HOW MENTAL ILLNESS LOSES OUT IN THE NHS

The Foundation for Science and Technology
11 September 2012

RICHARD LAYARD

MENTAL ILLNESS

1. 40% of all ill health.
2. More debilitating than most chronic physical conditions.
3. Raises the costs of physical healthcare by some £10 billion p.a.
4. Cost-effective treatments exist, which pay for themselves in savings on physical healthcare (and also in savings on benefits and lost taxes).
5. Yet under 1/3 of sufferers get treated.
1. THE BURDEN OF DISEASE

<table>
<thead>
<tr>
<th></th>
<th>% of all morbidity</th>
<th>% of all QALYs lost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental illness</td>
<td>38</td>
<td>23</td>
</tr>
<tr>
<td>Cardiovascular</td>
<td>6</td>
<td>16</td>
</tr>
<tr>
<td>Cancer</td>
<td>3</td>
<td>16</td>
</tr>
<tr>
<td>Respiratory</td>
<td>11</td>
<td>8</td>
</tr>
<tr>
<td>Sense organs</td>
<td>13</td>
<td>7</td>
</tr>
<tr>
<td>Diabetes</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Other</td>
<td>27</td>
<td>28</td>
</tr>
<tr>
<td>TOTAL</td>
<td>100</td>
<td>100</td>
</tr>
</tbody>
</table>


For the same reason, mental illness accounts for

- 40% of all sickness absence
- 40% of all incapacity benefits
2. EFFECTS OF MENTAL ILLNESS

(1) Loss in health-related quality of life
(Difference from “No chronic condition”, % points)

Source: Moussavi et al., 2007.

(2) Effects on age-specific mortality rates
(Odds ratios)

<table>
<thead>
<tr>
<th></th>
<th>Adjusted for age/sex</th>
<th>“Fully adjusted”</th>
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<tbody>
<tr>
<td>Depression</td>
<td>1.52</td>
<td>1.27</td>
</tr>
<tr>
<td>Smoking</td>
<td>1.59</td>
<td>1.42</td>
</tr>
</tbody>
</table>

Source: Mykletun et al., 2009.
3. EXTRA COSTS OF PHYSICAL HEALTHCARE

- For people with chronic physical illness of given severity, mental illness increases healthcare costs by 45-75% i.e. by at least £10 billion.

- “Medically unexplained symptoms” cost another £3 billion.

Sources: Naylor et al., 2012; Katon, 2003; Unutzer et al., 2009; Welch et al., 2009; Bermingham et al., 2010; Hochlehnert et al., 2011; Maslow, 2004; Hutter et al., 2010.

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**Annual cost of physical healthcare per patient (Colorado Access claims)**

Source: Welch et al., 2009.
4. COST-EFFECTIVE TREATMENTS EXIST

e.g. Cognitive Behavioural Therapy (CBT)

- Low cost (£900 for 10 sessions)
- Good recovery rates (32% compared with no treatment)
- Low number needed to treat (3)

Source: Layard et al., 2007.

EFFECT ON COST OF PHYSICAL HEALTHCARE

- In 26 of 28 U.S. trials savings on physical care exceeded cost of CBT.
- For people with COPD, angina and diabetes, CBT-based interventions reduce the net cost.
- So CBT expansion likely to have negative cost to the NHS. Treating 15% of the untreated cases could give gross savings of £1/2 billion.
- This exceeds the gross cost of £300m.

Sources: Chiles et al., 1999; Howard et al., 2010; Moore et al., 2007.
EFFECT ON BENEFITS AND LOST TAXES

In 2006 we forecast that these savings would outweigh the costs of extra CBT. Subsequent evidence supports this claim.

Source: Layard et al., 2007.

5. GROSS UNDER-TREATMENT

% of people with depression and anxiety in treatment (2007)

<table>
<thead>
<tr>
<th>Treatment Type</th>
<th>%</th>
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<tbody>
<tr>
<td>Medication only</td>
<td>14</td>
</tr>
<tr>
<td>Counselling or therapy (mostly counselling)</td>
<td>10</td>
</tr>
<tr>
<td></td>
<td>24</td>
</tr>
<tr>
<td>By 2011 still under 33%</td>
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Source: Data from the study.
Expenditure on depression and anxiety disorders (2011) (£billion, approx)

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<tbody>
<tr>
<td>GP consultations</td>
<td>1.5</td>
</tr>
<tr>
<td>Prescriptions</td>
<td>0.8</td>
</tr>
<tr>
<td>Secondary care</td>
<td>0.5</td>
</tr>
<tr>
<td>Improved Access to</td>
<td>0.2</td>
</tr>
<tr>
<td>Psychological Therapies</td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>3.0</strong></td>
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i.e. 3% of NHS expenditure on 15% of the burden of disease

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**IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES (IAPT)**

- **Aim**: provide NICE-recommended therapies to all who need them.
- **Method**: rigorous 1-year training programme
  - new services, using session-by-session monitoring of patient’s progress
- **Now reaching** 10% of diagnosable population, with recovery rates above 40%.
THE WAY FORWARD FOR IAPT

• Government has provided commissioners with money to treat 15% of the diagnosable population in 2015.

• But the 60 outcomes in the NHS Outcomes Framework include neither access to nor recovery from depression/anxiety. This is totally unacceptable.

• 2015-2020. Expansion needed to reach 25% of diagnosable population, especially chronic physically ill with mental health problems. Close link to physical care.

• By 2020 transform CAMHS into evidence-based service.

• Can only happen if Commissioning Board has a single IAPT unit.

OTHER CHANGES NEEDED

• GP training. Should include a mental health rotation (ideally in IAPT)

• Improved recruitment in psychiatry

• Above all, commissioners who treat mental illness as at least ¼ of their business
REFERENCES


