

WE **NEED** TO TALK

The case for psychological therapy on the NHS



A report from:

Mental Health Foundation



rethink



This report was commissioned by five leading mental health charities to make the case for greater access to psychological therapies on the NHS. It was written by Anna Bird and published by the Mental Health Foundation. Advice and input on regulation and public protection provided by WITNESS: against abuse by health & care workers.

The report uses real-life testimonies from people whose lives have been affected by mental ill-health. Names have been changed to safeguard their anonymity.

This campaign is supported by:

- The Mental Health Foundation
- Mind
- Rethink
- The Sainsbury Centre for Mental Health
- Young Minds

- Age Concern
- Alcohol Concern
- British Heart Foundation
- The Charlie Waller Memorial Trust
- Drug Scope
- Diabetes UK
- Help the Aged
- Long Term Medical Conditions Alliance
- Mencap
- Nacro
- Turning Point

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1. SUMMARY

Psychological therapies are known to be effective for treating a wide range of mental health conditions. These include depression, anxiety and schizophrenia. The most widely accepted psychological treatment is cognitive behavioural therapy (CBT).

Availability of CBT and other evidence-based therapies on the NHS is extremely limited. Waiting times of more than a year are commonplace. This forces GPs to give, for example, antidepressant medications for depression when they think CBT would be preferable. While some people pay for private treatment, others cannot and go without.

This is a major inequality in health care. The NHS exists to offer effective and cost-effective treatments free at the point of delivery in a timely manner. A failure to offer evidence-based treatments for physical health problems like cancer would rightly lead to a national outcry. We believe the non-availability of psychological therapies is equally unacceptable.

The cost of not offering psychological therapy is considerable. The human cost of prolonged ill-health amounts to the equivalent of £41 billion a year. The economic cost of lost work is a further £23 billion. In addition, the NHS spends £338 million a year on antidepressant medication alone.

Offering timely access to evidence-based psychological therapies could help to reduce these costs. It can help young people achieve better educational outcomes. It can help people stay in work rather than go on benefits. It can prevent unnecessary suffering among people of all ages, cultural backgrounds, and with a range of mental and physical health conditions.

Better access to psychological therapies requires investment. We need resources to identify new and existing workers to provide therapies. We need a robust system of regulation and training to ensure high standards are met. And we need more investment in research to find out more about what therapies work in which cases.

This is not an optional extra to existing health and social care provision – it is as necessary as any proven technology for any illness in any part of the NHS.

We recommend that:

- 1. The NHS should implement NICE guidance as a matter of urgency.**
- 2. The Government's 2007 Comprehensive Spending Review should provide for improved access to talking therapies.**
- 3. The NHS should introduce waiting time measures for access to mental health treatments.**
- 4. The Department of Health should make a realistic assessment of the workforce and training implications of delivering psychological therapies.**
- 5. The Department of Health and regulatory bodies should ensure substantive measures for public protection from malpractice.**
- 6. The Department of Health should investigate the current bias in research priorities and address it by supporting more research into psychological therapies.**

Barry:

"I was about 17 when I first noticed symptoms...but I was about 24 when I went to see the GP when I got really, really depressed. The GP prescribed antidepressants, which turned me into a zombie for a few years, and referred me to a psychiatrist. I was on a waiting list for a few weeks or months.

"The psychiatrist was dreadful. They dug up all the past, right back to the day I was born. Instead of digging it up and then looking at it in a different way or putting it to rest, he was just digging it up and leaving it. It seemed like he was cutting me open and, instead of stitching me up at the end, he was leaving me open and then he was saying 'right, I'll see you in three months time. Go away and take some more pills'.

"Each appointment was about every three to six months and in between I'd just see the GP and, because I wasn't getting any better, I'd just get prescribed more and more pills and get more and more drugged up.

"I found out about CBT by accident. About ten years ago, I'd been to my GP and the GP was delayed so the nurse came into the waiting area and sat with me. She said, '...we've got this new thing going, Cognitive Behavioural Therapy. I can refer you'. I only had to wait a few weeks.

I used to think I was really thick and I couldn't go to college because I wasn't clever enough. But, I did go to college shortly after completing the CBT. All the time I was there I kept thinking 'I'm not going to complete this course, it's too difficult, I'll never get the qualification, nobody will want to work with me, I'll be the laughing stock of the class'. But, the whole time I was getting all this positivity from the college and from classmates and clients we were working with.

When I completed the course I thought 'they're going to give me the certificate because they felt sorry for me'. I was convinced all summer that this was going to happen. But I got a call from the college halfway through the summer, saying 'are you coming to your presentation evening?' I said, 'No...'. The tutor said, 'you've got to go because you've won the student of the year award'. I was gobsmacked. That proved to me that your thoughts aren't necessarily the truth and you can change your way of thinking. That was a real turning point.

"CBT was really, really useful. Years ago I had automatic negative thoughts. Nowadays it's automatic positive thoughts. CBT has more or less reversed the equation."

2. ACCESS TO PSYCHOLOGICAL THERAPIES

The National Institute for Health and Clinical Excellence (NICE) has recommended that a range of psychological therapies be made available on the NHS. There is persuasive evidence of their effectiveness and cost-effectiveness in improving outcomes for people experiencing a range of common and severe mental health problems. The guidelines state that, for depression and anxiety disorders, psychological therapies are preferable to drug treatments on first contact with services. Psychological therapies can be as effective for older people as for younger adults, and are preferable to drug treatments for people under the age of 18.

There is also clear public demand for psychological therapies. Many people find them to be a particularly positive treatment option, either as an alternative to or complementary to drug treatments. A recent BBC web site discussion about psychological therapies received some 800 responses and over 30,000 visitors in just one week.

Angela:

"Because I felt like I had to tell the counsellor everything, I learnt to talk openly about my self-harm. Before I'd been quite shy because it was quite a taboo subject and I think people shy away from it a lot. Being able to talk to her openly about it relieved a lot of the stress I was carrying so the self harming gradually got less and less and it was my way of ending it.

"Telling people was the biggest relief I'd ever had and it pretty much made me stop. As soon as I started telling people and I built my confidence back up, I felt 'what people think doesn't matter. I can be who I want to be'. It helped me recover and helped me become who I want to be, who I am today."

Despite all the evidence and the widespread public support, NICE guidance on psychological therapies has in many places not been implemented, more than three years after much of it was published.

According to an online survey by the Mental Health Foundation, only 42% of people visiting their GP with depression were offered counselling by their doctor, although 82% would have been willing to try it¹. A further survey found that many doctors believe that they under-prescribe psychological therapies. Over half (55%) of GPs believe that talking treatments are the most effective way to treat mild or moderate depression, yet 78% have prescribed an antidepressant while believing an alternative would have been preferable².

Long waiting times deter or prevent people from getting treatments that might benefit them. It takes an average of six to nine months to receive psychological therapies, and waiting lists of up to two years are not uncommon. Approximately 18% of children referred to a child and adolescent mental health team wait over six months to be seen³. Waiting times of up to a year for assessment and two years for treatment have also been reported⁴.

GPs are concerned about the poor services on offer in primary care. One in four primary care organisations do not offer CBT. Over half said that there was no access to bibliotherapy, 35% said there was no interpersonal psychotherapy and 17% said there was no access to any psychotherapy in their area⁵.

Angela:

“When I went to see a mental health nurse she said that the best thing was counselling but I had to phone them myself. I phoned but had to wait about a good six months before I even got anywhere. That was really hard because I had so much doubt in my head that I was ever going to get help. I had to keep ringing up and chasing them because to do counselling they said that you had to show that you were keen to get it. That made it a lot harder because I was nervous about it anyway and really didn't want to speak about it. Having to chase it myself just added to the pressure...I wanted the help but because it was taking so long I was getting so depressed and just didn't really know what to do.”

In contrast, in 2005, 27.7 million antidepressant prescriptions were written in England, at a cost of £338 million to the NHS⁶. Eight out of ten GPs admit that they are over-prescribing anti-depressants and three quarters say they are handing out more of the drugs than they did five years ago⁷.

Tracey:

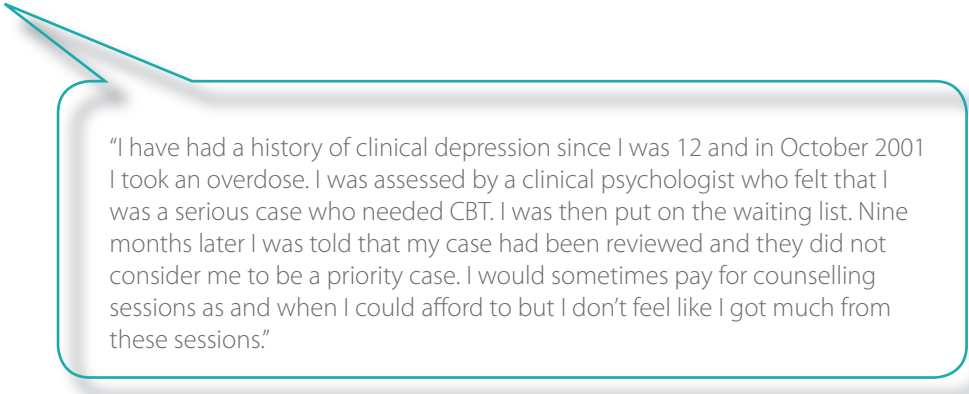
“I have been trying to get my GP to refer me for CBT since April 2005 but he didn't know what it was or where it is available in my local area. In August 2006 he realised that he would need to refer me to the local mental health team first”

A Healthcare Commission survey of over 18,000 people in secondary - hospital based - mental health services in England in 2005 found that just 39% had received some kind of talking treatment (compared to 57% who would have liked to do so). Rates of access varied widely - from nearly three quarters of people using services in Oxfordshire and Somerset, to 45% or fewer in Cheshire, Walsall and North East London⁸. A Sainsbury Centre for Mental Health study of acute inpatient services in 2004 found that just one ward in five regularly offers CBT to patients⁹.

Access to psychological therapies can be easier for some social groups than others. There is evidence to show that:

- Black people are less likely to be offered talking treatments, and more likely to be given medication and coercive treatments¹⁰. Refugees and asylum seekers often find it difficult to access therapies, especially in languages other than English.
- People with learning disabilities and a mental health problem state that talking treatments would be helpful¹¹, but very few professionals have the specialist skills needed.
- Despite the extremely high prevalence of mental health problems amongst people in prison, there is little access to psychological therapies.
- People with alcohol or other drug dependency problems have problems finding services which meet their multiple needs.
- Although NICE guidelines recommend that older people should have the same access to talking treatments as younger adults, in fact they are less likely to receive such treatments.
- Despite many antidepressants being contra-indicated, talking therapies for children are not universally available, with long waiting times for treatment¹².

Charlotte:



"I have had a history of clinical depression since I was 12 and in October 2001 I took an overdose. I was assessed by a clinical psychologist who felt that I was a serious case who needed CBT. I was then put on the waiting list. Nine months later I was told that my case had been reviewed and they did not consider me to be a priority case. I would sometimes pay for counselling sessions as and when I could afford to but I don't feel like I got much from these sessions."

All the available evidence points in the same direction – there is insufficient provision of psychological therapies across the country and there are worrying inequalities in access.

However, the evidence is incomplete. Collecting information on the length of waiting lists or on how long people wait is patchy. Where services do not exist, nothing is recorded about who might benefit from them. Where a service does exist, demand for it is controlled by waiting lists, so that the number of people who would benefit is underestimated. The Department of Health claims that waiting times data is not collected for psychological therapies because it is not a service provided by consultant doctors.

In many areas of physical health, waiting times and the numbers of people on waiting lists have become key measures of success and failure. In mental health, the lack of these indicators hides the true extent of the problem.

3. THE COSTS OF MENTAL ILL-HEALTH

One in four people will experience mental distress in their lives¹³. At any one time one in ten children have a mental health condition¹⁴. The argument for providing adequate services, including access to evidence-based psychological therapies, rests on the sheer weight of the unmet need.

Developing a mental health problem can have a tremendous negative impact on a person's life: their health, their social networks, their finances, and their future prospects.


Human costs

The World Health Organisation measures the impact of illness on quality of life in 'Disability Adjusted Life Years'. They found that, in 2000, mental and neurological disorders accounted for 12% of all DALYs lost to people worldwide, and the numbers are increasing year on year¹⁵. Poor mental health also affects physical health, can lead to an earlier death—up to ten years earlier¹⁶—and is a major cause of suicide.

The Sainsbury Centre for Mental Health has put a price on the human cost of mental illness based on calculations of health-related quality of life, the burden of disability and premature death. It outweighs the cost to health and social services five-fold, totalling £41.8 billion in England alone in 2002/3¹⁷.

The stigma and prejudices that surround mental ill-health can affect people's relationships and how they interact with people, or prevent them from participating in or enjoying activities they used to enjoy. This isolation reinforces the need for psychological therapy by reducing people's opportunities to talk informally with friends and family.

Alison:



"As I have become well and rebuilt my life I have found how very lonely mental illness can be. Friends never refer to it. They never ask how I am or tell me how well I am doing now. If I was recovering from a physical illness such as cancer I believe their attitude would be totally different. Nowadays I can count the number of friends I have on the fingers of one hand."

Health and care costs

In 2002/3, spending on mental health by the NHS and local social services in England was estimated to be £7.9 billion, equivalent to 11.8% of public spending on health services. In addition, mental health problems account for some 21 million hours of informal care from families and friends, which translated into staff costs would total an additional £4.9 billion a year. Children whose parents have experienced mental ill-health are more likely to experience mental ill-health themselves, and the estimated cost of supporting a child with severe conduct disorder ranges from £5,000 to £40,000 a year¹⁸.

Where people are not getting the services they need, many resign themselves to paying for them privately. This means access to talking therapies can be determined by a person's ability to pay – at odds with the founding principle of the NHS.

With the right care from the health service, people with mental health problems can recover and regain control over their lives. Where care falls short, is insufficient or inappropriate to the needs of the individual, a person's condition is unlikely to improve and may deteriorate. People with common mental health problems such as anxiety and depression should be offered a choice of drugs or psychological therapies. People with more severe mental illness should be provided with a care plan, which might include psychological therapies alongside medication.

Where this doesn't happen, the result may be a larger bill for the NHS and other care agencies, on top of the failure to deliver evidence-based care.

Economic costs

The LSE Depression Report, authored by Lord Layard, highlighted the cost of mental illness to the economy, and proposed that greater access to psychological therapies could reduce this financial burden.

People with depression, anxiety or severe mental illness are more likely to be unemployed or economically inactive than the wider population¹⁹. Less than 25% of people with long-term mental illness have a job, compared to 75% of the general working age population²⁰. Motivation is not the problem; people with mental health problems want to work. In fact, they have the highest "want to work" rate of any disability group²¹. Barriers to opportunities to work come from a benefits system that is inflexible, negative attitudes of employers and a widespread culture (including in the NHS) that equates mental ill-health with hopelessness.

The report calculated that unemployment due to depression and chronic anxiety costs the taxpayer £7 billion a year. In addition, overall productivity decreases when people do not work; the report estimates the loss of output attributed to mental illness at £12 billion per year, or 1% of total national income²².

In work, a lack of attention to the mental wellbeing of the workforce can also prove costly. One third of all working days lost in the UK for health or other related reasons can be attributed to common mental health problems such as stress, anxiety and depression (that's over 50 million working days, at a cost of some £4.1 billion).

Overall, the cost of depression to employment as been shown to be 23 times higher than its cost to the health service²³.

4. CHILDREN AND OLDER PEOPLE

It would be a huge missed opportunity to limit access to psychological therapies to only those of working age. It is an affront to the basic principles of our health system that treatment is not available to everyone who needs it.

Children can have a wide range of mental health disorders such as depression, conduct disorder, ADHD, hyperkinetic disorders, anxiety, post traumatic stress disorder, eating disorders and self harm. Some have more than one condition at the same time. According to the Office for National Statistics, 45% of children and young people aged between 5-17 years who are 'looked after' by the local authority will have a mental health problem²⁴. Rates of mental ill-health among young offenders are far higher still.

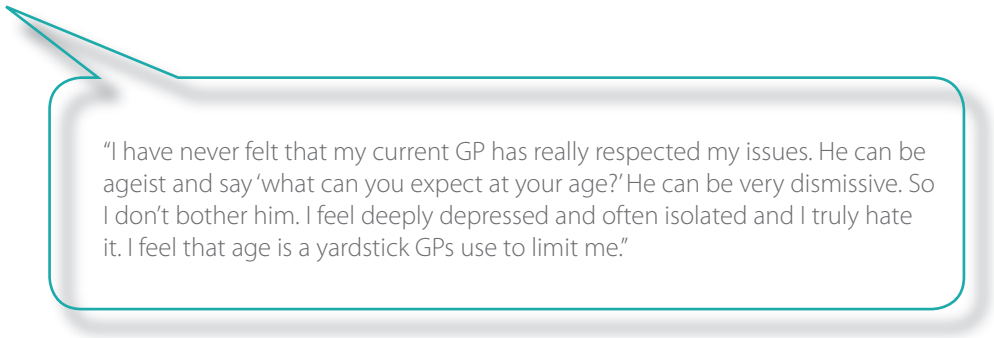
Although there has been an increase in investment in mental health services to meet children's needs, there is no uniform pattern of service provision and, for many young people, services are not available when they need them.

For children, mental illness can imply substantial disruption to family life, and in particular can affect parents' ability to parent effectively, to work full-time and maintain their social lives. Children with mental health problems are likely to be isolated from their peer group and their illness and behaviour may cause high levels of mental distress to their parents and family. They can also appear to be disruptive at school, making it difficult for the child and the class to learn effectively. Finally, mental distress disrupts the ability of children to develop to their full potential. It may lead to dropping out of education early, homelessness and higher levels of risky behaviour, including self-medication with drugs and alcohol.

Depression is one of the most common health conditions affecting older people, yet services and support are frequently in short supply. Research indicates that around 15 per cent of older people living in the community are affected with minor depression. The rate for older people in residential or nursing care is at least 2 or 3 times higher²⁵.

Complex factors, such as ill-health, disability, bereavement and loss of social relationships can put older people at risk of depression. However, research from Help the Aged has also highlighted the impact of what researchers termed the 'daily hassles' for older people - the impact that increasing disability or frailty can have on a person's mental wellbeing²⁶.

Anonymous:



"I have never felt that my current GP has really respected my issues. He can be ageist and say 'what can you expect at your age?' He can be very dismissive. So I don't bother him. I feel deeply depressed and often isolated and I truly hate it. I feel that age is a yardstick GPs use to limit me."

For too many older people, depression in later life continues to be dismissed as a 'normal' part of ageing. Older people with depression neither receive the support from the services that they need, nor do they gain access to specialist mental health services. Fewer than ten per cent of older people with depression are referred to specialist mental health services²⁷. Almost two-thirds have never discussed it with their GP and, among the third that have raised it, only half are receiving any specific therapy or treatment²⁸. Even when older people are offered any treatment or support for depression, it is frequently drug therapy, without adequate consideration of other psychosocial interventions that may be more suitable²⁹.

Table 1: Psychological therapies recommended by NICE

Therapy	How it works	NICE Guidelines recommend for the treatment of:
Bibliotherapy	As in CBT (see below) but delivered through a book based system rather than through face to face sessions with a therapist.	Anxiety Disorders – Generalised Anxiety Disorder and Panic Disorder
Cognitive Analytic Therapy (CAT)	Aims to improve the client’s coping skills and tackles potentially harmful coping habits so that future problems are easier to deal with.	Anorexia Nervosa
Cognitive Behavioural Therapy (CBT)	The individual works with the therapist to identify negative emotions, beliefs and thoughts; to understand why and when they may be harmful; to understand how they relate to the symptoms of their illness; and to develop skills in getting rid of them or learning how to cope with them.	Anxiety disorders; depression; moderate–severe depression in children and young people; persistent depressive episodes in people with bipolar disorder; post-traumatic stress disorder; obsessive compulsive disorder; eating disorders. Should also be available for people with schizophrenia. Extensive evidence that CBT is effective for people with long term conditions to help them manage their conditions more effectively
Computerised Cognitive Behavioural Therapy (CCBT)	As in CBT, but the therapy is provided via computer rather than through sessions with a therapist.	Two versions of CCBT, Beating the Blues and Fear Fighter, should be available in all PCTs in England by March 2007 for the treatment of anxiety disorders and depression.
Counselling	The most basic form of psychological intervention. The client talks about their difficulties with a counsellor, who plays a supportive role and may sometimes provide practical advice on problem solving.	Mild depression in children and young people; also recommended where CBT and family therapies are not available for people with schizophrenia.
Dialectical Behavioural Therapy (DBT)	A form of behavioural therapy designed to treat borderline personality disorder. The individual is encouraged to adapt their reactions to emotional triggers. It is given individually or in groups, and may aim specifically to reduce self harming behaviour.	Persistent binge eating disorder; personality disorder manifesting in self-harm behaviours.

Therapy	How it works	NICE Guidelines recommend for the treatment of:
Family Therapy/couple focused therapy	The therapist encourages dialogue amongst members of the family or the couple to resolve differences, and provides counselling to improve communication between them. Family or couple-centred therapy also allows the therapist to understand each person's difficulties within the context of the group.	Family therapy: Anorexia Nervosa; moderate-severe and persistent depression in children and young people. Should also be available for the families and carers of people with schizophrenia. Couple-focused therapy: depression where individual therapy has not helped.
Group Therapy	People who share a common problem may be invited to participate in group therapy. Group therapy allows people to share the support and experiences of others with similar difficulties and may help them to recognise that they are not alone in their experiences.	Obsessive compulsive disorder; mild depression in children and young people.
Interpersonal Psychotherapy	Interpersonal psychotherapy helps people to learn to link their mood with their relationships with people close to them, and to recognise that differences in the way they are with people may improve both their relationships and depressive state.	Interpersonal psychotherapy (IPT) recommended for eating disorders, moderate-severe depression for children and young people; depression in adults when the individual expresses a preference for IPT or the professional feels it may be beneficial. Individual child psychotherapy recommended for persistent depression in children and young people.
Motivational Counselling/ Interviewing	A way of talking about things the client may be sensitive about that avoids confrontation. Sessions may focus on hopes and aspirations for career and life, and potential problems that could be obstacles to achieving goals.	Alcohol or substance misuse in people with mental disorder.
Psychoanalysis	Uses the principles described by Sigmund Freud to provide a structure to understand emotional disturbance in the context of the development of the personality and character of the individual.	
Psychodynamic Therapy	Similar to psychoanalysis except that the discussion concentrates on identified problems.	Focal psychodynamic therapy is effective for treating anorexia nervosa. Psychodynamic therapy may also be useful for the treatment of depression accompanied by other complex illnesses

5. THE BENEFITS OF PSYCHOLOGICAL THERAPIES

Psychological therapies are based on the idea that talking to someone provides people with an opportunity to explore their thoughts and feelings and how they relate to behaviour, mood and psychological wellbeing.

Verbalising emotions and thought patterns can help people to identify where negative feelings and ideas come from and why they are there. Having a greater understanding of how they think and feel can help people to find ways to change their lives for the better, by acting and thinking in a more constructive or positive manner. The therapeutic element of “talking treatments” allows people to take greater control over thought processes, to alter patterns of negative thoughts and to build their confidence.

A list of psychological therapies that are supported by NICE guidance is shown in Table 1 on page 10. Research shows that, compared to antidepressants, CBT is as effective in the short term and more effective in the long-term in the treatment of mild and moderate depression and anxiety disorders. It reduces the symptoms of the illness and prevents them from returning. CBT has also been found to be effective in helping people stay in their jobs when they become unwell with depression³⁰.

Barry:

“[CBT]’s about recognising that just because you think a thought, it doesn’t necessarily mean it’s real... about how your thoughts create your feelings and how you react to those. So you get an automatic bad thought and it makes you feel depressed or low or sad. And you think ‘challenge that thought’. So you look for a more positive thought or you change the way you think about that thought and...it makes me feel positive or relaxed or whatever...You can apply that process in so many different ways in your life.”

For more severe depression, CBT can boost the effects of antidepressants and the combination of the two treatments is cheaper than any other approach³¹. Psychological therapies can also be useful where a person’s mental health problem is complicated by other conditions, such as alcohol or drug addiction, or long-term physical health problems.

Charlotte:

“In Autumn 2004 I was put forward for Cognitive Analytic Therapy. I completed a 16 week course and I feel that receiving the therapy has helped me immensely. It felt like I was being helped to address the core issues and causes for my depression rather than just being given medication.”

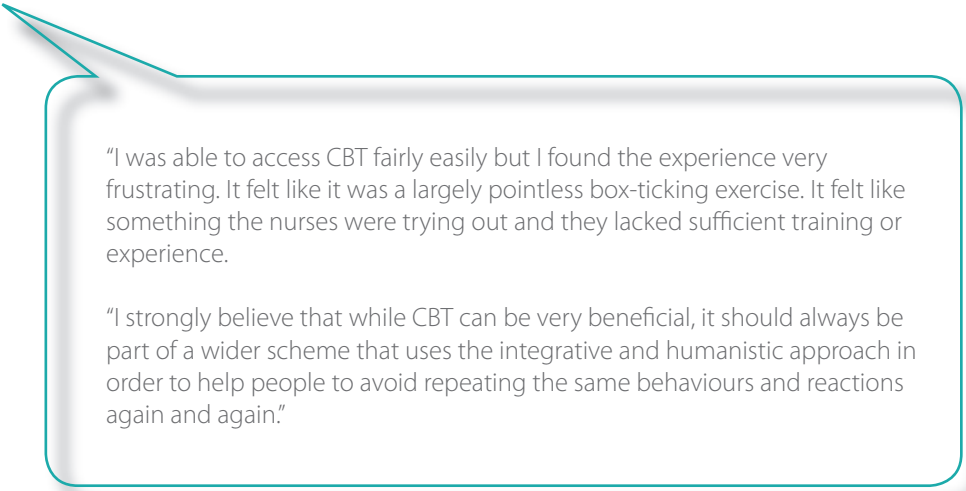
For people with schizophrenia, there is evidence that family therapies, interpersonal psychotherapy and CBT can reduce the amount of time spent in hospital and the likelihood of relapse, can improve mental wellbeing and mental state and can increase people's understanding of drug treatment and their willingness to comply with it^{32,33,34}. In a recent survey, more than half (out of a sample of 8,300) of people using specialist mental health services who received psychological treatment said it was "definitely" helpful and only 14% said it was not at all helpful³⁵.

For children, in addition to NICE guidance, there is evidence that CBT can help with pain disorders, ADHD and anxiety; that family therapy works with conduct disorder, substance use and chronic physical illness and that group therapy is effective for anxiety and self-harm³⁶.

Psychological therapies can also be useful for people with a range of physical health conditions. People who have diabetes, multiple sclerosis (MS), coronary heart disease, or had a stroke have a very high risk of experiencing depression³⁷. Supporting the mental health of people with chronic physical health problems can improve their ability to adhere to treatment regimes, to take part in rehabilitation activities and to engage in health-promoting activities³⁸. Offering timely access to psychological therapies for those at risk of depression because of a physical health condition can be highly effective in improving their quality of life, minimising disability, and reducing the burden on the individual and their family.

No single therapy will work for everyone. Different treatments suit different people and different health conditions. Not everyone feels comfortable with talking therapies and not everyone will feel the benefits. Yet there are good reasons for making available treatments that can be provided either as an alternative to, or complementary to drug treatments.

Nick:



"I was able to access CBT fairly easily but I found the experience very frustrating. It felt like it was a largely pointless box-ticking exercise. It felt like something the nurses were trying out and they lacked sufficient training or experience.

"I strongly believe that while CBT can be very beneficial, it should always be part of a wider scheme that uses the integrative and humanistic approach in order to help people to avoid repeating the same behaviours and reactions again and again."

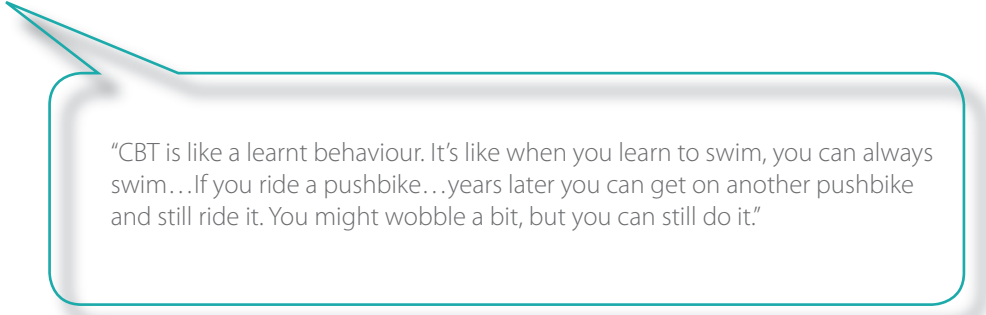
Psychological therapies have less risk of harmful or disabling physical side effects than medication. NICE specifically recommends psychological therapies for children and adolescents and for pregnant women with depression, because antidepressants have higher risks for under-18s and for unborn children. They can also be better for people managing other health problems, particularly long-term physical conditions, who are likely to be taking other medication which might have harmful interactions with antidepressant or antipsychotic drugs.

By actively involving the individual in their own treatment, psychological therapies can empower people and encourage them to engage in the process of recovery. This active, constructive approach can help to fight some of the disabling and disempowering effects of living with mental illness.

6. RESEARCH PRIORITIES

Much of the evidence about psychological therapies points to the benefits of CBT. This is arguably because CBT can be tested more easily than other psychological therapies according to the scientific “gold standard”, the randomised control trial, which is also used for drug testing. In CBT, both a “dose” (i.e. what is learnt during one session of the therapy) and the “course” (the duration of the treatment, which is usually determined at the start) can be fairly easily reproduced under trial conditions. Counselling or psychoanalysis, on the other hand, are less easy to test because there is no agenda (people are encouraged to talk freely) and the duration of the course of treatment may depend on the progress of the individual.

Barry says:



“CBT is like a learnt behaviour. It’s like when you learn to swim, you can always swim...If you ride a pushbike...years later you can get on another pushbike and still ride it. You might wobble a bit, but you can still do it.”

As a result of these and other factors, there is more evidence about the effectiveness - and cost-effectiveness - of CBT compared to other therapies. NICE acknowledges the lack of research on other treatments as a limitation of its recommendations, which favour CBT over other psychological therapies. Similar limitations have been noted in the available evidence on what helps to keep people in employment³⁹.

More broadly, psychological and complementary therapies are under-researched compared with pharmaceutical and other high-technology health care products. The research economy is skewed towards such treatments: most of Britain’s £4 billion health research spend is commercially funded and aimed at producing and testing new technologies for profit⁴⁰.

Yet there is much that needs to be researched. People have differing needs in terms of the talking treatments that will benefit them. Some need a structured, practical way to deal with their illness. Others feel the need to explore the root causes of why they feel the way they do, and find a problem-solving approach unsatisfactory. The principle of choice in the NHS would suggest that the full range of therapies that are known to be effective should be offered to those who need them, supported by accurate and accessible information to help people to exercise choice.

Rigorous, qualitative research would enable more to be known about what works for different groups of people – especially those from minority ethnic communities – to inform future commissioning decisions and give more choice to patients.

7. REGULATION

Psychological therapies often involve the disclosure of intimate details and private thoughts and feelings. This means that it is essential to maintain high standards in service delivery.

Yet psychological therapies remain one of the least regulated areas of mental health practice, and the piecemeal approach to service delivery in this area makes regulation all the more difficult. There is a paucity of inspection and audit, accountability structures are weak and the involvement of service users in professional associations is minimal.

At present, anyone can advertise as a psychotherapist, counsellor, psychoanalyst or psychologist because there is no statutory protection of these particular titles. Training standards are inconsistent and there are significant differences within these professions about the depth and breadth of training necessary.

The Department of Health has estimated that 2% of unregistered psychologists may be unsafe to practice⁴¹. This is likely to be an underestimate, as reports about abuse are significantly under-reported⁴². Poor quality treatment or breaches of professional trust can lead to a need for additional treatment, which may be more prolonged and costly⁴³.

Complaints procedures and codes of practice vary from association to association, so the outcomes for people raising a concern may differ according to which body receives the complaint. When practitioners are disbarred by their professional association they may be legally entitled to continue working. Where sanctions are imposed there is no legal obligation to implement them⁴⁴.

8. CURRENT WORK AND NEXT STEPS

The Department of Health is supporting work in Doncaster and Newham to examine different ways of organising the implementation of talking treatments as part of its Improving Access to Psychological Therapies (IAPT) programme. In addition, access to psychological therapy and the development of 'stepped care' for mental health are key measures in the Our Health, Our Care, Our Say white paper. These are positive signs, following the 2005 Labour Manifesto promise to improve mental health services, "including behavioural as well as drug therapies". They show that the Government recognises the need to improve access to psychological therapies and is committed to investigating methods of service delivery which will work across the country.

However, there is a need for cross-government commitment in order to create a mental health service that is appropriately constructed, resourced and regulated.

It is now time to make this change happen. Some estimates about the scale of what is needed have already been made. Lord Layard calculated that 10,000 psychological therapists would be required nationwide⁴⁵. The Sainsbury Centre for Mental Health concluded that, to meet the National Service Framework for Mental Health standards for primary care and to implement NICE guidance (for working age adults in England) the number required would be 11,377⁴⁶.

These may appear to be large figures but a trained and capable workforce may already exist. There are an estimated 100,000 psychological therapists in the UK, some of whom are currently in private practice. There are many more health and social care staff who have skills in brief therapies such as CBT. The task is to identify where the workforce is and to enable it to provide the services which people demand, either through direct NHS provision or by purchasing services from individuals, private providers and voluntary organisations.

9. RECOMMENDATIONS

1. The NHS should implement NICE guidance as a matter of urgency

NICE guidance is already mandatory. The NHS has a duty to make the treatments and resources available to implement guidance within three months of publication, and treatment should be available to all who need it. Most of the guidance for treating mental illness was last updated in 2004. In the intervening 2-3 years, there has been no major effort on the part of the NHS to adhere to the recommendations on psychological therapies.

In other areas of health care, this would be unacceptable. People going to the doctor with heart problems or diabetes do not need to make the case for getting services based on how much money could be saved if they were treated. People with mental health problems should have the same right to receive treatment simply because it will make them better.

How psychological therapies are delivered in practice should be discussed further in the light of the outcomes of the IAPT programme. It is vital, however, that provision is extended to prisons and that culturally appropriate services are made available to groups of people for whom generic provision may not be adequate, such as refugees and asylum seekers or people whose first language is not English.

2. The Government's 2007 Comprehensive Spending Review should provide for improved access to talking therapies

The implementation of talking therapies will cost money. The Government is currently reviewing its spending priorities in advance of the 2007 Comprehensive Spending Review (CSR). This should take note of the evidence in this paper as well as the strong economic argument laid out in the Depression Report and other documents. It is clear that investment in talking therapies will:

- enable more people to hold on to jobs and regain them;
- cut the cost of unemployment and long-term incapacity benefits;
- reduce the demand for other health care interventions.

A large injection of cash is needed, over a sustained period, to ensure that the implementation of psychological therapies is adequate to meet demand. The level of funding needed should be investigated as a matter of urgency to support the CSR process.

3. The NHS should introduce waiting time measures for access to mental health treatments.

Mental health is no longer the Cinderella service of the NHS. It is a government priority for investment and modernisation. It needs its own waiting time measures to reflect that.

While the Government has rightly moved away from a target-based approach to improving NHS performance, it is clear that waiting time measures have improved performance in elective care and that monitoring the time it takes to receive access to psychological therapies would be an important marker of improvement.

The introduction of waiting time measures would provide a clear incentive for better care. It would show that mental health is a priority and encourage commissioners to invest in improving services. It would reward early intervention and raise awareness among primary care professionals of the specific needs of people presenting with mental health problems. It would also provide an opportunity to collect information centrally, which should be used for evaluation of the service.

4. The Department of Health should make a realistic assessment of the workforce and training implications of delivering psychological therapies.

We need to increase the pace of training for health professionals in the knowledge and skills needed to deliver talking therapies. We need to make the best use of professionals already trained in these skills but ensure gaps are not left in the existing work of those who take on new roles.

The long-term costs of sourcing the numbers of professionals necessary to provide the service, and the time it takes to train them, may be considerable and should be included in any investment plan. Use will need to be made of accredited private and voluntary providers by local NHS commissioners.

Training of psychological therapists should include awareness of and responsiveness to diverse cultural, religious, linguistic and social values. Specific training should be provided for professionals working in child and adolescent mental health services, later life services including dementia and for those working with people with severe mental health problems and people with learning disabilities. Therapies should be offered which address the specific needs of those with complex health problems. Recruitment should consider the needs of the community being served and the need for therapists able to practise in more than one language. This is already being developed through the IAPT programme and the lessons from that will need to be fed into mainstream practice

5. The Department of Health and regulatory bodies should ensure substantive measures for public protection from malpractice

Any treatment delivered poorly could put people at risk. It may have adverse health consequences or hamper recovery. It is important that standards are set for the delivery of psychological treatments, and monitoring systems are put in place with the task of overseeing that these standards are maintained and that complaints about abuse are dealt with properly.

The Our Health, Our Care, Our Say white paper commits the Department of Health to introduce statutory regulation for psychological therapies. Agreed training standards should link with an agreed code of practice and detailed guidance. Access to independent support and advocacy should be ensured and detailed information for service users should be developed.

6. The Department of Health should investigate the current imbalance in research priorities and address it by supporting more research into psychological therapies.

The National Institute for Health and Clinical Excellence acknowledges that there are some psychological therapies which may be effective for a number of mental health problems but where the evidence is insufficient to support their wide-scale recommendation.

Gathering evidence about effectiveness of psychological treatments is costly. The research community cannot hope to find financial support equivalent to that which supports the clinical testing of pharmaceutical treatments. Nevertheless, it is important that the evidence put to NICE is comprehensive, so that the recommendations it makes are as objective as possible in their evaluation of drugs and the alternatives.

The Department of Health should examine its research and development priorities and ensure that there is support for the evaluation of psychological therapies, so that the services on offer are as effective, and cost-effective, as possible.

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This report was commissioned by five leading mental health charities to make the cause for greater access to psychological therapies on the NHS. The report marks the start of a campaign to increase investment and widen access. It is also supported by a wide range of other voluntary sector organisations, including:

