Strange bedfellows: economics, happiness and mental disorder

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SUMMARY. **Aim** – The high economic and social costs associated with the 'common mental disorders', and the need to scale up appropriate care services, are now widely recognized, but responses vary from country to country. In Britain, a current government initiative to promote psychological therapy is driven both by economic pressures and by research on the factors of happiness, or life-satisfaction. This article provides a short critical review of the project. **Method** – A health policy analysis, with regard to problem definition; objectives; sources of information; criteria for evaluation; impact on existing services, and comparison with alternative strategies. **Results** – The new programme, *Improving Access to Psychological Therapies* (IAPT), aims to expand treatment services by training 3,600 'psychological therapists' in cognitive behavioural therapy (CBT), which they will then apply in the wider community. This service, with an initial budget of £173 million, will provide treatment for depression and chronic anxiety from local centres across the country. The programme is intended to pay for itself by reducing incapacity costs. Closer examination, however, raises questions concerning the project's theoretical basis, logistics and research methodology, and casts doubt on its advantages over alternative approaches. **Conclusions** – The IAPT project is ill-designed to achieve its objectives and unsuitable as a model for treatment and care of the common mental disorders in other countries. An alternative strategy, based on closer integration of community mental health and primary health care, should be tested and on previous experience seems likely to prove more cost-effective.

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Ninety years ago, Sigmund Freud remarked on "the vast amount of neurotic misery which there is in the world and perhaps need not be", foreseeing a day when the state would come to accept its collective responsibility and make psychological therapy available to its citizens according to need (Freud, 1919). The high economic and social costs associated with the 'common mental disorders' (depression, anxiety state and related neuroses), and the need to scale up appropriate care services, are now widely recognized (World Health Organization, 2008), but national responses are inconsistent. Provision of psychological therapy, in particular, varies even among high-income countries in relation to training, organisation and funding (Priebe, 2006).

In the British National Health Service (NHS), estimates of treatment need draw upon psychiatric prevalence data. Current policy on treatment services is, however, unusual in being influenced both by economic pressures and by psychological research on the factors of happiness, subjective well-being or life-satisfaction. Here a key role has been played by Richard (Lord) Layard, professor emeritus of economics, who argues that mental illness has replaced unemployment as Britain's biggest social problem; that the economic consequences are grave, and that a national strategy is needed to make psychological therapy more widely available. The present review summarizes Layard's proposal and its implementation in a national programme, *Improving Access to Psychological Therapies* (IAPT), and assesses its suitability as a model for mental health services elsewhere.

METHOD

Although an on-line search yields some 5,000 'hits' for the IAPT project, empirical findings are limited to

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descriptive data from two demonstration sites (Clark *et al.*, 2008), and no systematic statistical analysis is yet possible. The most useful approach, at this stage, is to follow the steps of a health policy analysis, in order to define the basic problem and clarify objectives; to check sources of information; to identify the criteria for use in evaluation; to assess the likely impact of changes arising from the selected programme, and to distinguish one or more alternative strategies (Patton & Sawicki, 1993; Weiner, 2005). With regard to the British situation this analysis must be largely retrospective, insofar as the policy in question has already been decided and is in process of being realised.

RESULTS

A proposed new service for psychological therapy

Layard's starting point was that economic growth should be seen, not as an end in itself but as a means to the true end – namely, raising standards of human happiness – but that, in high-income countries, increasing personal wealth appears not to bring a corresponding increase in happiness (Layard, 2006). His argument, succinctly presented in *The Depression Report* (Centre for Economic Performance, 2006), runs as follows. In Britain, depression explains more variation in happiness than does income, even allowing for the association between depression and poverty. Reported prevalence of the common mental disorders is very high: in the National Psychiatric Morbidity Survey 2000 (Office for National Statistics, 2002) one adult in six was found to be suffering from depression or chronic anxiety state, and one family in three was affected. Official statistics put the number of people on support allowances because of mental illness at nearly one million: at that time more than the total for those seeking employment. Taking into account absenteeism, the loss of output due to depression and anxiety was estimated at £12 billion a year, or 1% of national income. On this evidence it is concluded that "crippling depression and chronic anxiety are the biggest causes of misery in Britain today" (Centre for Economic Performance, 2006).

The Depression Report claims that most cases of depression and chronic anxiety go untreated or inadequately treated. In the national survey sample, it states, only one-quarter of affected adults were currently under treatment, mostly with medication only, and only one in twelve had been seen by a psychiatrist in the previous twelve months. Wherever psychological therapy is available, there are long waiting lists. Fortunately, it goes on, we now have cognitive behavioural therapy (CBT), a form of treatment confirmed as effective in many clinical trials (National Institute for Clinical Excellence, 2004). A single course of CBT, costing about £750, will yield 12 additional months free from depression, and nearly two extra months at work. As incapacity support costs that much in a single month, the treatment should more than pay for itself.

Layard's solution was the creation of a new service in which psychological therapists would work in teams of about 40, based on treatment centres around the country. Each team would cover a population of about 200,000 people on a hub-and-spokes model, with quality control from the centre, corresponding to a national requirement for 250 teams. Deployment of 10,000 new therapists could be achieved over a seven-year period by training 5,000 clinical psychologists and about the same number of health-care professionals – nurses, social workers and others. Combined training and running costs would amount to £650 million over the first three years.

Implementation: the IAPT Project

This proposal was welcomed by the Department of Health (partly as a means of reducing long waiting times for therapy or counselling, which had become a political embarrassment), and was used as basis for the IAPT programme. (Department of Health, 2008a). The Department did not query Layard's estimated level of treatment need, but nonetheless modified his proposal in two important respects.

First, a 'stepped-care' approach to treatment will be applied (see Table I). Mild cases will receive advice, explanation and if need be guided self-help, while counselling, interpersonal therapy and, in particular, CBT with trained therapists will be employed from Step 3 onward, for moderate-to-severe and complex cases. Secondly, manpower and budget costs have been much reduced. The new programme's target is to train 3,600 instead of 10,000 therapists; it is to be implemented in stages and the budget for the first three years will be, not £650 but £173 million. According to a government press release, however, the project's aims are still ambitious: 900,000 patients to be treated in the first three years, of whom it is hoped that around half will be 'completely cured'.

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Table I – *Stepped care model for management of depression.*

Guidance steps	Care agency	Interventions
1 Recognition	GP; practice nurse	Assessment
2 Mild depression	Primary care team, incl. mental health worker	Guided self-help; cCBT;[1] brief psychol, therapy
3 Moderate depression	Primary care team, incl. mental health worker	Anti-dep. medication; CBT;[2] social support
4 Severe depression	Mental health team; crisis management	Anti-dep. medication & CBT[2] conbined
5 Risk to life; severe self-neglect	In-patient care; crisis management	Medication; combined treatments; ECT

[1] computerised cognitive behavioural therapy
[2] or other psychological therapy
Source: National Institute for Clinical Excellence, 2004 (simplified)

Table II – *IAPT demonstration project: outcome of referrals to service*[1]

Outcome of referral process	No.	%
Total referrals	5,494	100.0
Unsuitable for therapy (incl. referrals on to employment agencies)	667	12.1
Declined therapy	964	17.5
Dropped out after first session	604	11.0
Therapy concluded after 2 or more sessions	1,903	34.6
Still in system at one year	1,356	24.7

[1] Two demonstration sites combined
Source: Clark *et al.*, 2008

Table III – *'Pathfinder' referrals by diagnostic category (N=11,800).*

Referral diagnosis/presenting problem	%
Depression	31.8
Generalised anxiety	17.2
Mixed depression & anxiety	15.4
	64.4
Other neuroses	4.9
Drug / alcohol problems	0.7
Psychoses (incl. bipolar disorders)	0.3
Other conditions	3.5
Unspecified	26.2
Total	100.0

Source: Improving Access to Psychological Therapies, 2008a

Two demonstration projects, which ran for a year in areas with contrasting features, are now being analysed; and preliminary findings are set out in an initial report (Clark *et al.*, 2008). From this first, sketchy report, uptake of the new service appears to be good, with well over 5,000 referrals in one year. In all, however, 40 per cent of patients were deemed unsuitable, declined therapy or dropped out after a single session.

Subsequently, 11 so-called 'Pathfinder' sites were established at locations across the country and are now in operation (Improving Access to Psychological Therapies, 2008a). Nearly 12,000 patients were referred, over 90 per cent of them from general medical practice, and diagnoses of depression and / or anxiety state predominated (see Table III). A majority of referred patients were judged to require Step 2 interventions; most often guided self-help with work-books. Only one-quarter (27.3%) were offered CBT with trained therapists, and this core group received on average 6-7 treatment sessions, or under half the full course. A high proportion of clinical contacts are made by telephone, as opposed to face-to-face. Half the patients who had been ill for six months or longer are said to be recovered, but details are not yet available.

Critical appraisal of the programme

It thus appears that the new service will operate quite differently from the original concept, and in particular will employ CBT in only a fraction of cases. This calls in question the whole rationale of the IAPT project. Nevertheless, its advent has been greeted as a major advance by many clinical psychologists as well as by their professional bodies. Viewed as a public health initiative, the programme has definite advantages. It is based on defined area populations; treatment is intended to be free at the point of delivery, and case referrals will come mostly from general medical practice – which is where in Britain most mentally distressed people first present (Goldberg, 2003). Many depressed or anxious patients, moreover, find some kind of supportive therapy more helpful than medication alone, and will welcome this increase in choice. All that being said, however, a simple policy analysis raises doubts about both Lord Layard's proposal and the programme derived from it.

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1. Defining the problem

The basic *clinical* problem is the currently unsatisfactory treatment and care of common mental disorders in the NHS, but this has to be disentangled from broader issues of public happiness and the economic problems of unemployment. Happiness, prosperity and mental health are here being conflated as though, in practice, social psychologists, economists and medical clinicians are all working towards one common goal – which, for better or worse, is not the case. There is as yet no empirical evidence that improved access to psychological therapy will either raise public standards of happiness, or reduce the burden of unemployment in a faltering economy.

In high-income countries, levels of reported happiness do not change over time in line with income levels, or gross domestic product (GDP) per capita (Johns & Ormerod, 2007). In the UK, reported life-satisfaction remained constant over the 30-year period 1973-2002, despite a steady rise in GDP. This finding does not, in itself, refute Layard's case. More surprising is the fact that reported happiness levels also fail to correlate either with social indicators (e.g., income inequality; rates of violent crime) or with health indicators such as life expectancy, or even reported rates of depression. Johns & Ormerod (2007, p. 13) concluded that "Either ….attempting to improve the human lot through economic or social policy is futile, or….happiness data over time is (*sic*) an extremely insensitive measure of welfare. The evidence points to the latter". This may be in large part because the assessment of public happiness relies mainly on questionnaire techniques. People are asked to rate their own level of happiness on scales that often specify only *not happy, fairly happy or very happy*. Although the findings are generally consistent, their validity is not at all clear. Much more basic research is required in order to ensure the validity of such data.

2. Clarifying the objectives

The programme objective is defined as improved access to psychological therapy for common mental disorders. A focus of concern among therapists has been over-valuation of CBT as the method of choice for such conditions. Holmes (2002), for example, pointed out that this technique fared less well than others in a major treatment-of-depression trial, and that little is known about the relative benefits of different forms of psychological therapy on longer-term outcome.

For other critics, the central weakness of behavioural therapy in general is that, as the name implies, it is focused on behaviour and symptomatology, rather than underlying causal factors, and hence is unsuited to dealing with disturbances whose prime causes can be located in relationship problems and social conditions. The epidemiological evidence suggests that improved outcomes for psychological disorders will depend largely on reducing social risk factors in the domains of housing, occupation, finances, marriage and family life (Foresight Mental Capital and Wellbeing Project, 2008).

Thirty years ago, Brown & Harris (1978), in *The Social Origins of Depression*, concluded – like the happiness theorists – that 'it is change in thought about the world that is crucial', but went on to explain such changes by a more complex scenario which stressed the importance of past experience on personal self-esteem and the way one views the world. Their model helps to explain why in Britain, for example, working-class women are four times as likely to be depressed as those in the middle classes. Neither in the Depression Report nor in the happiness literature generally do we find these issues dealt with (Ferguson, 2007).

3. Checking sources of information

There are indications that the IAPT project is based on an overstated requirement for trained psychological therapists, First, it relies on prevalence estimates from the National Psychiatric Morbidity Survey (Office for National Statistics, 2002), which reported an overall rate of 16% for depression, anxiety and related neurotic disorders among persons aged 16-75 years. Diagnoses for non-psychotic conditions in the main survey sample, however, relied on screening with the revised Clinical Interview Schedule (CIS-R), carried out by lay interviewers who had been on a one-day course of 'survey-specific training', and no clinical judgements were involved. The survey report actually cautioned that ratings made under these conditions tend to provide higher prevalence estimates than those made by experienced clinicians (Office for National Statistics, 2002, p. 13).

Secondly, while in severe to moderate depression the case for psychological therapy (preferably combined with medication) is strong, this cannot be said for mild depressive or mixed anxiety-depressive states (Middleton *et al*., 2005), and data from the two demonstration sites suggest that in fact cases of the latter type predominated. Thirdly, a proportion of referred patients (40% in the demonstration project) declined treatment or dropped out quickly, while of those who completed a course, only a minority were judged to require CBT from trained therapists. The possibility must be considered,

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that many others could have been managed at least as well by primary care teams, given a short period of training.

4. Establishing criteria for evaluation

Scientific evaluation of an experimental service calls for the use of standardized clinical and social measures. In this instance, information is to be collected about change in four domains (health and wellbeing, social inclusion – including employment status –, available choice of services, and improvement in access and waiting times) by means of a 'minimum data set'. This is in fact an elaborate system, involving a large battery of questionnaires, but the planning specification does not call for random allocation, matched control groups or other clear research design (Improving Access to Psychological Therapies, 2008b). A university-based team has been awarded a three-year contract to evaluate data from the demonstration project, which is now classed as a pilot study.

How seriously, in fact, are the requirements for evaluation being taken? The demonstration project's core purpose was defined (while it was still in progress) as being "to collect evidence of delivery to substantiate the development of a business case for a national roll-out of the IAPT service model". This is the language of business management, not of science. The fact that by then resources had been allocated for the subsequent 'Pathfinders' phase implies that a political decision to go ahead was taken before any pilot results were available.

5. Estimating impact on the existing health service

Commissioning guidelines (Department of Health, 2008b) make it clear that the new treatment centres need not form an integral part of the public-service NHS, but that contracts will be awarded, subject to tender, on the basis of 'world-class commissioning'. Those who commission psychological therapy, it is stressed, should invite interest from the broadest possible range of providers. This means in practice that private companies, whether based in Britain or elsewhere, will be eligible to submit bids if they have any claim to relevant experience.

Meanwhile the NHS as a whole has been opened up to market competition (Pollock *et al*., 2007). Since 2003, new legislation allows primary care trusts to commission care from "anyone capable of securing delivery of such services" and are being advised on procurement by consultants from a list of approved business corporations (Department. of Health, 2007). That is to say, commissioning of private care agencies can be recommended by representatives of the industry. In some areas local primary care has already been privatized under a so-called 'alternative providers' scheme. The whole system, it seems, will be transformed so that government is no longer accountable for service provision, but only for service commissioning. How under these conditions psychological therapists and primary care professionals, responsible to different employers with competing interests, can be welded into a single effective team serving the patients' best interests remains an unanswered question.

6. Identifying and assessing alternative strategies

A discussion of mental health in primary care, published by the Department of Health, comments that "expecting professionals with specific expertise in physical health care to become involved in mental health could lead to poor care or diversion of precious resources" (Care Services Improvement Partnership, 2006): a statement implying that psychosocial treatment and care are not integral to general medical practice, and that general practitioners have little to contribute, apart from writing prescriptions. To make such a split between physical and mental health at the primary care level would in effect put the calendar back more than half a century. Already in the 1960s a trend towards shared care of mental illness had begun to emerge in Britain, whereby psychiatrists held regular clinical sessions and case discussions in local practices.

The new form of service grew rapidly within the NHS, particularly in large urban practices. Primary care attachments were held by one in five adult psychiatry consultants in England and Wales by 1982 (Strathdee & Williams, 1984) and by over half those in Scotland a few years later (Pullen & Yellowlees, 1988). This development, moreover, occurred silently with no extra budgeting, suggesting that it was no more costly than hospital out-patient services – as indeed one control study demonstrated (Goldberg *et al*., 1996).

The intervening years have seen analogous developments in many countries, influenced by the British experience, though in each instance adapted to national service conditions (Goldberg, 2003). In the USA, shared care models are reported to be cost-effective in reducing impairment due to depression (e.g., Rost *et al*., 2005). It is thus ironic that in Britain this form of collaboration now appears to be in decline, and the gap between primary care and mental health services to be widening (Banks & Gask, 2008).

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CONCLUSION

This simple policy analysis reveals serious weaknesses both in Layard's original proposal and in the IAPT programme derived from it. Already their guiding assumptions are being challenged by the advent of global economic recession and a rising tide of unemployment. But even apart from the problems of work resettlement, creation of a separate agency for psychological therapy, outside the health service mainstream, is an unpromising direction for mental health reform. Such a deeply flawed project seems unlikely either to realise Freud's vision in a British context, or to provide a suitable working model for other countries.

A different approach is called for: one that brings diagnosis and treatment of common mental disorders into the front line of medicine and adds a social dimension to the whole complex (Tansella & Thornicroft, 1999). The risk factors of mental disorder include major social components, and the psychosocial resources of primary care need to be strengthened accordingly (Foresight Mental Capital and Wellbeing Project, 2008). A shared-care system featuring psychiatric liaison, attachment and case-centred teaching in primary health care affords the brightest prospects for community 'outreach' in the truest sense. In this model, trained psychological therapists could play a valuable role, but they would do so as an integral part of the public health service, not in an independent specialism. There are today encouraging signs in Britain of a renewed interest in a form of primary care psychiatry that incorporates these features (Banks & Gask, 2008), and similar initiatives in other countries would be timely.

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