

The case for psychological treatment centres

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The government is committed to “improved access to psychological therapy”. But if we are to meet the NICE guidelines on depression and anxiety, how big an expansion is necessary and how should it be organised? The author expands on his widely-discussed proposals.

If you have schizophrenia or bipolar depression, you will generally get specialist help.¹ But only about 1% of us have these terrible conditions. Very many more (15%) suffer from unipolar depression or anxiety disorders (at any one moment). If you have one of these, often crippling, conditions, you are unlikely to get any specialist help at all. You can see the GP, but the GP is unlikely to prescribe any treatment other than medication.

This pattern of prescribing is completely at variance with the NICE guidelines for depression and anxiety disorders.² These guidelines recommend that cognitive behavioural therapy (CBT) should be available as an option for all but the mildest or most recent forms of depression and anxiety. The guidelines also recommend other forms of psychological therapy for selected conditions. The guidelines are of course based on hundreds of randomised clinical trials. These show clearly that CBT is as effective as drugs when treating depression and anxiety in the short term, and tends to have more durable effects.^{2,3} Moreover psychological help is what thousands or even millions of patients want.⁴

But at present it is simply impossible for GPs to implement the NICE guidelines because the therapists are not available. Thus specialist help is denied for mentally ill people, where it would automatically be supplied for equally disabling cases of physical illness. If the NICE guidelines were implemented, many more people would receive help and massive suffering would be avoided. And the cost of implementing the guidelines would be largely offset by savings to the government on Incapacity Benefits.

In what follows I shall discuss the scale of need and show that the overall benefits of meeting it exceed the costs. I shall then show why the expanded provision should be provided through psychological treatment centres.

The cost of depression and anxiety

According to the WHO, one half of all the suffering due to ill-health in western Europe is due to mental illness.⁵ It accounts for as much suffering as all physical illnesses put together. And the bulk of this suffering is due to depression and anxiety.

There is also a huge economic cost, because depression and anxiety make it much more difficult, or often impossible, to do a job. And, even if in work, you are much more likely to need days off.¹ The resulting loss of output can be calculated as £17 billion, or 1½% of GDP.⁶ Much of this cost falls on the Exchequer, which loses in consequence roughly £9 billion in benefit payments to mentally ill people and reduced tax receipts.

There are now over 1 million mentally ill people receiving incapacity benefits, - more than the total number of unemployed people on unemployment benefits (JSA). So in Britain mental illness has now taken over from unemployment as our greatest social problem.

Cost-effective treatments

Fortunately much of this suffering and this economic waste can be prevented by new treatments developed in the last fifty years. The new drug treatments are now available to all who want them. But the psychological therapies are not - only 4% of all those with depression and anxiety disorders have received such therapy in the last year.¹ Yet, according to NICE, they are at least as effective as drugs. Many patients do not want drugs, but would like 'therapy'. This is one of many reasons why only a quarter of all those who are mentally ill are receiving any form of treatment (including medication).¹ If we are to tackle our mental health problems effectively, we shall have to deploy the evidence-based psychological therapies on a large scale.

These therapies are quite different from traditional psychoanalysis. They are forward-looking and practical, and they typically involve no more than 16 sessions. The best developed, and most studied, is cognitive-behavioural therapy in which patients are taught to challenge their negative thoughts and to pursue positive strategies to build on their strengths. A typical finding for depression (in double-blind clinical trials) is that either drugs or weekly therapy will lift out of depression within four months about 50% of those treated. After successful treatment the risk of relapse is greater for those treated with drugs, unless they keep on taking them.⁷ Thus the cost-effectiveness of the procedures is similar, but many people refuse drugs because of their side-effects and because they want to feel more in control of their emotions.

Should the Treasury support psychological therapy? The cost of therapy would be about £750 for each patient who embarked on treatment.⁸ The likely effect, compared with no treatment, would be about 12 extra months free of depression and 1½ extra months in work – after allowing for the spontaneous process of recovery which would otherwise occur.

In terms of extra output this means about £2,000, which more than repays the cost of £750, without including the benefits of reduced suffering. To value the reduced suffering in money terms is not easy, but if we assume that a year free of depression is worth 0.2 QALYs (quality-adjusted life years)⁹ this extra year without depression is worth about £6,000.¹⁰

Even for the Treasury's own book-keeping, the policy pays off, with savings on incapacity benefits and higher taxes of around £1,000. On top of this there would be significant savings to the rest of the National Health Service. Fewer people would become so mentally ill that they needed hospitalisation or out-patient treatment. (In one study where computerised CBT was made available to patients, their GPs referred 80% fewer patients to secondary services.)¹¹ In addition fewer people would keep besieging their GPs, or be sent to counselling. And fewer people would be referred for supposed physical illnesses. (In London one half of referrals to acute hospitals failed to reveal a "medically explicable" physical condition.)¹²

If we consider anxiety disorders rather than depression, then recovery rates are similar to those from depression (when weighted by the types of disorder)², but the benefits are greater because spontaneous recovery rates are lower. So the case for wider access to therapy becomes even more compelling.

Based on the evidence, CBT is recommended by NICE for every type of disorder, while various other treatments (like family therapy and interpersonal therapy) are each recommended for a limited range of disorders. While further research will probably show the wider value of other types of treatment, it seems sensible to base any proposed expansion at this stage predominantly on CBT. This does not mean that existing alternatives should disappear. But a major expansion, involving large expenditure, has to be guaranteed to succeed, and can therefore rely only on whatever evidence is available so far. These ideas have received general support with the British Psychological Society.¹³

More therapists

So what scale of expansion is needed? It is important for the government to begin by envisaging what kind of provision is necessary and justified, and only after that to consider how fast it could be established.

At present about 2¾ million people will go to the GP with a mental problem some time during a year. Of these it seems likely that roughly ⅓ would opt for therapy (and more would then go to the GP). This paper therefore assumes a need to treat 800,000 patients a year with (mostly) CBT.

If we assume there is 1 therapist for every 80 patients treated in a year, this means that we need an extra 10,000 therapists. There are two possible sources – clinical psychologists and a new type of “psychological therapist”. At present we produce 550 new clinical psychologists a year; this number should rise sharply and the majority of them should go into providing therapy – say 5,000 extra by 2013. The other 5,000 extra therapists should be newly trained “psychological therapists” drawn mainly from older people with experience of mentally-ill people – nurses, occupational therapists, social workers and counsellors. They should be given rigorous training in (mostly) CBT, while being employed in the NHS. The off-the-job training would be part-time. There would be a one-year qualification in CBT for a limited range of conditions, and a 2-year qualification for a wider range of conditions, including some which are more complex.

Treatment centres

The final issue is how the work of these therapists should be organised, in order to guarantee its effectiveness. The answer is that it should be organised in as similar a way as possible to the clinical trials which showed how effective it could be. This means that the therapists should work in teams, where junior therapists can be properly supervised, motivated, supported and trained by senior therapists. CBT is not like a drug, which is the same whoever administers it; it is much more effective when it is professionally administered.¹⁴ So GPs should welcome the opportunity to refer patients to such teams rather than trying to organise the therapists themselves. These teams would operate on a hub-and-spoke basis, with the senior therapists being based in one building but the bulk of therapy being delivered in GP practices, job centres and so on.

The team structure makes it possible for the senior therapists to make the initial diagnosis and assign the patient to an appropriate therapist. All therapists would use a standard one-page questionnaire to measure patient progress, which makes effective

monitoring possible – and, if used nationally, makes it possible to compare the effectiveness of different centres.

A team structure also allows for more flexible appointments and for individual therapists to develop particular areas of expertise. And a central building provides a location for case conferences, consulting rooms where these are not otherwise available, and a place to which patients can self-refer when they do not wish to go through their GP.

The name for these teams should make clear their connection with the central building and they might be called Psychological Treatment Centres (or Well-being Centres, if the phrase appeals). The idea of Psychological Treatment Centres has received widespread support. A suitable objective for say 2013 would be one treatment centre for every 250,000 people: the centres would have much longer spokes in rural than in urban areas. This would mean roughly 250 centres altogether. In rolling out such a system it is vital to maintain quality throughout. A sensible objective could be to roll out 40 new centres each year, with each centre providing a training ground for future centres.

The alternative is a more decentralised approach, with provision organised through GP practises and varying from place to place. This approach might make it more difficult to ensure quality and patient safety: bad therapy can easily do harm. Clearly, to achieve the volume and quality of therapy needed will require in the initial phase a strong lead from the Department of Health.

The fundamental case for expansion is the evidence that therapy works. This evidence comes from trials conducted in psychological treatment centres. The expansion should therefore be provided through teams based in centres but reaching out to people near their homes. If this is well done, it could transform the lives of millions, at no great cost to the Exchequer.

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Contributor and sources

Lord Layard directs the Well-being Programme in the Centre for Economic Performance at the London School of Economics. In January 2005 he was invited by the Prime Minister's Strategy Unit to present a paper "Mental health: Britain's biggest social problem?". Discussions following this led to a Labour Party Manifesto commitment to expand psychological therapy within the NHS. The Department of Health now has a programme on Improved Access to Psychological Therapy, to design and promote the necessary expansion. Two pilots will begin shortly. Lord Layard and other members of the Mental Health Policy Group, which meets at the Centre for Economic Performance, have written a preliminary cost-benefit analysis for the expansion.

Competing interests

None.

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Summary points

The NICE Guidelines say that most patients with depression and anxiety disorders should be offered evidence-based psychological therapies.

Such treatments yield economic benefits that exceed the cost. The net cost to the government is small, owing to savings on Incapacity Benefits and other NHS costs.

To implement the Guidelines requires some 10,000 more therapists. Training this number is feasible over a 7 year period.

The extra therapists should work in teams with a central building, but much of the therapy should be given on GP premises and in job centres. Some 250 of these “Psychological Treatment Centres” should be set up over the next 7 years.

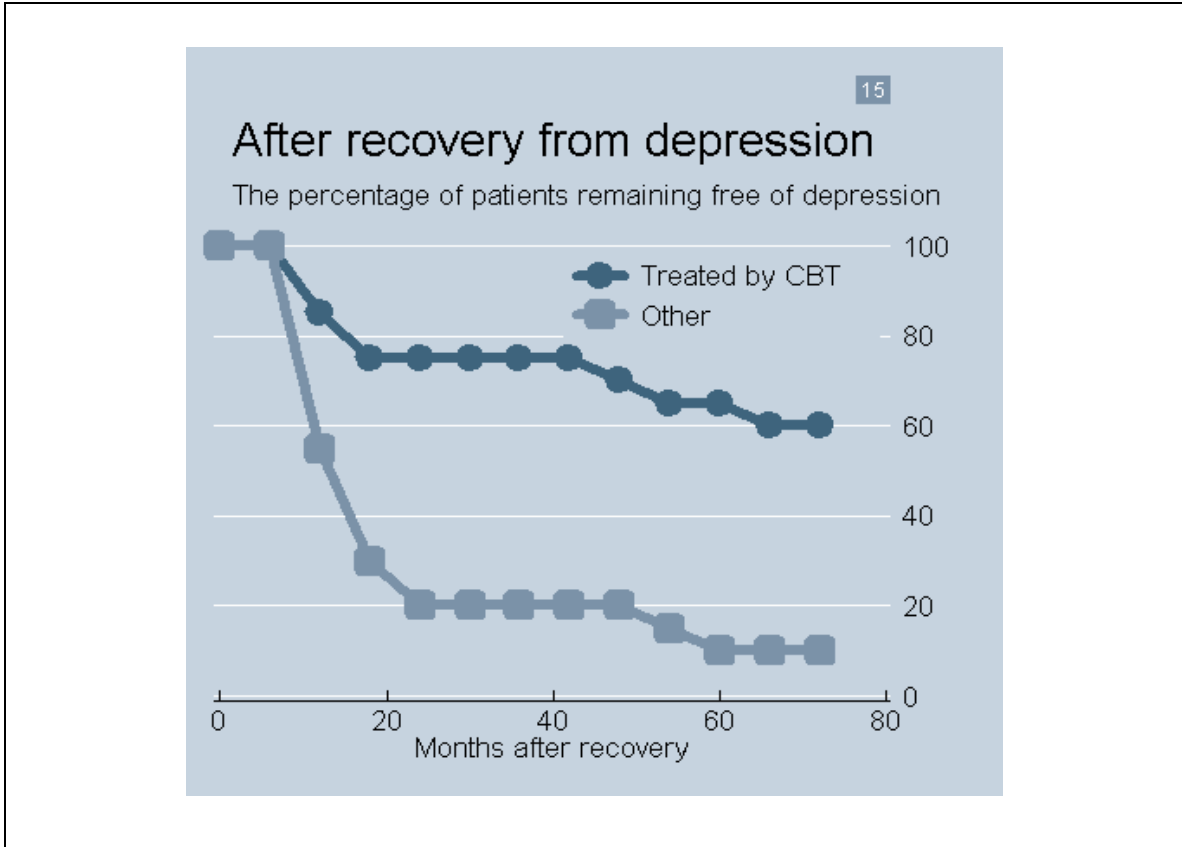
Quotes from the NICE Guidelines

CBT should be offered to patients with moderate or severe depression who do not take or who refuse anti-depressant medication.

For patients with generalised anxiety disorder or panic disorder, the interventions that have evidence for the longest duration of effect, in descending order, are

- psychological therapy (CBT)
- pharmacological therapy
- self-help (bibliotherapy based on CBT principles)

All patients with post-traumatic stress disorder should be offered a course of trauma-focussed CBT



Relevant web site for author’s papers

<http://cep.lse.ac.uk/layard>

Picture

Portrait of Aaron Beck (founder of CBT)

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