very likely to continue suffering from mental illness into adult life. There is therefore an overwhelming social case for early intervention, on top of our clear obligation to help every child in need.

Among adults, one in six is suffering from diagnosable depression or a crippling anxiety disorder like social phobia or post-traumatic stress disorder. Such patients account for a third of all the people who come to GP's surgeries.[4] A recent WHO study compared the disabling effect of depression with that of angina, asthma, arthritis and diabetes and found that depression was 50% more disabling.[5] Thus in this country depression and anxiety disorders account for nearly a half of all those not working and on incapacity benefits (see Figure 1). On WHO estimates they account for one third of all disability (see Figure 2). [6]

The cost to the economy of adult depression and anxiety is some £12 billion a year – 1% of our national income. Of this the cost to the taxpayer is some £7 billion – mainly incapacity benefits and lost tax receipts.

Figure 1

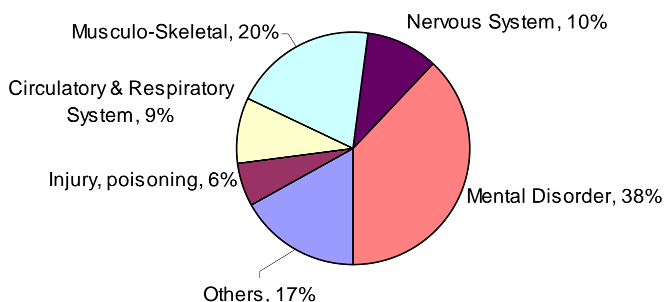
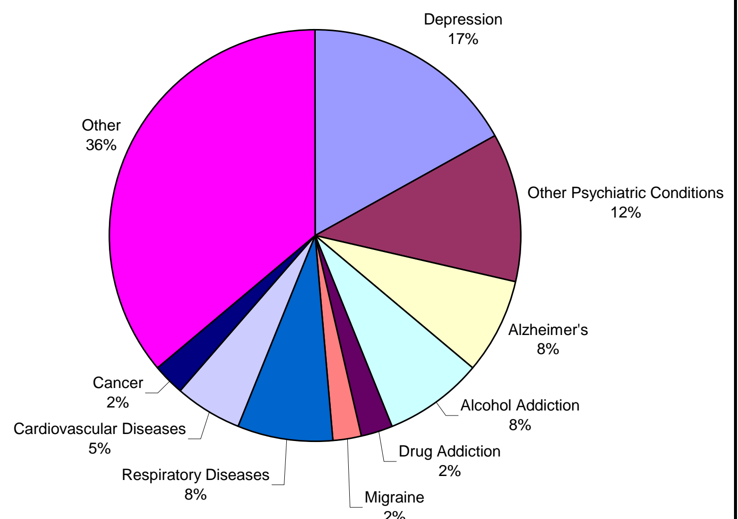


Figure 2



NICE-RECOMMENDED TREATMENTS

Yet all these conditions can be treated by psychological therapies, and the success rates are good by normal medical standards. The treatments have been tested in rigorous clinical trials and it is on this basis that NICE prescribes that they should be offered to those who need them. They are spelt out in detail in NICE Guidelines, for children and for adults.[7] Under the new NHS Constitution, patients are legally entitled to these treatments. The main treatments are these.

For children with conduct disorder, parent training leads to improvement in two-thirds of young children, with effects still detectable four years later. For older children with conduct disorder, problem-solving programmes have good effects, if combined with parent training. And for adolescents, functional family therapy has significant effects in randomised controlled trials. For attention-deficit hyperactivity disorder (ADHD), medication can lead to normal patterns of behaviour in three quarters of treated children.

For anxiety disorders, cognitive behavioural therapy (CBT) clears the disorder in over half of children treated in randomised controlled trials, and the effect is still there when they are followed two years later. For depression, CBT, inter-personal therapy (IPT) and (in carefully selected cases) medication have good success rates.

For adults with depression or anxiety disorders, the general finding is that psychological therapy is as effective as drugs in the short-run, and that both are better than no treatment. In the longer run therapy has more lasting effects than drugs. Patients should therefore have the choice of psychological therapy, and not only drugs.

The typical short-term success rate for CBT is about 50%. In other words, if 100 people start attending up to sixteen weekly sessions (one-on-one, lasting one hour each), within four months 50 people will have lost their psychiatric symptoms over and above those who would have done so anyway. After recovery from anxiety disorders, people are unlikely to relapse. With depression, the probability of relapse is greatly reduced.

The cost of the treatments is not large and would in fact be completely re-couped in lower spending on incapacity benefits and higher tax receipts.[8] A typical course of CBT costs £750. As a result of treatment, those treated will on average work for at least one extra month, and the resulting savings from one month off benefit will be £750. **So the treatment costs the government nothing.**

Availability

These treatments ought to be universally available. But they are not. The situation varies greatly from PCT to PCT - it is a postcode lottery. But in most areas access to specialist psychological help for **children** is quite severely rationed. Only a quarter of children with mental health problems are currently receiving specialist help. And specialist CAMHS services have only two-thirds the staffing levels recommended in the 2004 National Service Framework. Equally serious, much of the treatment offered is not evidence-based – with no serious measurement of success or failure. So there are severe problems of both access and quality.[9]

For **adults** with depression and anxiety disorders the position has until recently been worse, with very limited services available from primary or secondary psychological therapy services. Only a quarter of all those in need are in any form of treatment – mostly medication. But the majority would prefer psychological therapy,[10] and because it is not widely available,

many people preferred to go untreated. In the most recent official survey in 2007, of those in a "depressive episode" only 7% were receiving evidence-based psychological therapy. [11]

The situation is however being radically changed through the government's programme for Improved Access to Psychological Therapy (IAPT), which began in September 2008. If this programme is rolled out faithfully over the next 4 years, it will deliver what is needed for all adults with depression or anxiety disorders. But for this to happen there will have to be a major commitment from our political masters.

THE WAYS FORWARD

So our demand is that within 5 years **evidence-based psychological therapy should be offered to all children and adults who need it.** Though the details are less crucial than the principle, there are three clear steps which could deliver what is needed.

1. Complete the national roll-out of IAPT for adults

The IAPT has two components. The first is a training programme to give a one-year training in evidence-based psychological therapy to 6,500 trainees between 2008/9 and 2013/2014. The second is a process to create state-of-the-art services in every PCT area, offering evidence-based therapy to enough people to meet the local demand. This is happening through a rolling process in which PCT services submit detailed staffing plans for approval before they can be designated as an IAPT service (i.e. one suitable to provide an adequate environment for trainees and patients).

The training programme is based on a newly-devised national curriculum, and trainees leave their previous job to take up new trainee positions where they spend 1-2 days in college and 3-4 days in supervised casework. For a service to be approved as an IAPT service it must have enough staff, with an adequate mix of training and experience. For a typical population of 250,000, a service should employ around 40 therapists. They should operate on a hub-and-spoke basis, with most of the treatment occurring close to people's homes, and much of it on GP premises. And there should be a record of each patient's progress at every session.

In its first two years, the programme has gone extremely well. But from September 2010 for the first time there will be very little earmarked funding. The programme's future success thus depends almost entirely on decisions by PCTs. Since the programme is new, it can only succeed if it is strongly performance-managed by SHAs. It cannot be an optional local decision for the PCT.

This means there has to be a change in the NHS Operating Framework, under which PCTs operate. At present IAPT is a Tier 3 priority, meaning that it is up to local decision. **IAPT needs to be raised to a Tier 1 or 2 priority, making it a national priority.**

It is vital that IAPT cover older people with depression and anxiety disorders in exactly the same way that they cover people of working age. Another neglected group are people suffering form schizophrenia. According to NICE Guidelines, CBT can significantly improve their quality of life, and it should be provided. And family interventions should be available to their relatives, as the Guidelines indicate. It is just not right that so many people in real distress receive no form of talking therapy.

2. Upgrade specialist CAMHS for children

There must also be a major improvement of child and adolescent mental health services (CAMHS). The recent CAMHS Review has set in train important improvements in mental health awareness and competence among teachers and GPs. These are the people who are most likely to notice and act on signs of disturbance in children.

The Review also recommended re-consideration of the training needs of specialist CAMHS.[12] As we have said, improvements at this level are vital. It is simply unacceptable for children diagnosed as ill to be turned away from specialist care because they are not ill enough. And those who are accepted ought to be treated according to NICE Guidelines. When CAMHS teams are asked if they are implementing NICE Guidelines, only 50% say Yes. And half say they "need training in evidence-based treatment".[13] Very few therapists working with children have had sustained training in how to do it.

The obvious way forward would draw on the lessons from IAPT. There would be a training programme for say 1,000 therapists in total over a 5-year period, based on a new one-year national curriculum. PCTs would be asked to bid to become a CAMHS-IAPT service, and to achieve this status they would need to give evidence of an adequate quality and quantity of staff, and extensive use of outcome measurement.

Most of the therapy should of course be near to where the youngsters live – in schools, GP practices, youth clubs and elsewhere. But it would be desirable that over time all psychological therapy for children in an area was provided within a single team – capable of providing high-quality supervision, in-service training and career progression.

Over a 5-year period every PCT service would be upgraded into a CAMHS-IAPT service. Thus by the end of the five years the objective would be satisfied – that every child who needed it received the offer of evidence-based psychological therapy.

3. Cost

The cost of our request is not large. Compared with what is planned for 2010/11, PCTs' annual expenditure would rise by some £200m.[14] NHS finances will, of course, be tight: the main political parties are promising roughly constant real expenditure on the NHS, but there will be some £20 billion of cuts in annual expenditure being used to finance new developments. Surely 1% of these new outlays could be for psychological therapy.

Psychological therapy is indeed the entitlement of every person, young or old, with diagnosed mental health needs. We can no longer accept a lower standard of care for people with mental rather than physical problems. One in three families are affected. But they do not protest as much as other groups, because of the dreadful stigma that has surrounded mental illness. But that is beginning to change. Today voters expect politicians to recognise what is such a central problem in so many families. Parents and relatives are often desperate with worry, and the suffering is immense. Much of it is needless.

For some years, the We Need To Talk alliance and the New Savoy Partnership have been demanding change. They now join with the Royal Colleges in asking that every political party make the following simple undertaking in its manifesto: **Within 5 years they will ensure that evidence-based psychological therapy is available for all who need it, throughout the land.**

Signatories

Mind and the other mental health charities

Royal College of Psychiatry

Royal College of General Practitioners

Royal College of Paediatrics and Child Health

New Savoy Partnership, including the main associations of psychological therapists

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[1] Evidence from the National Child development study. See Layard (2005) p.267, footnote, 36. When M is replaced by malaise at age 23 the results are quite similar.
[2] ONS Survey reported in Green et al (2004)
[3] Richards and Abbott (2009)
[4] Depression Report (2006)
[5] Moussavi et al (2007)
[6] WHO figures see www.who.org. Data for European Union and USA.
[7] For children, see Wolpert et al (2006). In 2006 there were 'guidelines' on OCD, PTSD, depression, eating disorders, self-harm, substance abuse, and 'technology appraisals' (which have stronger force) on parent training for conduct disorder, and medication for ADHD. For adults
[8] Layard et al (2007).
[9] For further detail, see Kelvin et al (2009).
[10] See for example C. Chilvers et al (2001)
[11] McManus et al (2009)
[12] CAMHS Review, Para 8.28
[13] Kelvin et al (2009).
[14] This assumes 1,000 more child therapists in employment and 3,000 more adult therapists (beyond those in 2010/11). At £50k each this costs £200m. (Total expenditure on CAMHS is currently around £1/2 b and on adult depression and anxiety £3b (mainly GPs' time and drugs).