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The depression report : a new deal for depression and anxiety disorders

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London School of Economics

THE DEPRESSION REPORT
A New Deal for Depression and Anxiety Disorders

The Centre for Economic Performance's
Mental Health Policy Group

June 2006

THE DEPRESSION REPORT

A New Deal for Depression and Anxiety Disorders

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SUMMARY

Crippling depression and chronic anxiety are the biggest causes of misery in Britain today. They are the great submerged problem, which shame keeps out of sight. But if you mention them, you soon discover how many families are affected. According to the respected Psychiatric Morbidity Survey, **one in six of us would be diagnosed as having depression or chronic anxiety disorder**, which means that one family in three is affected.

That is the bad news. The good news is that **we now have evidence-based psychological therapies that can lift at least a half of those affected out of their depression or their chronic fear**. These new therapies are not endless nor backward-looking treatments. They are short, forward-looking treatments that enable people to challenge their negative thinking and build on the positive side of their personalities and situations. The most developed of these therapies is cognitive behaviour therapy (CBT). The official guidelines from the National Institute for Clinical Excellence (NICE) say these treatments should be available to all people with depression or anxiety disorders or schizophrenia, unless the problem is very mild or recent.

But the **NICE guidelines cannot be implemented** because we do not have enough therapists. In most areas waiting lists for therapy are over nine months, or there is no waiting list at all because there are no therapists. So, if you go to the GP, all that can be provided is medication (plus at some surgeries a little counselling). But many people will not take medication, either because they dislike the side effects or because they want to control their own mood.

The result is tragic. **Only one in four of those who suffer from depression or chronic anxiety is receiving any kind of treatment**. The rest continue to suffer, even though at least half of them could be cured at a cost of no more than £750.

This is a waste of people's lives. It is also costing a lot of money. For depression and anxiety make it difficult or impossible to work, and drive people onto Incapacity Benefits. **We now have a million people on Incapacity Benefits because of mental illness** – more than the total number of unemployed people receiving unemployment benefits. At one time unemployment was our biggest social problem, but we have done a lot to reduce it. So mental illness is now the biggest problem, and we know what to do about it. It is time to use that knowledge.

But can we afford the £750 it costs to treat someone? **The money which the government spends will pay for itself.** For someone on Incapacity Benefit costs us £750 **a month** in extra benefits and lost taxes. If the person works just a month more as a result of the treatment, the treatment pays for itself.

So we have a massive problem – the biggest problem they have for one in three of our families. But we also have a solution that can improve the lives of millions of families, and cost the taxpayer nothing. We should implement the NICE guidelines; and **most people with mental illness should be offered the choice of psychological therapy**.

Everyone who wants something done should write to their MP calling for action.

INTRODUCTION

This pamphlet is about action, based on analysis. First we give **six reasons for action**:

- there is massive distress
- such suffering is a major form of deprivation
- much of it goes untreated
- this involves huge economic costs
- treatments exist that can relieve the distress, and that pay for themselves
- NICE Guidelines should be implemented

Then we describe the **key elements of a solution**

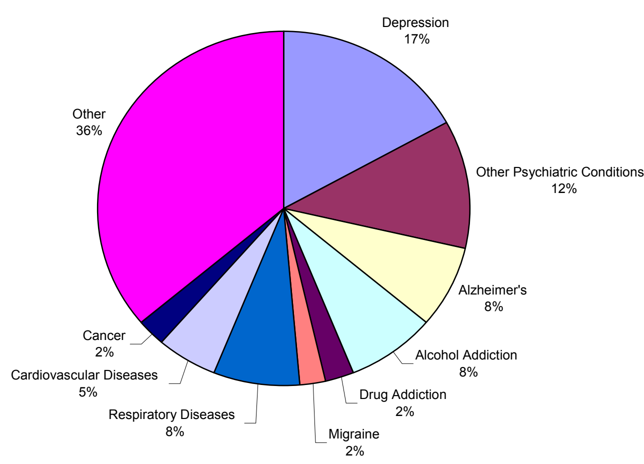
- ten thousand more therapists
- working in teams
- according to a 7-year plan, centrally funded and commissioned

THE SCALE OF MENTAL ILLNESS

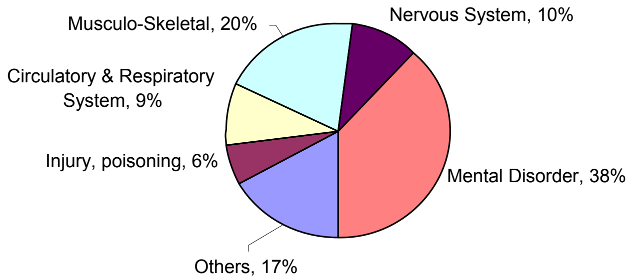
Mental illness accounts for over a third of the burden of illness in Britain. For example, **some 40% of all disability (physical and mental) is due to mental illness**.[1] Similarly, roughly 40% of people on Incapacity Benefits are there because of mental illness, (and mental illness is a secondary factor for at least another 10%).[2] Likewise at the surgery one third of those who appear each year have mental health problems, and they take up at least a third of GP time.[3]

The attached diagrams show just how important mental illness is within the general spectrum of disease.

Causes of Disability



Incapacity Benefits recipients: by medical condition, 2004



Percentage of people currently suffering from mental illness (people aged 16-75)	
Schizophrenia	½
Depression	2 ½
Anxiety disorders	
Generalised anxiety	4½
Social phobia, agoraphobia, etc	2
Obsessive compulsive disorder	1
Panic disorder	1
Mixed depression and anxiety	5½
Total	16½

The numbers affected are huge. According to the respected Psychiatric Morbidity Survey, some 6 million people are suffering from depression or anxiety disorders or both, using the standard international classification of disease. This is almost one in six of the adult population, and is broadly similar for men and women.[4]

MENTAL ILLNESS AND DEPRIVATION

We are not talking about the "worried well". We are talking about people whose lives are crippled by their distress. Such mental pain is often worse than physical pain and it affects more people – not to mention their families. Here is Berlioz's description of one of his fits of depression.

> "The fit fell upon me with appalling force. I suffered agonies and lay groaning on the ground, stretching out abandoned arms, convulsively tearing up handfuls of grass and wide-eyed innocent daisies, struggling against the crushing sense of *absence*, against a mortal isolation. Yet such an attack is not to be compared with the tortures that I have known since then in ever-increasing measure."

Thus, when psychologists study how different types of disability affect a person's subjective well-being, they regularly find that mental illness is the single most powerful predictor of distress.[5]

More widely, one can ask, What is the biggest single cause of misery in our community? Most people would answer 'poverty'. But they would be wrong. **If we try to predict who is unhappy we find that the strongest predictor is a person's prior mental illness.** Prior mental illness (ten years earlier) explains more current unhappiness than poverty does.[6]

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**.

UNTREATED ILLNESS

Yet most of this illness goes untreated. Only a quarter of those diagnosed in the survey are in treatment. Even among those in a "depressive episode" under a half are in treatment; only 8% have seen a psychiatrist in the last twelve months and 3% a psychologist. Most of those in treatment are on medication prescribed by a GP, although the majority of patients would prefer 'therapy'.[7] The fact that therapy is not generally available is one reason why so much illness goes untreated.

Therapy is not available for many reasons. Effective therapies have been developed more recently than drugs. But expenditure priorities also play their role. **While depression and anxiety account for a third of all disability,[8] they attract only about 2% of NHS expenditure**.[9] Most NHS expenditure on mental health goes on the most seriously ill people, who suffer from schizophrenia or manic depression. These people are only 1% of the population and they desperately need better care. But so do the 16% of the population who suffer from depression and chronic anxiety disorders. Their under-treatment exerts a huge cost in terms of distress - and of economic loss.

THE ECONOMIC COST

Depression and anxiety prevent many people from working. Some lose their jobs; others who are already out of work lose the will or skills to get back to work. And even if people are in work, they have more time off sick.

All this means a loss of output and income. The loss of output is a loss to society. The individual sufferer bears only a part of this loss, because in most cases he receives incapacity benefits which partly offset the loss of earnings. Thus the loss is shared between the individual and the taxpayer.

We can put broad numbers on these costs, by comparing the employment rates of sufferers with those of the rest of the population.[10] If we also allow for increased absenteeism, **the total loss of output due to depression and chronic anxiety is some £12 billion a year** – 1% of our total national income.[11] **Of this the cost to the taxpayer is some £7 billion** – including incapacity benefits and lost tax receipts. The tragedy is that work is a powerful aid to recovery, but so many people are in a vicious circle where the loss of work adds to depression which makes the return to work even more difficult - unless help is provided. **These billions of pounds lost through inactivity are a huge**

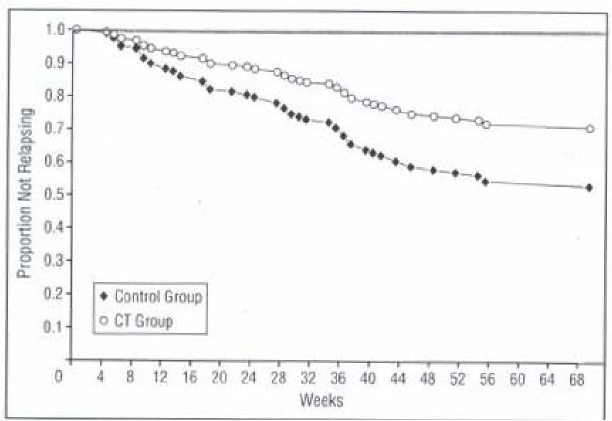
cost when compared with the £0.6 billion a year which a proper therapy service would cost.

However that is not enough to justify the service. The service is only justified if it is effective enough – in terms of making people better and, when relevant, helping them back to work.

COST-EFFECTIVE THERAPIES

Fortunately we now have therapies with good success rates. They have been tested in hundreds of clinical trials where sufferers are randomly assigned between therapy and some alternative. (In some cases the alternative is drugs, and in some cases a wait-list.) The outcomes are then compared by researchers who do not know what treatment the person had. The general finding is that **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 long-lasting effects than drugs.**

The typical short-term success rate for CBT is about 50%. In other words, if 100 people attend up to sixteen weekly sessions one-on-one lasting one hour each, some will drop out but within four months 50 people will have lost their psychiatric symptoms over and above those who would have done so anyway.[12] After recovery, people who suffered from anxiety are unlikely to relapse. With depression, there is always the possibility of relapse. But, as the figure shows, people who recover from depression and have received CBT are much less likely to relapse than people who are only taking pills.[13]



After recovering from depression, those treated by CBT (the 'CT Group') remain well longer.

So how much depression can a course of CBT relieve, and how much more work will result? One course of CBT is likely to produce 12 extra months free of depression. This means nearly two months more of work. And, if treatment is combined with the extra employment advice which the government is planning, we can expect a much bigger response in terms of work. So does the treatment pay for itself?

The treatment costs £750. The result is nearly two months extra in work, and nearly two months less on incapacity benefits. And the cost of **one** month on incapacity benefits is £750 (if we include the fall in tax receipts as well as the benefit payments). **So the treatment pays for itself**.

On top of this there are savings on other NHS services. People spend less time visiting their GP. The drug bill falls, and fewer people are referred to hospital – for mental or physical reasons. (Many people complain of physical symptoms because they have mental problems, and half of all patients referred to consultants for physical symptoms are found to have no "medically treatable" physical illness.[14]) So investing in mental health also has a pay-off through physical health.

Thus from the Treasury's narrow financial point of view, this is a good investment. From society's point of view it is an even better one, because the benefits to society include the extra output produced when someone works (which is more than the value of incapacity benefits and lost taxes), as well as the savings to the NHS, **and**, most important of all, the reduction in distress.

So much for depression. If the problem is anxiety the case is even stronger, since spontaneous recovery is less common with anxiety than with depression. And the risk of relapse once cured is also less. And for people with schizophrenia, the most difficult of all mental illnesses, the evidence is also clear: CBT will on average produce significant improvement.

So there is an overwhelming case for making these therapies available to all who need them on the NHS:

- (i) The money which the government spends will be fully offset by the money which the government saves.
- (ii) The financial benefits to society as a whole are at least double the benefits to the government (while the costs of the treatment are the same).
- (iii) On top of these financial benefits, there is the reduced suffering. Life becomes more worth living.

THE NICE GUIDELINES

The National Institute of Clinical Excellence has reached the same conclusion.[15] Their guidelines are based on an exhaustive review of the evidence about the effects of treatment upon the symptoms of illness. They conclude that CBT therapy is as effective as drugs, and the costs of CBT and drugs are broadly similar if drugs continue to be taken. NICE therefore recommend that, except for mild or recent cases, patients with anxiety disorders or depression should have the option of CBT. For certain conditions, other therapies are also suggested.[16]

These recommendations are fairly new and at present they simply cannot be implemented. Waiting times for therapy average nine months or more, which is useless for such illnesses, and in some places therapy is not available at all. **So the central task in the next period of mental health reform is to implement the NICE guidelines**. If the NICE guidelines for breast cancer were not implemented, there would be uproar. No NICE guidelines are so far from being implemented as those for depression and anxiety, and the public and politicians should demand that they now be implemented as fast as possible.

A NEW THERAPY SERVICE

If the NICE guidelines were to be implemented, how should it be done? How many more therapists would be needed, and of what kind? How should their work be organised, and how could we make sure it got the necessary finance?

What is needed is a concerted plan to deal with this major national problem. Therapy is not like anti-depressants: it differs according to who provides it. We know how well it can work if it is provided by properly qualified people, and most studies suggest it is much less effective if given by less qualified people.[17] Indeed, if badly done, it can even do harm.

So we should plan to build a high quality therapy service to which GPs and Occupational Health Services could refer people with depression and anxiety who want therapy. People could also refer themselves, and people on incapacity benefits could be referred through Job Centres. The service should be available near people's homes, but it should be organised in a highly professional way that guarantees its quality.

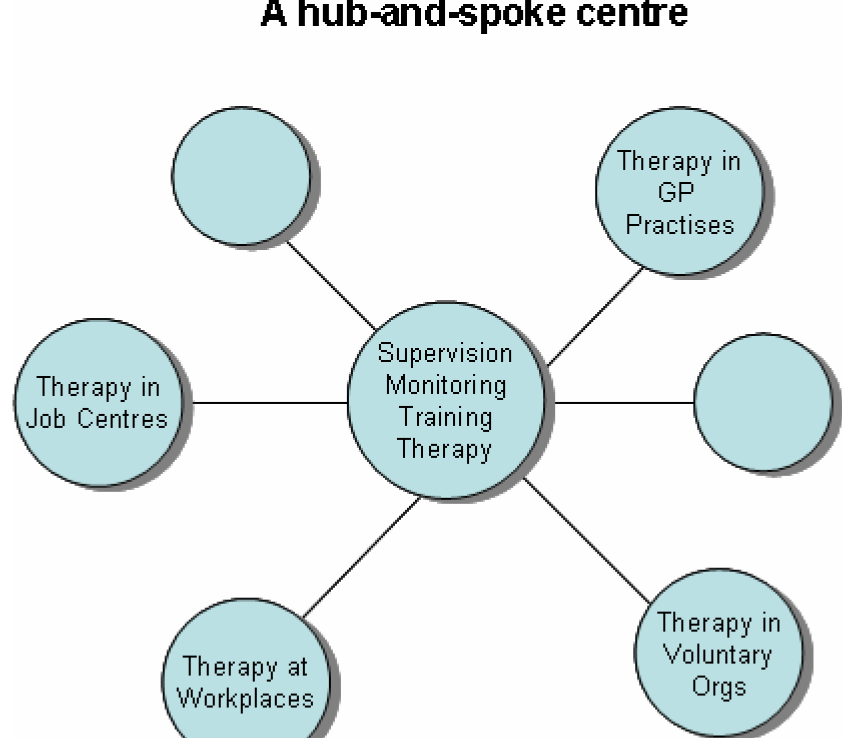
This means that **the therapists should work together in teams** which include senior therapists who can supervise the junior therapists, who can monitor what results they achieve, and who can provide on-the-job training to trainees. For a service to be effective, it is essential to monitor how patients progress. With depression and anxiety disorders this is quite easy, using standard questionnaires administered before each session. The information provided is extremely useful for the therapy session, but it is also essential for seeing what problems are arising and how individual therapists are doing. If the same questionnaire is used everywhere, it can also show clearly how different teams are doing. Through monitoring outcome we can make sure of getting value for money throughout the service which is more than happens in many other parts of the NHS at present.

For many patients, work is an essential element in recovery and it is vital that they keep their jobs or are helped to get back into work. Each team should therefore include an employment adviser working closely with JobcentrePlus, a benefit adviser and an adviser on housing.

The typical team might cover a population of about 200,000 – meaning 250 teams nationally. Each team would have a central office but **most of the therapy would be done in GP surgeries, job centres, workplaces or premises provided by voluntary organisations**. Patients could be referred through any of these organisations and would be assessed by the team before being allocated to a suitable therapist.

Each team would thus operate on a hub-and-spoke basis, in order to generate quality control. The reasoning here is clear. The clinical trials on which our case rests were obtained in conditions of strong quality control. To be sure we can obtain similar results nationally, we have to replicate that level of quality control.

At the same time it is vital that GPs and practice nurses increase their ability to identify and diagnose cases of depression and anxiety. Some GPs will also wish to develop (in conjunction with other GPs) a therapy capacity within their practice. But the majority will welcome the provision of a high-quality service outside the practice, to which they can refer their patients. This service would be separate from the Mental Health Trusts which mainly service severely mentally ill people with schizophrenia or manic depression. And it would work more closely with GPs.



TEN THOUSAND THERAPISTS

How many therapists would be needed to staff this system and what sort of people should they be? At present 2¾ million patients come to GP surgeries each year with depression or anxiety. Most receive drugs or nothing. 1½ million ill people are on drugs, but there are altogether 6 million in the population who are mentally ill, and a minority of them go to the GP at all. If the service we describe were available with minimal waiting (as in some countries), many of these untreated people would request therapy, as would many of those who now receive drugs.

We suggest that the therapy service should aim to treat 800,000 people a year. Since a therapist can treat roughly 80 people a year, this means that **we need an extra 10,000 therapists**. This is a big increase in the number of therapists, since so few are now available. But it is not so large when compared with the 70,000 professional staff now working in mental health trusts for (mainly) patients with schizophrenia and manic-depression.

If the will is there, we could easily train 10,000 new therapists within the next seven years. **Some 5,000 of these should be “clinical psychologists”** – mainly younger people who get 3 years postgraduate training linked to practical work in the NHS. This number could be achieved if the current intake of 550 trainees a year were expanded temporarily to around 800 and some other psychologists were recruited from outside the NHS. The training in clinical psychology should in the meantime become much more heavily slanted towards therapy, and especially CBT.

At the same time **another 5,000 “psychological therapists” could be trained** from among the 60,000 nurses, social workers, occupational therapists and counsellors already working on mental health in the NHS. These people have a wealth of experience of people’s mental problems and many of them have just the right personal qualities to make good therapists. To make them into fully professional therapists they should be re-employed as trainee “psychological therapists” in the new mental health teams and given one- or two-year part-time off-the-job courses in therapy.

The different branches of therapy (like CBT, family therapy, interpersonal therapy and so on) each have their own qualifications. **Anyone wishing to practise a particular therapy should be required to have the relevant training in that therapy** (this includes clinical psychologists). This is ideal because bad therapy can actually be dangerous. There should be two levels of qualification accredited with the Department of Health, one entitling a person to practise, and the other entitling a person to supervise and train other therapists.

A SEVEN YEAR PLAN

Proceeding in this way we could by 2013 have a new service fit for purpose, giving results which can be forecast on the basis of evidence. By that time we should have in place some 250 teams, averaging around 40 therapists each.

But Rome was not built in a day and it will take time to reach that position. The objective should be an orderly expansion, in which quality is maintained at every stage. We should avoid short-term expedients and headlong expansion, as occurred in social services in the 1960s, leaving the service with thousands of unsuitable staff for decades thereafter. **We need a 7-year plan. A sensible objective would be to establish about 40 new teams each year for seven years**. These teams would provide the training grounds for therapists in future teams.

Thus the cost would build up gradually without putting an excessive strain on the NHS budget. By 2013 the gross cost of the service would have reached about £600 million a year, but by 2010 it would have reached only £300 million – fully offset, of course, by rapid savings to the Department of Work and Pensions and HM Revenue & Customs. At the same time there would be an annual training cost of around £50 million a year.

How could such a result be achieved? It could not be achieved in a system where all expenditure decisions are fully decentralised – whatever clever incentives were devised.[18] For the aim is to provide a new service unlike any that existed before. If we had no Midwifery service we would not leave it to GPs to make their own arrangements; we would create a national system of provision and training, that was recognisable from one area to another and of dependable quality. How much more is this true of psychological therapy, about which most GPs have limited knowledge?

Once the service is fully established, it can then be sustained by decentralised methods, in which GPs' experience of the results obtained can influence their choice of supplier. But to **get good suppliers established throughout the country will require in the next seven years a centrally-led and centrally-funded pattern of development**. There should be national decisions about where teams should be established. These opportunities should then be open to tender, with decisions involving local and national representatives. There should also be a national framework for the expansion of training. The leading representative body for GPs, the Royal College of General Practitioners, support the idea of a centrally-led effort to establish the new service.

CONCLUSION

We start from a very bad situation. Millions of people who suffer from depression and chronic anxiety are left without help, even though therapies exist which could lift at least half out of their misery. Shame keeps their misery a secret. And the cost to the Exchequer exceeds the cost of cure.

We need a New Deal for depression and anxiety – a complete revolution. We need to admit that it exists in one third of our families, that it is a major national problem, and that we are not doing even a half of what we should be doing.

The demand from each of us should be quite simple: "**Implement the NICE guidelines**". In other words, **give people with mental illness the choice of psychological therapy**.

But those who control our public expenditure can only respond if they hear the demand. We ask each reader to make the demand known.

Signatories

Stuart Bell,
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Lord Turnberg,
Former President of the Royal College of Physicians

Dr Ben Wright,
Consultant Psychiatrist; Lead Clinician, Newham Psychological Treatment Centre

Notes

[1] WHO figure for Western Europe. The US figure is similar. Source: *WHO. The Global Burden of Disease.*
[2] DWP.
[3] Social Exclusion Unit, Mental health and social exclusion (2004) p.40.
[4] **percentage suffering from mental illness**

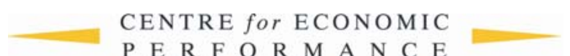
	All	Women	Men
Psychosis (mainly schizophrenia)	0.5	0.6	0.5
Depressive episode	2.6	2.8	2.3
Generalised anxiety	4.4	4.6	4.3
Phobias	1.8	2.2	1.3
Obsessive compulsive disorder	1.1	1.3	0.9
Panic attacks	0.7	0.7	0.7
Other (mixed depression and anxiety)	8.8	10.8	6.8
Any of the above[4]	16.4	19.4	13.5

Source: Psychiatric Morbidity Survey, 2000. adults aged 16-75. More than one condition is possible.
[5] A. Michalos, 'Social indicators research and health-related quality of life research', *Social Indicators Research*, 65, (2004), 27-72.
[6] Evidence from the National Child Development study. See R. Layard, *Happiness: Lessons from a New* Science, p.267, footnote 36. When M is replaced by malaise at age 23 the results are quite similar.
[7] See for example C. Chilvers et al, 'Anti-depressant drugs and generic counselling for treatment of major depression in primary care, *British Medical Journal*, 322, (31 March 2001), Table on p.2.
[8] I am including addictions. If we also allow for premature death, depression and anxiety account for about a quarter of the *total* "burden of disease".
[9] In 2002/3, £0.9b of GP time and a share of the £0.8b spent on drugs. The £6.3b spent on mental health trusts and mental health social services were almost entirely devoted to people suffering from schizophrenia or manic-depression.

[10] See R. Layard et al, 'Implementing the NICE Guidelines: a cost-benefit analysis', Annex Tables 1 and 2 (2006) drawn from the Psychiatric Morbidity Survey (available at http://cep.lse.ac.uk/research/mentalhealth/).

[11] Sainsbury Centre for Mental Health, 'The economic and social costs of mental illness', (2003), Figure 4, adjusted to exclude psychotic conditions.
[12] Others will also have improved but not enough to lose all their main symptoms.
[13] E.S. Paykel et al, 'Prevention of relapse in residual depression by cognitive therapy. A controlled trial', *Arch Gen Psychiatry*, 56, (Sept 1999), 825-835.
[14] C. Nimnuan et al, 'Medically unexplained symptoms: an epidemiological study in seven specialities', *Journal of Psychsom Res*, 51 (2001), 361-7.
[15] See their separate guidelines on Depression, Anxiety, Post-traumatic Stress Disorder and Schizophrenia. For physical illness, NICE measure benefits in Quality-Adjusted-Life-years (QALYs) and approve treatments where the cost per additional QALY is less than around £30,000. On our calculations the cost per additional QALY from CBT treatment of depression / anxiety is around £4,000.
[16] For example interpersonal therapy for depression.
[17] See for example P. Roy-Byrne et al, 'A randomised effectiveness trial of CBT and medication for primary care panic disorder', *Arch Gen Psychiatry*, 62 (2005), 290-8.

[18] S. Bell, 'Modes of commissioning expanded psychological treatment services and related incentives', 2006 (available at http://cep.lse.ac.uk/research/mentalhealth/).



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