

A series of background briefings on the policy
issues in the May 2015 UK General Election

A New Priority for Mental Health

Richard Layard



CEP ELECTION ANALYSIS

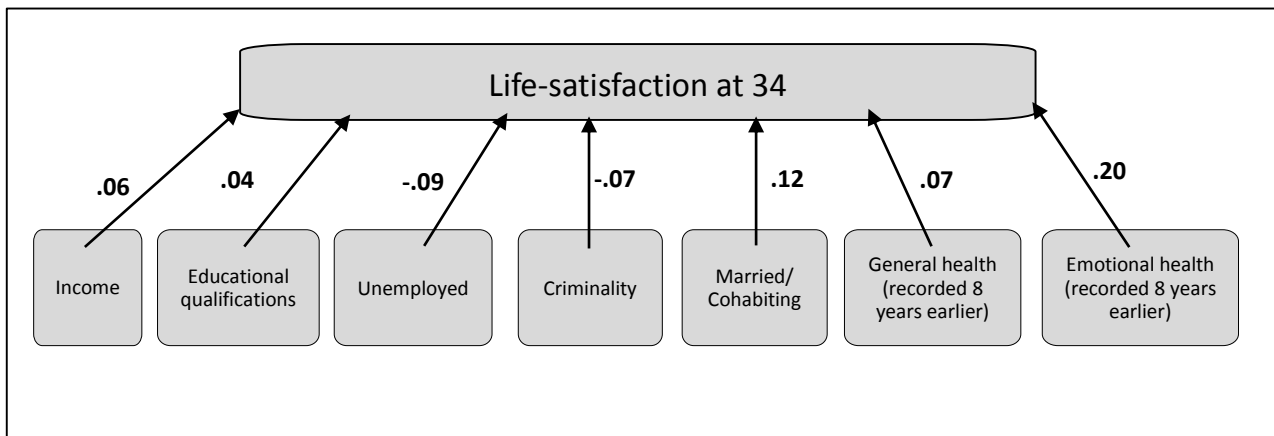
A New Priority for Mental Health

- All the three main parties' manifestos give mental health much greater priority than in any previous election.
- Mental health is the biggest single factor affecting whether people are satisfied with their lives.
- Bad mental health costs the economy at least £70 billion in lost output and costs the economy £10 billion in extra physical healthcare due to mental illness.
- At present, only 15% of adults with depression and anxiety disorders are offered psychological therapy recommended by the National Institute for Health and Care Excellence (NICE). By 2020, this should increase to 25%.
- Only 25% of children with mental health disorders receive any form of treatment. By 2020 this should rise to 33% receiving NICE-recommended treatments. This expansion should be mainly school-based, with a clear integration of Children and Adolescent Mental Health Services (CAMHS) and school-based provision.
- The net cost of providing these treatments would be zero due to the huge savings on disability benefits, crime, social services and additional physical healthcare.

Why mental health matters

Mental health is a key determinant of life satisfaction and of economic performance. As Figure 1 shows, it accounts for more of the variance in adult life satisfaction than any other single factor. In childhood, the best predictor of a satisfying adult life is emotional development – much more important than intellectual development (see Figure 2).

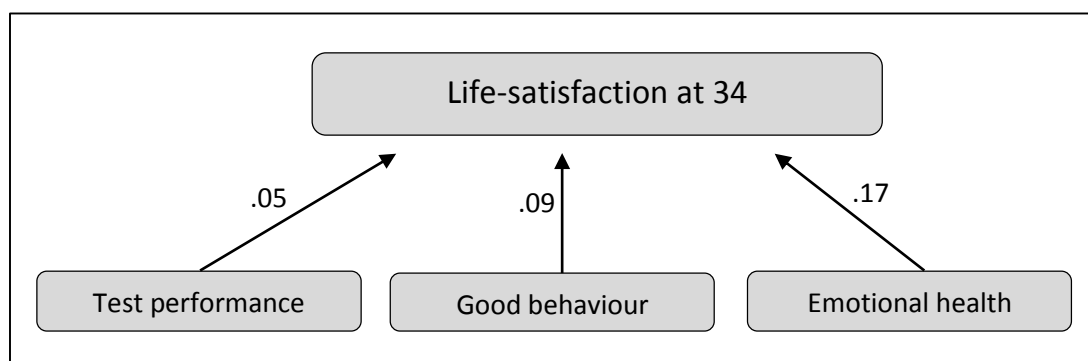
Figure 1: What are the main immediate influences on adult life satisfaction in the UK?
(Partial correlation coefficients)



Source: Layard et al, 2014.

Note: A partial correlation coefficient is the strength of the association between life satisfaction at 34 with the variable indicated, controlling for all the other variables shown plus age and gender.

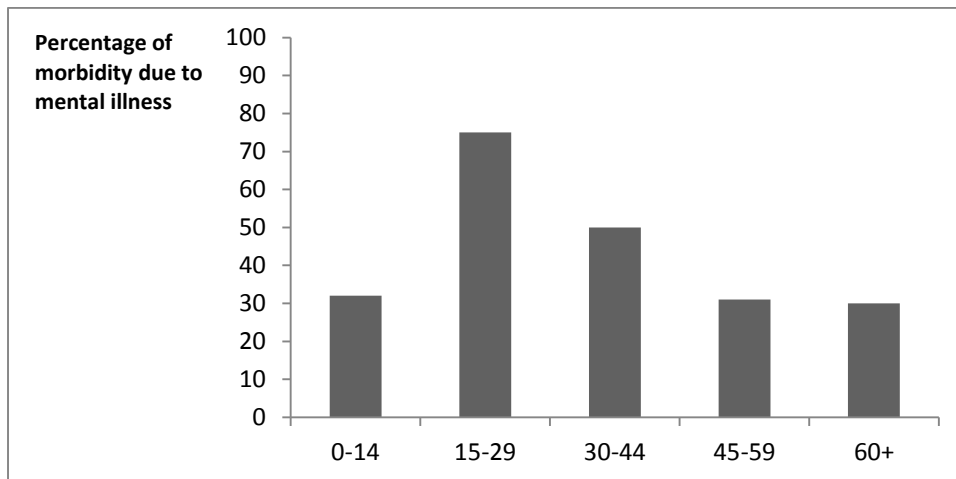
Figure 2: What are the main childhood influences on adult life satisfaction in the UK?
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Source: Layard et al, 2014.

Note: A partial correlation coefficient is the strength of the association between life satisfaction at 34 with the variable indicated, controlling for all the other variables shown plus age and gender.

Figure 3: Mental illness is the main health problem of working age in rich countries



Source: WHO, 2008.

Moreover, mental health problems are concentrated among people of working age, while physical health problems are mainly problems of retirement (see Figure 3). So the economics is completely different for mental health and for physical health. Mental illness accounts for 40% of all disability (claimants of Employment and Support Allowance) and 40% of all absenteeism. Its overall cost to the economy is around £70 billion, of which roughly half is borne by taxpayers (Layard and Clark, 2014). Mental illness also adds 50% to the cost of physical healthcare (another £10 billion).

Yet of over six million adults with depression or anxiety disorders, under 33% are in treatment (mainly medication). Only 9% a year receive psychological treatments recommended by the National Institute for Health and Care Excellence (NICE). Similarly, there are roughly one million children with diagnosable mental health problems. Only 25% of these are in treatment, and that is rarely a treatment recommended by NICE.

Recent developments

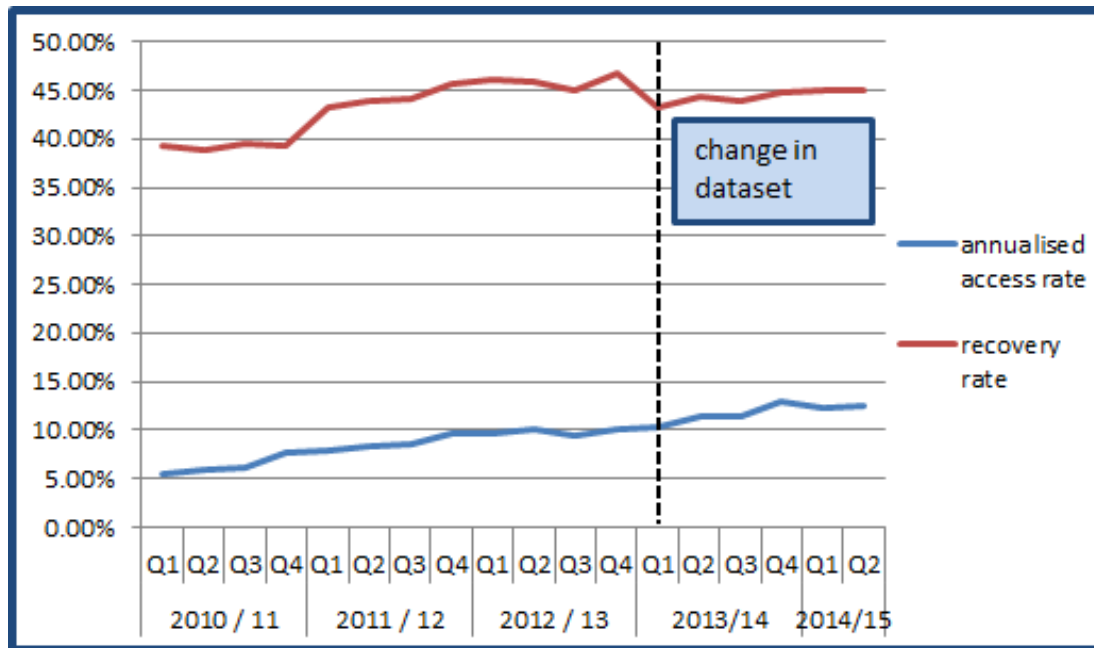
The key development in the 2010-2015 Parliament was the Health and Social Care Act 2012, which established ‘parity of esteem’ for mental and physical health. This means that people should have the same access to NICE-recommended treatments whether their problem is with mental or physical health. We are currently far from that situation.

The main failing is the shortage of psychological therapy, and the main achievement of previous governments has been to begin reducing that shortage. For adults with depression and anxiety, the Improving Access to Psychological Therapies (IAPT) programme for **adults** was launched in 2008, and by the summer of 2014, it was seeing an annual rate of 13% of the six million people in need – with self-referral allowed. Of those treated, 45% were recovering during treatment (see Figure 4).

The target for access is 15% by 2015 and it is likely to be hit. But this rate varies hugely (between 3% and 29%), across clinical commissioning groups (CCGs) as does the recovery rate (between 8% and 63%). Data on outcomes are available for almost every patient seen – a first in the world. Indeed more generally, the journal *Nature* has called IAPT a ‘world-beating’

programme. Its success is due to the training of over 6,000 therapists on national curricula and their employment in high-quality approved services.

Figure 4: National access (referrals) and recovery rates 2010-14



Data source: IAPT dataset, Health and Social Care Information Centre (HSCIC).

In 2010, a separate IAPT programme was established for **children and young people**. The aim here was to transform existing Children and Adolescent Mental Health Services (CAMHS) to services delivering NICE-recommended therapies and monitoring outcomes. This has involved a major training programme that now cover 68% of the country (but still only 56% of their therapies are NICE-recommended). Over 1,000 therapists and supervisors have been trained in the first four years of the programme.

But at the same time, CAMHS has in many areas been subject to massive funding cuts, due to its part-funding by local authorities. Fortunately, the coalition government has recently responded to this by the promise of an extra £250 million a year (at least 33% extra) but the way this will be used remains to be determined.

The bulk of mental health expenditure (which is around 13% of all NHS expenditure) goes on people with severe mental illness. Shockingly, this expenditure has declined somewhat in real terms over the 2010-2015 Parliament, causing major pressures on many in-patient wards. A new priority for crisis resolution may help here.

Future needs

The most important task is to maintain the expansion of IAPT. Figure 5 contains our proposals. This will mean increasing the adult IAPT budget from £306 million in 2015 to £600 million by 2020.

Figure 5: IAPT proposals for 2020

<u>Numbers seen as percentage of need</u>			
Adults	2015	15%	(including 9% treated)
	2020	25%	(including 15% treated)
Children	2020	33%	

Source: Layard and Clark, 2014.

For **adults**, the main challenge is to extend expert help to people with co-morbid physical conditions. This will require a new way of working closely with acute specialists and GPs, normally on their premises. At the same time, ‘payment by results’ needs to be introduced to improve funding.

For **children**, the whole expansion in therapy should be on school premises, which provide a much more acceptable location for early intervention. At the same time, psychological therapy and routine outcome measurement needs to be extended to all patients with **severe mental illness** – not through IAPT but by an upgrading of existing services for these patients.

Why IAPT expansion costs nothing

The IAPT programme costs commissioners nothing. This is because people with depression and anxiety disorders cost the NHS a huge amount in terms of their physical healthcare. Thus people with long-term physical conditions cost the NHS around £6,000 per year in physical healthcare if they are mentally ill, but only £4,000 if they are not mentally ill. This difference of £2,000 compares with the cost per person treated in IAPT of around £650 – a one-off cost.

So it is not surprising that 91 controlled trials in the United States have found that people who have been given psychological therapy cost on average 20% less in physical healthcare compared with people not treated for the same psychological problems (Chiles et al, 1999). In UK terms, this is a saving of £1,200 – more than the cost of therapy. And in nine out of ten of the US studies, the savings on physical healthcare did indeed exceed the costs of the psychological healthcare.

This is an enormously important finding and it is supported by the only matched data we have in the UK – in a West Berkshire practice (Layard and Clark, 2014). People given a full course of treatment in IAPT in that practice cost £1,050 a year less in physical healthcare than people with the same psychological problems not treated by IAPT.

These savings were nearly all cash-in-hand for commissioners: fewer outpatient sessions; fewer hospital admissions; and fewer appearances at Accident and Emergency wards. In cases where psychological therapy is specifically designed for groups with particular problems (for example, breathing problems, or chest pain, or diabetes) the savings are even bigger. So for commissioners, IAPT is a good deal.

What are the main parties promising?

All the three main parties have much fuller commitments on mental health than in previous elections. Key features include the following:

Labour:

1. A new right to talking therapies in the NHS constitution.
2. Access to talking therapy for the great majority within 28 days.
3. A greater share of mental health spending to be devoted to children and all children who need it able to access school-based counselling.
4. All healthcare workers and teachers trained to identify mental health problems.
5. Teaching of social and emotional skills, for example, through mindfulness.

Liberal Democrats (the fullest):

1. Interim target of getting 25% of those suffering into treatment.
2. Waiting times standard of within six weeks for depression and anxiety and two weeks for adolescent psychosis.
3. Revolutionise children's mental health services.
4. All frontline professionals trained to identify mental health problems.
5. Schools will develop mental resilience.
6. A £50 million research fund.

Conservatives (the least explicit):

1. Ensure that there are therapists in every part of the country providing treatment for those who need it.
2. Enforce the new access and waiting time standards for people experiencing mental ill-health, including children and young people.
3. Ensure women have access to mental health support during and after pregnancy.
4. Help people back into work if they have a long-term treatable condition, including significant new support for mental health.

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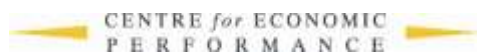
Further reading

Chiles, J A, M J Lambert and A L Hatch (1999), 'The Impact of Psychological Interventions on Medical Cost Offset: A Meta-analytic Review', *Clinical Psychology: Science and Practice* 6(2): 204-220.

Layard, R, A E Clark, F Cornaglia, N Powdthavee and J Vernoit (2014) 'What Predicts a Successful Life? A Life-course Model of Well-being', *Economic Journal* 124: F720-738.

Layard, R and D M Clark (2014) *Thrive: The Power of Evidence-based Psychological Therapies*, Penguin.

WHO (2008) *The Global Burden of Disease: 2004 update*, Geneva: World Health Organisation.



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