THE FOUNDATION FOR SCIENCE AND TECHNOLOGY

DINNER/DISCUSSION SUMMARY

The future strategy for the management of mental health in the UK[1]

Held at The Royal Society on 11th September, 2012

The Foundation is grateful for the support for this meeting from The Wellcome Trust

Chair: **The Earl of Selborne GBE FRS**
Chairman, The Foundation for Science and Technology

Speakers: **Professor Lord Layard FBA**
Director, Wellbeing Programme, Centre for Economic Performance,
London School of Economics and Political Science
Professor Simon Wessely FRCP FRCPsych FMedSci
Chair and Head of Department of Psychological Medicine, and Vice Dean, Institute of Psychiatry King's College London and Consultant Liaison Psychiatrist, Maudsley and King's College Hospital
Professor Sir Bruce Keogh KBE DSc FRCS FRCP
Medical Director, National Health Service for England

LORD LAYARD reiterated some of the factual findings in the Report of the LSE Mental Health Policy Group: (a) mental health (MH) diseases formed 40% of all diseases; (b) their effects were more debilitating than many physical diseases; (c) they substantially increased the costs of dealing with physical diseases; (d) there were cost effective treatments available for them which would offset the costs of providing them; and (e) we were treating only one-third of patients who had MH problems. The morbidity from MH was the highest of all diseases - 38% - and the overall burden, including premature death, 23%. Half the patients referred to consultants for physical ills, had mental problems. But only £3bn out of the £15bn of MH funds was spent on medically unexplained symptoms (MES). Cognitive Behaviour Therapy (CBT) is a proven therapy costing only £900 for 10 sessions, with a 32% recovery rate. Most US evidence shows that CBT costs are less than the savings from physical care.

The Improved Access to Psychological Treatment Programme (IAPT) launched in 2008, which aimed to provide NICE recommended therapy, has gone well, with an effective training programme and good recovery rates. But although funds are allocated in the Comprehensive Spending Review, they are not being spent, and insufficient trainees are coming forward, there is a risk the programme will not be delivered. The NHS needs to change the vision many have of MH. The Commissioning Board should make continuing and expanding IAPT a high priority and include it in the mandate to Commissioning boards; child MH services should be expanded, not cut; GPs should be better trained in diagnosing MH and more students urged to become psychologists.

PROFESSOR WESSELY asked why, in spite of the 40% figure for MH, with good and effective therapies, there were wide inequalities in treatment and discrimination in the use of resources. Stigma was an important element - popular culture did not register the suffering as it did for physical ailments (support for Great Ormond Street hospital had much greater appeal than for the Maudsley hospital). This was not entirely irrational - in extreme situations (such as military operations) where mutual interdependence was crucial, MH would be ignored. There was also fear of overstretch - medicalizing problems which might arise from the normal stress of life - such as grief, or exceptional intelligence. But the philosophical Cartesian ethos in the NHS - that mind and body were two separate entities (as exemplified in the separation the Maudsley and King's College hospitals) played a major part. Consider, as an analogy, that life deals individuals a handful of cards. Some can play their hand successfully, others cannot, and they are the ones who need help, often because they think they have physical problems, although diagnosis and treatment, after huge expenditure, does not reveal any. MH is not enquired into. If a psychologist had been consulted at the start, and effective remedies such as CBT instituted, the patient would recover, and the NHS saved money. The institutional problems are failure to accept that physical care cannot be separated from mental care, and that GPs find it difficult to know who to whom to refer cases where they know that physical complaints may well have an

[1] This debate is a follow-up to a debate with the same title held on 4th May, 2011 – see www.foundation.org.uk .

MH basis. But we should recognize that primary care in the UK is good, and that, while we need improved therapies for serious mental illnesses, we are good at utilizing the existing knowledge.

SIR BRUCE KEOGH said he would from 1st April, 2013 as Medical Director of the NHS assume responsibility for both mental and physical health; he recognized the problems of the Cartesian divide which Professor Wessely had raised. His aim was to restore, in the NHS, the feeling of compassion for those suffering, which had animated the founders of the NHS in 1948. His concern was that, since then, although funds had increased, and our science was top class, there had been a focus on technological improvement, bureaucratic and clinical structures, and arbitrary targets, which had ignored individual suffering. Lengthy delays for appointments and operations were a sign. The aims of the reorganized NHS - to focus on clinical outcomes; to put more responsibility and accountability on clinicians and give patients more choice - should help. A high level framework is to be structured around fundamental NHS tasks - to stop you dying if possible; look after you in long term care; deal effectively and speedily with short term cases; be vigilant on safety; and provide good patient experience. But, he acknowledged that the service could benefit from an external stimulus when clinical views had been too complacent – for example the drive by Ministers to reduce deaths from MRSA.

The new commissioning boards will have the difficult task of allocating funds, for both physical and MH problems. They will need to understand the business case for funding projects and Lord Layard's working group report, with its emphasis on cost effectiveness and recovery rates will be very valuable but if MH was to achieve its proper position within the NHS, there must be robust clinical leadership, as in other fields. Only then could the NHS become more responsive to customers (as he viewed patients) needs.

In the following discussion there was full acceptance of the seriousness of MH issues, as Lord Layard had said, and also strong, sometimes passionate, support for Professor Keogh's call for compassion. But speakers questioned whether we had got to the root of the problem of public perception of MH. Cultural change was crucial, in the public as well as in the medical mindset. Children should be told about MH problems as they are about physical problems; they should understand that help is available and there is no shame in seeking it. Indeed, intervening with children is crucial, as the social and economic costs of failing to deal with their MH problems are large and maybe lifelong. But how much understanding can we expect from the public? If a patient is to be able to make an effective choice about treatment, he needs information. How is this to be provided? Moreover can we dissociate MH problems from the wider problems people face in society today, such a job insecurity, broken families, ethnic discrimination and poverty? We are in danger of thinking that MH can be treated separately from working towards better "well-being". Similarly, in schools, there is a view that "well-being" is in competition with academic excellence. A false view; one supports the other. Layard wrote about costs to the economy, not NHS costs, and this discussion should not therefore ignore those wider costs, which are increasing because of the impact of other Governmental policies, such as cutting benefits.

A speaker suggested that health policies should be directed towards preventing MH problems arising; but others thought it would be inadvisable; it would remove focus from curing, and there were many problems in trying to alter those habits, which might lead to a need for MH therapy.

There are particular problems with ethnic groups, who view "white" professionals with suspicion, as driving values that may not be part of their culture. The key is promoting self-referral; encouraging families of sufferers to accept that help is available and making it easy for them to apply for it. The other key is widening the range of acceptable therapies, so that genuine choice exists. Do not ignore, or downplay, therapies such as those provided by faith or religion. For those outside the professional world, they can be more healing than conventional therapy.

Within the medical profession itself, 40% of GPs do not have MH training and medical directors in Trusts often have little awareness of psychological treatments. The Cartesian divide means that there is no consensus between clinicians about how MH and physical health care can be brought together. Indeed, there is a danger that they are drifting further apart. It is crucial that psychiatry remains part of medicine, and is not seen as a disconnected field. Speakers suggested that perhaps the problems of how to provide treatment of less severe MH disorders would be to have psychiatrists who were not fully medically trained. But others thought this would be a damaging development. A key problem was the shortage of psychiatrists - of whom 95% came from abroad. Psychiatry should be a prime choice for students, as it dealt with the whole human personality, but, perhaps stemming from public attitudes about MH, it was failing to attract students from what they perceived as more glamorous specialities. There was also the impression that many MH cases are long term, and that little can be done and that research is not being undertaken. This is false; the NHS is anxious to support research, but needs specific proposals to be

made for funding. The Commissioning board has a specific mandate to support research. It is in facilitating better understanding that clinical leadership can be vital.

Speakers were concerned that the new commissioning structures might mean that IATP would be fragmented. It had succeeded because of its unified application, and commissioning bodies must not be allowed to cut back on its implementation. But it was stressed that the boards have to make choices, and they will be faced with increasing financial austerity. If they follow the principles laid out by the Commissioning board, then IATP, with its cost effectiveness and good recovery rates should do well. But there were doubts about some of the figures that had been quoted. We should not accept too easily the view that the number of those with MH are increasing. Half of those with MH are in work and functioning. We need to focus on those who actually need treatment - not all those who may have problems. We need also to study carefully the reported success rates of IATP. Many of those referred for IATP do not take it up, or leave after the first session.

The effectiveness of CBT was also raised; there were some studies that showed its effects were little different over the long term from placebos. But three points were made - first, the personality of the person delivering it was vital; it worked only with a sympathetic listener; second, the danger of raising false expectations. If the impression were given that, no matter what life threw at you, anxiety and depression could be conquered, therapy could not succeed, third, that there must be a hope of a positive outcome.

Speakers stressed that MH was a public good as well as a private one. It was linked with the commitment of society to help its most troubled members, and that compassion towards the individual was the only way to build a healthy society. But such compassion could only be effective if it were recognized that the mind/body division was false, that individuals needed to be treated as a unity; that professionals understood their responsibilities and had the training to undertake them; and that institutional structures did not stand in the way. The discussion had shown that, while there was wide acceptance of Lord Layard's arguments, and strong endorsement of Sir Bruce Keogh's vision of the NHS, there was a long way to go before the public accepted the importance of MH and stigma reduced; that they understood NHS could not deal with the results of the stresses imposed by modern society; and the medical profession fully understood its role in the reformed NHS.

Sir Geoffrey Chipperfield KCB

Useful web links:

Academy of Medical Sciences
www.acmedsci.ac.uk

Department of Health – Mental Health
www.dh.gov.uk/health/category/policy-areas/social-care/mental-health/

The Foundation for Science and Technology
www.foundation.org.uk

MIND
www.mind.org.uk

National Health Service
www.nhs.uk

King's College London
www.kcl.ac.uk

London School of Economics and Political Science
www.lse.ac.uk

How mental illness loses out in the NHS
http://cep.lse.ac.uk/pubs/download/special/cepsp26.pdf

Medical Research Council
www.mrc.ac.uk

The Royal Society
www.royalsociety.org

South London and Maudsley NHS Foundation Trust
www.slam.nhs.uk

The Wellcome Trust
www.wellcome.ac.uk

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