Interview

The Lord Layard interview

Interviewed by Paquita de Zulueta (Ethics Editor)

On 18 February 2009, at the London School of economics Lord Layard (LL) was interviewed by *LJPC* ethics editor Paquita de Zulueta (PdZ) about Improving Access to Psychology Therapies (IAPT). This is an edited transcript of the interview. It is also available as a podcast.

PdZ It's the 18th of February 2009. I'm in the London School of Economics and I am interviewing Lord Layard regarding IAPT. Lord Layard, thank you very much for agreeing to this interview.

LL Pleasure.

PdZ I am speaking on behalf of the *London Journal of Primary Care*. I'd like to start with how IAPT began and your role in its development. I believe that in 2005 you gave, at the Sainsbury Centre, an annual lecture regarding mental health in Britain. And you subsequently presented a paper to the Number 10 Strategy Unit entitled 'Mental Health: Britain's Biggest Social Problem' [*correction: The sequence was reversed* – PdZ]. This was followed by your Depression Report in 2006. Now, in 2009, we have IAPT beginning to be rolled out in various parts of the country. This seems to me to be a remarkable achievement. It would be really interesting to find out how it all began.

LL Well, I was writing a book on happiness and I thought I should look at what are the main causes of unhappiness in our society. There are some surveys in which people have been asked how happy they are and you can try and explain this by all the obvious factors, like their income and so on. And what you will find is that the factor which explains more the misery in our country than any other, is the record of mental illness. I wasn't actually surprised at this because I always had an interest in this area. My father was, actually, a Jungian psychoanalyst.

PdZ Oh, really?

LL Yes. But, given the importance of it, it struck me as remarkable how little attention is paid in public policy to the main forms of mental illness which of course are depression and anxiety disorders. When I looked into what were the treatments available in the NHS, it was obvious that only a small minority of people with these

problems were actually receiving any kind of help. In most cases this was medication, even though the NICE guidelines recommend that in all cases other than recent or mild, patients should also be offered CBT or certain other psychological therapies specific to particular conditions.

PdZ Yes.

LL But we know that in most parts of the country they simply can't be offered that and this has been a complaint which has been confirmed to me by GPs all over the country. The Royal College confirmed it as being a real problem: that GPs had patients who desperately needed psychological help and this was not available, even though it's recommended by NICE. It seemed to me that this was outrageous, really, and mental illness was not being treated on a par with physical illness. If we had people who weren't being treated for diabetes or other chronic diseases; we would consider it outrageous.

PdZ Yes. Right. So how did you manage to persuade the Government to take your view and to actually put money into it?

LL Well, I always made the case on a humanitarian basis, but I also pointed out that the Government was losing a lot of money through the employment effect of mental illness. This was costing them a lot in terms of the incapacity benefit and lost taxes, and that, in fact, if we implemented the NICE guidelines (I shared the paper with some other colleagues), it would pay for itself, in terms of savings on benefits and lost taxes. I am quite sure that that argument carried some weight, as well as the humanitarian one.

PdZ Yes. So you gave the humanitarian one and then some hard financial facts which seemed to have solved it. Was there anyone in particular that helped you in this process, in Government?

LL Well, there were a lot of people who helped. Ed Miliband was very helpful. Alan Milburn in particular helped us to get the manifesto commitment in the Labour party's 2005 manifesto to expand access to these therapies.

PdZ Yes. Excellent. So, you've answered really my question on why you focused on mental health. What drew you to CBT in particular?

- LL Well I discovered actually through earlier discussions with Louise Appleby and subsequently through my contact and friendship with David Clark that it has this very very strong evidence base. It appealed to me, I have to say, as well, in that it had this forward looking, positive approach which seemed to me more helpful than a lot of the more backward-looking types of treatment which I had heard of, which didn't seem to have helped a lot of people who have been through them. So I thought that the very hard edged evidence with randomised control trials was very important and very convincing to me. But of course it's the fact that some other therapies have been justified through randomised controlled trials and doubtless more will be, if they take seriously the challenge of proving their efficacy.
- PdZ Yes, absolutely. So, I mean CBT, as you say, has this quality of being very enabling, very collaborative and working in 'the here and now', so that it doesn't address the past necessarily, although it might do. Anything else of that sort that might be attractive for both individuals who need it and to those Government people - anything else about CBT that seems attractive, aside its strong evidence base? Anything else?
- LL Well obviously it's the case that most courses of CBT have a limited duration. Therefore they are not hugely expensive and it becomes practical to provide that to millions of people. Because we are actually talking about millions of people. If we insisted on giving very intensive and long courses to people as being the main acceptable treatments, that's the same as saying that we are not going to be offering treatment to millions of people who need it.
- PdZ Well, I think that it is a marvellous achievement to have got this through. I suppose my next question is just to ask a bit about yourself first. You're a social economist, can you explain what that means?
- LL I am not sure that this is the sort of phrase I would use.
- PdZ No. So how would you describe yourself?
- LL Well I became an economist actually in my 30s from an interest in public policy priorities - how does one think about that. I discovered that, really, economists haven't got any kind of systematic framework for doing that. But I was also a bit shocked by the limited range of factors that economists consider as influencing well-being. But I still think that economics is by far the best way into thinking about public policy, which I'm sure is why social policy, for example, has been largely taken over by economists. So I think that all of us need to widen our view. Economics is trying now to take into account the insights of psychology, and I'm trying to push this along as well.
- PdZ Yes, thank you.
- LL But obviously one of the main strengths of economics is that it has this very firm quantitative basis.
- PdZ Yes, yes. Just how do you think this IAPT will work over the next 2 years? How do you see it rolling out? What will facilitate it, do you think?
- LL Well, our original plan was that over a period of 6 years we would train enough people in evidence-based therapy to be able to implement the national guidelines throughout the country. And in the Comprehensive Spending Review in 2008 we got a commitment to provide all the money that we asked for, for the first 3 years, because it only lasts for 3 years. What has actually happened has been that things have gone rather faster than we had envisaged, because there has been a wave of enthusiasm at the PCT level. Because PCTs have been asked to tender for being the wave one, wave two and wave three sites for the national roll-out. Of course not all of them have succeeded but they still wanted to do things. So what has happened is that the Strategic Health Authorities who have been managing these at a regional level have in fact accepted more sites than we originally expected. But this has meant of course that the PCTs have been putting more of their own money into this than was originally envisaged, which is a very good thing, because it means that it is already entering into the mainstream in a thoroughly healthy way. What is important though is that, you know, increase in speed is not achieved at a decrease in quality and it's crucial that sites which are called IAPT sites satisfy the quality standards which we laid down: that there are enough staff able to provide NICE-recommended treatments and to supervise trainees to do that. So I think that a happy compromise has been reached. Now what has happened since, is that of course we are now still only in the first year, but we are entering one of the worst recessions in the post-war period, and there is a lot of interest in making sure that there are adequate IAPT services to help the additional number of people who will be suffering from depression as a result of the growth in unemployment. So the enthusiasm of the PCTs and SHAs is going to be mobilised to help in such a way that, in the second year, which is 2009, we will have already covered 40% of the population. Therefore, by the third year we will have covered more than half of the population, which means that we ought to be able to get the coverage of the whole

population in less than 6 years. And that will be the subject for discussion when the comprehensive spending reviews will be discussed in the autumn.

PdZ Yes. I mean do you think that these figures might change though with, as you say, you know, more unemployment and more unhappiness? Do you think that in fact it's an underestimate?

LL Well, I am now giving a personal opinion. My personal opinion is that we probably could get to that full national coverage during the fourth year, provided we get enough money to train the large number of people who would have to be trained.

PdZ So that could be a constraint – the lack of money to train?

LL Well I think it's very important. I mean we got, in the third year, we got 173 million. So it's really important that we get a great deal more than that in the fourth year if we try to complete the programme in the fourth year. So that by the time we get to the fifth year it's a part of the mainstream in the NHS.

PdZ Yes. Well, thank you for that. That's very helpful. Can you see anything else that might get in the way? Apart from financial constraints, can you see any other road blocks to IAPT?

LL I don't think there is anything that should stop us!

PdZ Yes, good. I just wanted to address a couple of criticisms and concerns about IAPT and would very much like to hear your response to them. There is a concern about fragmentation of services and that general practice might become deskilled or alienated from the care of the mentally ill. Can you say anything about that?

LL It's absolutely not the idea that there would be an IAPT service and a residual primary care psychological therapy service with disassociated elements of therapy and counselling going on at GP practices. The idea is to produce an integrated service which is what the NHS has to offer depression and anxiety disorders, and that most of it will be delivered on GP premises. In a typical PCT area there would be something like 40 therapists who would have a central building where the senior therapists would have rooms for supervision, training and, obviously, administration and record keeping. But that most of the therapy would be delivered by team members who are associated with particular GP practices.

PdZ With the primary health care team.

LL Yes, and it could well be that some of them would continue to be employed by individual GPs. But we believe strongly that the performance of counsellors and therapists will be better if they are part of a professional team with local supervision and a clear career prospect and so

on. So, we are talking about a progressive, not a forced, but a progressive integration of all the psychological therapies for depression and anxiety disorders in a PCT area within a team for purposes of clinical management. They would be physically cheek by jowl with the GPs with whom they would be able to interact and discuss individual patients.

PdZ So in fact GPs may, through this sort of process of interaction and communication, develop their own skills as well?

LL Well, it's crucial that GPs do develop their own skills and it's vital, of course, for purposes of improved recognition and diagnosis that GPs are better trained in detecting and diagnosing psychological problems and referring them appropriately. It's also of course important that GPs are represented within the team through a GP with a special interest who can represent the GPs interests at the local team and of course it's very important that there are enough GPs who are themselves psychologically skilled to be able to undertake some psychological treatment themselves where it's particularly appropriate. For example, where you have medically unexplained symptoms, it's very desirable that psychological therapists themselves have a medical background. So we are looking to a big up-skilling of GPs and I'm delighted that the Royal College is proposing that a part of the GP training rota would include say 3 months in IAPT and that would be a very very good thing.

PdZ Yes. And you mentioned training. I believe that IAPT is going to include a training package as well for primary health care team members. Is that right?

LL That's correct. Yes. Yes.

PdZ OK. Stigma is always an issue with mental health problems. Do you see IAPT. changing this in any way?

LL Well I think the main thing which will change stigma is that people will see that people with mental problems can be helped and can improve. I mean that is by far the most important thing that would reduce the fear that people have about employing people with mental illness and generally interacting with people with people who have mental illness.

PdZ Yes. I think you've really answered all the questions I wanted to ask. There was a more philosophical one about the Cartesian splitting of mind and body, but I don't know if you want to say anything about that? Do you not think that so often the two can co-exist? Certainly as GPs we find this quite a lot.

LL Yes, I think you are well-placed to achieve a more integrated approach, and I think that we

all know, you know, that we are both, but that there is a role for the division of labour; just as you would send people to a cardiologist, even though their heart may be affected by their mind. So if the central issue is their mind, and medication is not the appropriate treatment, then you should be sending them to a psychologist (psychological therapist) who has more time to deal with it than the typical GP.

PdZ Yes. That's fine. Is there anything (Thank you very much for this!) that you would like to add, any vision you have of all this?

LL I think that, given the fact that a third of the time of GPs is devoted to people who have mental health problems, I think that we are looking into a future in which GPs are much more mental health-conscious, and are better equipped. When they have the time to provide some treatment themselves, at least some of them, and are certainly expert at referring and interacting with the psychological therapy team to help a person back onto the road to recovery. Because there is a huge amount of co-morbidity, so the patients will be coming to the GP often for physical

requirements, as well as going to IAPT team to try to get back onto the road. It's a combined effort to get them back, I think. As part of this, it is important that there is a new attitude to work as a part of the process of therapy. And I think that the effort which the Government is promoting now is to encourage GPs to use the sick note as a 'fit note', if you like, an instrument for a therapeutic programme to help them back onto the road to normal life. This is very important. We don't want people to give up on their current jobs, if they have them. We want to help them to keep them, if we possibly can, and we also want to encourage them to find other jobs if they've lost them. That is why in the IAPT programme there will be employment support workers as well as psychological therapists. So there really is an important integration to be achieved between GPs, psychological therapies and employment support workers.

PdZ Yes. Thank you very much.

LL With pleasure!

PdZ Thank you.