

The challenge of the Layard initiative

John Marzillier and John Hall introduce a collection of opinion pieces on 'improving access to psychological therapies'

In 2006 the Mental Health Policy Group of the Centre for Economic Performance at the London School of Economics published a report urging that psychological therapy should be made available to everyone in Britain. The report, now commonly referred to as the Layard Report (London School of Economics, 2006), argued that 'such a service would pay for itself by the reduced expenditure on incapacity benefits from people being able to go back to work.' It has led to a number of government-funded initiatives, known as the Increasing Access to Psychological Therapies (IAPT) programme, focused on therapeutic help for adults with common mental health problems (in particular mild to moderate depression and anxiety). The core therapeutic modality that is recommended within these programmes is cognitive behavioural therapy (CBT), while other modalities, such as interpersonal therapy, are also commended. A clear distinction is made between low-intensity treatment

(four sessions) and high-intensity treatment. This initiative has already had an impact on NHS psychological therapy services within adult mental health services, injecting much needed extra finance and thus extra resources into a chronically under-funded service.

The programme now includes two initial demonstration sites at Newham in London and at Doncaster, and a national network of local psychological therapy programmes in each of the Care Services Improvement Partnership (CSIP) Regional Development Centres. These are linked to the introduction of nationwide training programmes for a new group of psychological therapists (not necessarily psychologists) who will deliver the therapies (Clark & Turpin, 2008). In association with these training and direct service delivery programmes, a range of supporting programmes has been developed, providing clinical practice protocols and commissioning guidance, for example. This initiative, totalling some

£300m, constitutes the largest ever programme in Britain to support the delivery of psychological therapies within the NHS.

There are good things about the Layard initiative. First, it seeks to redress the years of chronic underfunding in the mental health services. Second, it is a bold attempt to expand psychological therapies and to link that expansion to the use of effective therapies. Third, the IAPT pilot programmes have sought to improve access to psychological help and get through the logjam whereby too many people fail to get any form of psychological help simply because it is not available.

However, a close inspection of Layard reveals flaws in both analysis and implementation that cast doubt on how beneficial it will be. In this article we show what these flaws are and why they are important. Then we hand over to colleagues for two more articles, before our closing article suggests what else might be done in order to provide good psychological help to those people who need it most.

Layard's economic analysis

The impetus for the increased funding of psychological therapists came from an economic analysis whereby the costs of such an increase would be offset by savings in two main ways: reducing absenteeism and returning people to work (Layard et al, 2007). Other savings such as reduced use of NHS resources and an increase in the quality and quantity of life years were also mooted, but are of lesser significance economically. While it is possible to question the specific equations advanced by Layard and his colleagues, our major concern lies in the *assumptions* on which the analysis was based. Put starkly, the analysis is predicated on a naive view of mental health problems (essentially a simplistic 'illness' model) and of an overly optimistic assessment of how effective psychological treatments may be.

Although Layard's focus is very much on CBT, and this is particularly true of the IAPT programmes, we stress that our critique is not meant to be an attack on CBT, which has much to commend it. What concerns us more is the way CBT, and therapy in general, is seen as a collection of techniques to be delivered by a band of specially trained therapists in order to get



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people off benefits and back to work. Whether or not one supports what some might see as an Orwellian idea, there is one major drawback – it won't work. We explain why we think this below. One consequence is that, when the dust settles and it is realised that CBT is not the panacea it has been made out to be, there may well be a backlash against all psychological therapies. What started as a positive initiative for psychological treatments could end as reaction against them (especially if the cost savings underpinning the initiative fail to materialise as promised).

A simplistic view

In the Layard Report problems like depression and anxiety are viewed as discrete conditions that will get better with the right treatment. Layard writes about people being 'cured', implying that these conditions are similar to illnesses like measles that can reliably diagnosed and simply treated. This is the cornerstone of his economic argument. But it is a naive view of psychological problems and their treatment. The limitations of this medical model have

been well aired both generally (Bentall, 2003) and specifically, for example, in relation to depression (Dowrick, 2004). There is considerable evidence that social and economic factors – taking poverty as only one – are significant contributory factors to both depression and anxiety. Are people really ill or are they responding to the realities of stressful and difficult lives?

From a psychological perspective, anxiety and depression are better understood as a part of human experience, not necessarily a pathological condition or illness. It is true that some people can be crippled by such severe depression or pervasive anxiety that they are unable to function properly and desperately need help. However, they are in a minority, and it is those who are mild to moderately depressed or anxious who most commonly seek help and for whom CBT has been shown to be most effective.

Many psychologists now believe that relying on psychiatric diagnosis to separate the ill from the normal is problematic, as Horwitz and Wakefield (2007) have shown in relation to depression. A diagnosis is arrived at predominantly by listing symptoms

without relation to causes, and it can draw in many people who are depressed or anxious because of life circumstances. For example, in the current version of the standard American diagnostic manual, DSM-IV-R, major depressive disorder is diagnosed by ticking off the presence of five or more predetermined symptoms (out of nine) during the same two-week period, at least one of which is depressed mood or loss of interest or pleasure. There is an odd arbitrariness in the choice of five or more symptoms and of the two-week period. More significantly, bereavement apart, the diagnosis fails to address *why* people might be depressed. Significant psychological losses, such as relationship break-up, job loss or financial hardship are ignored. This can lead to a high number of false positives – people diagnosed as clinically depressed who are experiencing intense but normal sadness in response to life's vicissitudes. Once formally diagnosed, people may come to see themselves as 'ill' and requiring treatment. This has been one of the major criticisms of the proliferation of psychiatric diagnoses over the last 30 years: that they reify ordinary experiences as illnesses, pushing people into having

formal treatments, most commonly various types of drugs, that they do not need (Bentall, 2003).

If there is not a finite number of ill people that psychological treatments can cure, increasing the number of therapists and making them more accessible could well increase the numbers of people seeking help – especially those with mild to moderate depression/anxiety, for whom CBT seems to work best. This is likely to happen if, as Layard suggests, more therapists are placed in primary care where 90 per cent of mental health problems are managed. No longer will professionals have the referral barriers to filter out many potential patients. In the past decade the increase in the numbers of counsellors employed directly by GP practices has not stemmed the flow of referrals for psychological help. We are not arguing that psychological treatment should not be made more accessible, only that it is a mistake to assume that this would lead to a reduction of the numbers seeking help, the basis of Layard's economic argument.

According to statistics from the Department of Work and Pensions (DWP), cited in the Depression Report,

about 40 per cent of those on incapacity benefit have mental illness as their primary problem. Layard argued that the savings from getting a substantial number of these people better and back into work will underwrite the increased cost of providing the therapy (Layard et al., 2007). What do these figures represent? Through enquiries to the DWP we discovered that

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they are not derived from a formal psychiatric assessment, but from a combination of self-reporting and/or GP certification. In other words, these are what individuals say their major problem is or what they have reported to their GP. What the data do not reveal is how valid these assessments are, the extent or severity of the problems, to what extent people might suffer from more than one mental health problem, whether there are concomitant physical problems, whether they have already had treatment, nor anything about the familial, social or economic circumstances that might contribute to their being on benefit or

income support. Mental health problems rarely present as a single condition. The comorbidity of anxiety and depression for example is known to be high. Between 30 and 50 per cent of people with mental health problems also have problems with alcohol or drug misuse. The Office of National Statistics Psychiatric Morbidity Survey reveals that 57 per cent of people diagnosed as neurotic also have physical problems, 67 per cent when people have more than one neurosis (Singleton et al., 2001). It seems to us more probable than not that people on benefit have multiple problems and although they may need to specify a primary problem for the purpose of seeking benefit, this simplifies a complex picture. At best it cannot be assumed that all such people need is help with their depression or anxiety and they will be able to return to work (if work is available).

The evidence for the effectiveness of CBT

Much is made in Layard of the evidence supporting CBT, particularly the guidelines prepared by the National Institute of Health and Clinical

if the basis for this expansion is flawed, there will be trouble ahead. If the equations do not work, there may well be a backlash as the new breed of psychological therapists fails to deliver what it promises and the cost savings predicted by Layard do not materialise. The worry of the IAPT programmes is that people are being trained to work in one particular way (as CBT therapists) with the result that managers think this is the only way. Put crudely, the message is that most mental health problems will be 'solved' if we train enough therapists. This should be exposed for the nonsense it is. For a rigorous critique of the NICE guidelines and the way they have misrepresented both the complexity of clinical practice and large amounts of psychotherapy research evidence, see Mollon (2009).

Psychological therapy should be not be travestied as routine application of particular methods or techniques that can somehow deliver happy, adjusted people at low cost. Whatever the researchers may claim, the reality is that psychotherapy is a skilled and often uncertain endeavour that demands a high level of interpersonal skills and a particular expertise. This is as true of cognitive therapy as any other therapy.

In the next two articles we asked two leading therapists from different schools to look beyond the Layard initiative. In the first the highly respected cognitive therapist, Paul Gilbert, looks beyond the stereotyped view of CBT to bring out both innovation and complexity. He makes a plea for psychologists to take a broader perspective than that of delivering therapy, drawing on recent advances in psychological science. In the second the distinguished psychoanalyst, Patrick Casement, considers the claims of CBT in the light of his extensive experience of working as a psychoanalyst. He points out that the appeal of brief problem-solving therapies needs to be weighed against what can be lost in the drive to change, notably a deeper understanding of the problems patients present and the value of a therapist's capacity to tolerate seemingly unmanageable states of mind. Finally, we return to outline what psychologists working in the mental health services might do differently. We reject the one-size-fits-all, techniques-driven approach in favour of the virtues of initial psychological assessment, careful formulation and offering patients a range of options, amongst which therapy, CBT or otherwise, is just one.

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Excellence (NICE). NICE has been issuing guidance on 'mental health and behavioural conditions' since 2002. While it is true that for depression and anxiety CBT emerges as the preferred therapeutic modality, the most obvious conclusions from reading the guidance carefully – the full-length depression guidance is 363 pages long – is how many gaps there are in the evidence, how qualified are the recommendations, and the relatively poor effect size. Significantly, research effectiveness is judged by NICE on the basis of a standard hierarchy of research methods (that is applied to all other NICE guidelines for other medical conditions) that privileges randomised controlled trials (RCTs) and minimises the value of meta-analytic studies. For mild depression in primary care, problem-solving, brief CBT and counselling are equally recommended, but for moderate to severe depression the guidance for psychological therapy specifies CBT in seven specific circumstances. This has created the impression that CBT is the preferred mode of intervention in the Layard initiative. Noticeably, the IAPT training programme focuses on CBT as the preferred method of therapy, not on any other therapy (Clark & Turpin, 2008). There is little doubt that the Layard initiative is predominantly understood as increasing the availability of cognitive therapy.

But the transition from carefully controlled research trials to the messy reality of clinical practice – from efficacy to effectiveness – is not straightforward. Patients in research trials are carefully selected in order to conform to strict diagnostic criteria that will not apply in

the field. A significant proportion of patients in research trials fail to complete treatment and fail to be assessed on follow-up. Similarly in clinical practice, with less selected groups, rates of attrition during treatment may exceed 50 per cent. These levels of uncompleted treatment in both research and practice settings both bias success rates – what happened to those who did not complete formal treatment? – and seriously compromise the level of whole-population benefit that can be assumed. They also underline the importance of creating an effective therapeutic alliance with patients as a precondition for achieving effective outcome.

While there is an obvious value in drawing upon existing evidenced-based research, care must be taken not to rely exclusively on such findings or to overestimate their applicability. People who seek help for depression or anxiety do so for many reasons. Those with mild to moderate problems are the ones who will respond best to CBT or a similar therapy. Only a minority of those with more serious and complex problems – who are likely to be those on long-term incapacity benefit – will benefit from that approach alone, and many will need something different from short-term, specific treatments designed to alleviate symptoms.

What concerns us with the Layard analysis is the way this complexity has been glossed over to arrive at general conclusions that seem superficially plausible but in reality are not. The attraction may be that at last the value of psychological therapy is recognised and serious money made available for it. But