

Whole in One:

Achieving equality of status,
access and resources for
people with depression

March 2015

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MAKING HEALTH PERSONAL

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About this publication

This report focuses on depression in adults, with particular emphasis on access to NHS services and treatment, the funding of services, depression in the workplace, and the role of the National Institute for Health and Care Excellence (NICE).

It is surely not right that mental ill health represents nearly 40% of all disability and up to 23% of the total financial burden of ill health in the UK, yet only 13% of the NHS budget is spent on services. We question in this report the lack of diagnosis, treatment options and the apparent discrimination in availability of medicines, as well as the continued separation of mental health from physical health.

During the course of this work we benefited from interviews and discussions with many of those in research, in supportive roles and from people living with depression. We are very grateful to them for their time, and in particular to those who attended our round-table discussion in 2014.

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1. Executive Summary

Parity of esteem is a phrase now familiar to many working in health and social care. Signifying an ambition to see mental health given equal priority to physical health, it is a concept that resonates with policy makers, mental health practitioners, health economists and even business managers. It is a concept that should also appeal to the general public, who have currently restricted access to treatment of the leading cause of disability in Europe: depression (WHO, 2012).

Despite several years of political advocacy, the parity of esteem agenda has seen limited progress on the ground within the NHS. The Improving Access to Psychological Therapies (IAPT) programme has undoubtedly seen service expansion, but local investment varies widely, ranging from under £2 to over £14 per head of population across Clinical Commissioning Group (CCG) areas. Such incongruent allocation of funds surely testifies to the lack of recognition of depression as widespread, severely debilitating and often treatable. It also denies appropriate recognition of the close association of mental and physical illness, including the extra physical healthcare costs to the NHS resulting from untreated depression. IAPT remains a postcode lottery, although as our report shows, HSCIC ‘experimental’ performance data can be very wide of the mark, unfairly indicting some CCGs of gross inefficiency. In recognition of the programme’s potentially extensive societal benefits, we believe IAPT commissioning should become the joint responsibility of CCGs, Local Authorities and the Department of Work and Pensions, with one pooled budget for each locality.

Around two-thirds to three-quarters of people with depression go untreated. Some people are ignored by the medical establishment; some are in denial; others, fearing stigma and discrimination, attempt to conceal their illness. The ‘Time To Change’ campaign has been battling stigma and discrimination in the workplace and has reported some remarkable transformations. We would like to see guaranteed ongoing funding of this programme, although we believe Time To Change’s work needs to be validated by independent analyses, so to support a robust evidence base of interventions and outcomes.

We believe NICE has a role to play in the parity of esteem agenda. A much greater proportion of mental health treatments than physical health treatments have undergone a clinical guideline assessment process rather than a health technology appraisal (HTA) process, meaning there is not the same legal imperative for providers to make them available (RCPsych, 2013). NICE could support the parity agenda by bringing greater legal force to the realm of mental health treatments and services.

Parity should also extend to NICE HTA recognition of the full range of benefits – social and economic – successful treatments of common mental illness can bring. Depression is most prevalent in younger adults. Treatments that enable people to remain socially integrated and emotionally balanced as partners, parents and carers, and which enable people to stay in or return to work, introduce a societal and cost-efficiency factor that needs to be considered in NICE appraisals. The Department of Health has been encouraging the consideration of wider societal benefits; and it is of note that while the Treasury recognises factors associated with subjective wellbeing (DWP, 2013), NICE’s EQ-5D ‘quality of life’ assessments do not (NIHR, 2014).

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We need to be ever mindful that the working-age population is decreasing in ratio to older people. With the greater prevalence of long term conditions that accompany an aging population, society is set to become increasingly dependent on a health-optimised workforce. Policy makers, local commissioners, employers and NICE all need to recognise this matter as a national priority.

Noting the recommendations very recently made by the Chief Medical Officer in her excellent report Public Mental Health Priorities (2014), we offer further recommendations with particular emphasis on NHS parity for those who experience depressive illness.

Recommendations	Action to be taken by:
IAPT	
1. Publication of IAPT workforce recruitment data to identify whether targets have been met: both High Intensity Therapists and (low intensity) Psychological Wellbeing Practitioners. With recruitment now commissioned locally, data should include a breakdown of therapists by CCG.	DH CCGs
2. CCG spend on IAPT, proportional to CCG population, to be published on IAPT website to bring greater transparency and accountability to the programme.	NHS England CCGs
3. Area Teams to appoint regional GP IAPT Champions to disseminate best practice among CCGs, using case studies of the most successful and cost-effective local IAPT programmes	NHS England Area Teams
4. IAPT to be funded by both health and social services with one pooled budget (for each locality), in appropriate recognition of the programme’s potentially significant and wide-ranging societal benefits. Commissioning plans to involve national and local stakeholders.	NHS England Department of Work and Pensions (DWP) Local Authorities CCGs

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Recommendations	Action to be taken by:
Workplace	
5. Commissioning of independent analyses of 'Time to Change' interventions and outcomes, so to increase the evidence base and help ensure organisational buy-in.	DH DWP
6. Individual Placement Support (IPS) employment specialists to be instated within each IAPT service across England, joint-commissioned by LAs and CCGs with additional support from the DWP.	Local Authorities CCGs DWP
7. Appointment of local Workforce Mental Health Consultants (WMHC) to promote prevention and early intervention, particularly targeting small to medium size businesses. WMHCs to support employers in the safeguarding of jobs of those experiencing illness by close working with primary care / IAPT services.	Local Authorities CCGs DWP
8. HSE to bring legal force to the protection of workers' mental health through employer obligations already enshrined in the Health and Safety at Work Act, 1974.	Health and Safety Executive
9. High-profile dissemination of employer obligations under the Health and Safety at Work Act to be undertaken to support mental wellbeing in the workplace.	DH Public Health England DWP

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Recommendations	Action to be taken by:
NICE: parity of esteem	
10. Quality Standards on maximum waiting times and access to evidence-based treatments within mental health services; clear statement of public right to alternative providers (with fees chargeable to the NHS) where targets are missed.	NICE
11. Mandatory recommendation for CCGs to provide range and choice of evidence-based treatments for common mental illnesses.	NICE
12. CCGs to be alerted to obligations to observe NICE guidance on mental health services, with clarification where existing 'guidelines' carry legal implications.	DH Healthwatch
13. Health Technology Assessments (HTAs) to become standard on all new mental health pharmacological treatments.	NICE
14. Changes to be made to the HTA process to capture wider costs and benefits, recognising 'subjective wellbeing' (of patients, families/carers) and productivity gains.	NICE
Pharmaceutical Price Regulation Scheme (PPRS)	
15. To ensure understanding among CCGs and frontline clinicians of the implications of the 2014 PPRS agreement.	DH
16. NICE to consider a greater degree of flexibility around ICER uncertainty for depression and other mental health conditions in recognition of current PPRS arrangements (requiring pharma to reimburse NHS overspend on branded medicines).	NICE
17. Publication of local uptake on NICE-approved branded drugs (perhaps via the Innovation Scorecard) to support public access to latest treatments.	DH Healthwatch

2. Introduction

A number of recent publications have offered critical insights into the social and economic impact of mental illness in the UK, and made a powerful case for parity between mental and physical health.¹ Drawing upon those themes, the purpose of this report is to identify specific progress needed for the improved treatment of depression – the leading cause of disability in Europe.

Accounting for 7.2% of the overall burden of disease (WHO, 2012; Wittchen et al, 2011), depression often accompanies other forms of mental illness such as anxiety, post-traumatic stress disorder (PTSD) and schizophrenia, and commonly occurs as a co-morbidity in patients with chronic physical health problems (Buckley et al, 2009; NCCMH, 2010). The lifetime chances of an individual suffering one or more episodes of clinical depression could be as high as 30 – 40% (Andrews et al, 2005). With depression most common in working-age adults, no other condition, physical or mental, has such vast social and economic consequences. And yet, up to 75% of people with clinical depression do not receive treatment [LSE, 2012]: it is difficult to think of a common physical illness that has a comparable level of neglect by the medical establishment.

The Health and Social Care Act 2012 made clear the government’s objective to see mental illness gaining so-called ‘parity of esteem’ with physical illness. But are resources and treatments in place to meet need? Can the NHS afford to treat all depressive illness? And what changes in attitudes and policy are needed to de-stigmatise depressive illness and acknowledge it as one of the great health challenges of our present age? Following a consideration of the meaning of ‘parity of esteem’, we broadly confine our attention to four specific contexts: access & treatment; funding; depression in the workplace; and the National Institute for Health and Care Excellence (NICE).

2.1 Methodology

Research for this paper was undertaken between September and December 2014. The project incorporated desk-based literature review and research; four semi-structured interviews with leading figures from the Institute of Psychiatry (KCL), LSE and third sector; and a parliament round table attended by key stakeholders across healthcare, the third sector and business community (see Appendix A). We also attended two summits on mental health during the project period: a Policing and Mental Health summit (23rd October), co-hosted by Black Mental Health UK and the Home Office; and the ‘Global Crisis of Depression’ summit (25th November), hosted by the Economist Group. Attendance allowed us a range of informal discussions with UK stakeholders; informal information gathering also extended to emails and phonecalls with NICE and pharmaceutical companies.

1. E.G. Annual Report of the Chief Medical Officer, 2013; Royal College of Psychiatrists, Whole-person care: from rhetoric to reality, 2013; Centre for Mental Health, Parity of Esteem. Briefing note, 2013.

3. Parity of esteem

In the policy document No Health without Mental Health (2011) the government set out its ‘ambition to mainstream mental health, and establish parity of esteem between services for people with mental and physical health problems.’ This ambition was enshrined in the Social Health and Care Act of 2012.

As the Royal College of Psychiatrists (RCPsych) has noted, a definitive definition of ‘parity of esteem’ does not exist (RCPsych, 2013). However, the institution argues that a parity approach should be one of ‘valuing mental health equally with physical health’, delivering:

- equal access to effective, safe care
- equal efforts to improve the quality of care
- the allocation of resources on a basis commensurate with need
- equal status within healthcare education and practice
- equally high aspirations for service users
- equal status to the measurement of health outcomes
- holistic, integrated care with mental health considered alongside physical health

The government has set out a number of plans of action which may go some way to realising the above objectives. These include the 25 action points in Priorities for Essential Change in Mental Health (2014), which details expectations of tangible changes in mental health care and support for the next two years. The document introduces founding proposals for waiting time standards for referral (from 2015/16): to date, the public has had severely restricted rights of access to mental health services. The government has also set up a taskforce to investigate the state of CAMHS provision following reports of inadequate service provision in many areas across England. And the Crisis Care Concordat (2014) will seek to ensure a high quality response when people with mental health problems urgently need help (DH, 2014b).

There is more work yet to begin. This should include additional training for GPs to better understand mental illness (CMO, 2014): around one in three visits to the GP surgery is related to a mental health problem (MHF, 2014). The now well-recognised bi-directional relationship of mental and physical health demands that we cease the compartmentalisation of conditions and look instead at holistic, integrated care, which should be reflected in local commissioning models. Links and disparities are nowhere more obvious than in the findings that ‘people with a diagnosis of severe mental illness die on average 15–20 years before those without – largely from preventable physical diseases such as heart disease and diabetes’ (BMJ 2014). The reason is partly due to neglect by the medical establishment (Carson et al, 2011); it is also because people with mental illnesses are more likely to neglect their own health: they have higher levels of smoking, alcohol misuse and obesity than

.....
Among people under 65, nearly half of all ill health is mental illness.
NHS England
.....

3. Parity of esteem

the population as a whole, and do less physical activity (DH, 2014a). Mind and body should no longer be considered as separate entities.

To this end, Health and Wellbeing Boards need to give greater priority to both common and severe mental illness in their Joint Strategic Needs Assessments (JSNA) and make recommendations for joint commissioning across NHS and social care.

Beyond care services, there is also a pressing need to raise public understanding of mental health, not just to promote mental wellbeing, but also to reduce stigma and discrimination – especially in the workplace.

Achieving positive mental health – and true parity of esteem – requires a focus on the wider structural and environmental conditions that hinder people in their capacity to make healthy choices and engage with health services and treatment (MHF, 2010). Children and adolescents are a vulnerable group in this respect. Extreme poverty, inadequate social housing, family breakdown, abuse and social exclusion are linked to higher rates of mental ill-health among children and adolescents. Excluding dementia, the majority of mental illness begins before the age of 18, yet most of these individuals, as with adults, are not known to services (CMO, 2013).

Our report scope – focusing on depression in adults: access and treatment, funding, the workplace and NICE – is therefore not to deny recognition of the wide-ranging problems that contribute to institutionalised disparities between mental and physical health. Parity of esteem undoubtedly depends on a sea-change of attitudes in government, health care, social care, public and private organisations, the media and general public. Whether it can ever be truly achieved has been contested (BMJ 2014) since it is difficult to enforce by law, but no one should dispute that considerable progress *can* be made, and at relatively low cost, even in the short term (DH, 2014).

4. Considering depression

Depression refers to a wide range of mental health problems which can be characterised by low mood, feelings of hopelessness and loss of interest in every-day things, as well as a variety of associated emotional, cognitive, behavioural and physical symptoms (NCCMH, 2010). Combining all clinically-defined categories of ‘depression’ (with correlates), depressive illness affects as much as 11% – 13% of the population at any one time (Martín-Merino et al 2010; King et al, 2008). Depression has been shown to reduce life expectancy in women and men by an average of 7 and 10 years respectively (Chang et al, 2011), variously resulting from poor health behaviours, inadequate preventive care and insufficient medical care (Carson et al, 2011).

There has been much debate about the causes of depression, but these are widely considered genetic, biological and psycho-social. Whether depression can be almost completely genetic, or not really genetic at all, is unknown (Stanford School of Medicine, 2014).

4.1 Depression as an illness

Depressive illness is often insidious, developing gradually and imperceptibly. There are three categories of depression recognised by clinicians, organised by severity: ‘mild depression’, which has some impact on daily life; ‘moderate depression’, which has significant impact on daily life; and ‘severe depression’, which makes it almost impossible to get through daily life – a few people with severe depression may have psychotic symptoms (NHS Choices, 2014). Unipolar depression is roughly twice as common in women as in men (WHO, 2014). Depression by category prevalence is approximately: mild, 70%; moderate, 20% and severe, 10% (Secta/NICE, 2004).

Depression is considered a clinical illness when symptoms last at least two weeks (DSM IV, 2000). At the same time it is recognised that depressive symptoms below the threshold criteria for clinical illness can be distressing and disabling if persistent (NICE, 2009). Treatment studies report a median duration of about 20 weeks; for some individuals the condition is recurrent, and for a minority it becomes chronic, with symptoms lasting at least two years (Harvard, 2009). Around 20–25% of people who suffer major depression experience chronic symptoms. Chronic depression is associated with more frequent psychiatric and medical comorbidity, greater disability, increased health service use, and higher likelihood of suicidal thoughts and attempts (Satyanarayana et al, 2009).

Depressive illness is associated with a complex variety of symptoms, psychological and physical, as listed in table 4a.

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Table 4a: Symptoms of depression

Psychological symptoms	Physical symptoms
<ul style="list-style-type: none"> low mood or sadness much of the time feeling hopeless and helpless having low self-esteem feeling tearful feeling useless and inadequate feeling irritable and intolerant of others having no motivation or interest in things finding it difficult to make decisions loss of concentration forgetfulness not getting any enjoyment out of life feeling anxious or worried suicidal thoughts or thoughts of self-harming 	<ul style="list-style-type: none"> moving or speaking more slowly than usual change in appetite or weight (usually decreased, but sometimes increased) constipation unexplained aches and pains lack of energy extreme tiredness disturbed sleep patterns / insomnia lack of interest in sex changes to menstrual cycle

Principal sources: RCPsych/NHS Choices

These debilitating psychological and physical symptoms often have pronounced social and economic consequences, including strained relationships in home and family life, social fragmentation, workplace ‘presenteeism’ and absenteeism, and unemployment. A large WHO study of self-reported conditions concluded that major depression (on its own) causes greater detriment to health than a single chronic condition of asthma, angina, diabetes or arthritis (Moussavi et al, 2007). And as noted in Section 3, evidence indicates that depression may be variously a cause and a consequence of certain physical illnesses, including cardiovascular disease, cancer, epilepsy, diabetes and stroke (LSE, 2012; BMA, 2014).

The common occurrence of depression in those with chronic physical illness has led NICE to recommend a model of integrated care that includes ‘multi-professional working, case management, structured care plans, systematic follow-up, patient education and support for self-management, and a stepped-care approach to treatment which matches the intensity of intervention to gradations of severity in patient needs’ (RCPsych/CMH, 2013).

It is not just the physical symptoms caused or exacerbated by mental illness that are gaining attention from policy makers and medical professionals. The very nature of mental illness itself is becoming increasingly recognised as physical. This is arguably true of severe depression, together with schizophrenia, bipolar affective disorder, PTSD and OCD, all of which manifest measurable

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brain abnormalities. Advances in neuroscience have led some to argue that psychiatric disorders should be reclassified as disorders of the (central) nervous system. Such reclassification would ‘foster the integration of psychiatry into the mainstream of medicine, where it belongs’ (BMJ 2012).

4.2 Access and treatment

Medication and psychological therapy are the principal forms of management and treatment of depression. For moderate and severe depression, both psychotherapy and pharmacotherapy are frequently employed in combination for a limited period.

It is possible to recover from depression without treatment: most people will see recovery at some stage between three and six months (Toshiaki, 2000; Spijker et al, 2002). This should not invite a do-nothing approach, as treatment can vastly improve the quality of life of a patient and expedite remission. However the realities of gradual recovery no doubt contribute to the fact that up to 75% of people living with depression do not receive help from the NHS. It also makes mental health services an easy target for funding cuts, as we will examine in Section 5.

4.2.1 Stepped care model

The NHS has adopted a stepped-care model for the treatment of depression, as approved by NICE and recommended in the Improving Access to Psychological Therapies (IAPT) Outline Service Specification (see figure 4b below).

Figure 4b: NICE (2011) Stepped Care model for the treatment of depression

Focus of the intervention	Nature of the intervention
STEP 4: Severe and complex depression; risk to life; severe self-neglect	Medication, high-intensity psychological interventions, electroconvulsive therapy, crisis service, combined treatments, multiprofessional and inpatient care
STEP 3: Persistent subthreshold depressive symptoms or mild to moderate depression with inadequate response to initial interventions; moderate and severe depression	Medication, high-intensity psychological interventions, combined treatments, collaborative care and referral for further assessment and interventions
STEP 2: Persistent subthreshold depressive symptoms; mild to moderate depression	Low-intensity psychosocial interventions, psychological interventions, medication and referral for further assessment and interventions
STEP 1: All known and suspected presentations of depression	Assessment, support, psychoeducation, active monitoring and referral for further assessment and interventions

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Low intensity interventions include guided self-help based on CBT, computerised CBT, behavioural activation (encouraging activity the individual may be avoiding) and structured physical activity. High intensity interventions include Cognitive behavioural therapy (CBT) or interpersonal psychotherapy (IPT), each with medication; Couple Therapy and counselling are further options, and increasingly Mindfulness Based Cognitive Therapy (MBCT). The delivery of psychological therapies in the NHS may involve clinical psychologists, nurse practitioners, psychotherapists and counsellors. NHS-funded psychological therapy may also be provided by therapists working for private, independent or voluntary sector organisations (CFWI, 2013).

The NHS stepped care model gives indication of broader social actions that can help the ongoing management of depression, and indeed the Royal College of Psychiatrists has called for more social care research into mental health to enable self-management when problems persist. It is vital that people are equipped to understand their condition and maintain themselves in communities (RCPsych, 2013). The charity Depression Alliance is one of the organisations working towards this objective, promoting networks of self-help groups to end the isolation and loneliness of depression. Through its Friends in Need programme, people can share personal stories online to help others understand their own experiences of depression; the charity also encourages supportive friendships and meet-ups through community events.

4.2.2 Improving Access to Psychological Therapy (IAPT)

Launched in 2008, Improving Access to Psychological Therapy (IAPT) is an expansion programme of psychological therapy services offered by the NHS. Providers of IAPT services are increasingly a mix of NHS organisations, the private sector and the voluntary sector (CFWI, 2013). Training programmes were set up to ensure appropriately qualified NHS staff were in place by 2014 to enable access for at least 15% of adults suffering from common mental health problems who might benefit from appropriate psychological therapies (DH, 2012a).

The target IAPT workforce increase was set at 6,000, principally through the recruitment of High Intensity Therapists (HITs; Step 3) and Psychological Wellbeing Practitioners (PWPs; Step 2). The first phase (2008–11) saw some 3,600 staff recruited; however more recently recruitment responsibilities have been decentralised and targets numbers of both HITs and PWPs have not been realised (CFWI, 2013). IAPT's target recovery rates are set at 50% 'at least' (DH, 2012a).

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4.2.3 Is IAPT working?

According to data published by HSCIC, in 2013/14 just over 700,000 individuals were treated by IAPT services; 319,904 individuals who were initially recognised as 'clinical cases' finished a course of treatment; 143,833 (45%) were diagnosed as recovered² (HSCIC, 2014a). The original aim of the IAPT programme, however, was to see some 400,000 people a year recovering from depression or anxiety disorders by 2014 (LSE, 2012).

IAPT may be unlikely to hit its ambitious national targets (we will find out later this year), but it is vitally important to point out that HSCIC data is 'experimental'. What margin of error 'experimental' implies is not stated. The issue is of importance because this published data suggests considerable IAPT inefficiency in various areas of England.

A selection of Freedom of Information (FoI) requests we made during November 2014 revealed often huge variance between HSCIC and CCG data. The benchmarks of IAPT performance include the ratios of referrals received to referrals entering treatment, to referrals with a finished course of treatment. This is a vital index of correct diagnosis, access and drop-out rates (with significant implications for cost-efficiency). Table 4c presents three examples of HSCIC vs CCG data.

Table 4c: Selected IAPT data, 2013/14

CCG	Data source	Referrals received = n	Referrals entering treatment = n	Referrals entering treatment = %	Referrals with a finished course of treatment = n	Referrals with a finished course of treatment* = %
NHS Bristol CCG	HSCIC	4,695	3,005	64%	490	16%
	CCG	10,802	8,709	81%	4,977	57%
NHS Brighton and Hove CCG	HSCIC	4,680	570	12%	130	23%
	CCG	6,134	5,067	83%	4,890	97%
NHS Wiltshire CCG	HSCIC	10,670	11,110	104%	2,115	19%
	CCG	11,561	10,957	95%	6,972	64%
ENGLAND CCG AVERAGE (HSCIC)	HSCIC			63%		51%

* In order to finish a course of treatment, a referral must have ended in the year with at least two treatment appointments having been attended in the course of the referral. The % proportion relates to those entering treatment, not all referrals received.

2. 'Recovered' means no longer classified as clinical cases, as measured in terms of anxiety and depression. Scores do not necessarily exceed the 'measurement error' of the questionnaire. The number 'reliably recovered' – i.e. exceeding the measurement error – was 136,928 for the year.

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Five out of the seven³ FoIs we submitted targeted what HSCIC data indicated as some of the poorest IAPT services in England. We asked these CCGs to confirm or refute HSCIC data, and where necessary explain well below-average service outcomes. All CCGs returned a response that refuted HSCIC-held data, with the three cited in Table 4c indicating substantially better outcomes. Problems around data submission and upload, and in one case multiple counting of single referrals through system malfunction, has distorted the true picture of IAPT.

However, our limited series of FoIs were not enough to repudiate implications of notable variance of access and outcomes within IAPT across England. According to HSCIC data, some CCGs see less than 10% of service users accessing treatment within 28 days, compared to 90% in other areas; recovery rates appear to range from under 30% to above 60% (HSCIC, 2014a). There are several reasons why we might expect to see IAPT service inconsistencies from one region to the next. These include:

Funding: Funding for the IAPT programme has been found to be extremely variable; in 2013 this appeared to range from £1.76 to £14.55 per head of population across CCG areas (Pulse, 2013a).

Shortage of suitable providers: Some PCTs (and CCGs from 2013) were slow to implement increased service provision under IAPT. Moreover, as of 2013, less than half (44%) of CCGs were offering a service that GPs could refer to for severe mental illness (Pulse, 2013a).

GP expertise: Not all GPs have suitable expertise in diagnosing mental illness. According to the latest report by the Chief Medical Officer, GPs currently correctly diagnose only about half of the ‘true’ cases of depression they see (CMO, 2014).

We examine funding for IAPT in section 5. With regard to clinical expertise, it has been argued that parity of esteem for mental health requires GPs to become more expert in diagnosing mental illness (CMO, 2014), especially considering around 30% of all GP consultations relate to mental health problems (MHF, 2014). However, the difficulty of diagnosis needs to be recognised: mild depression, especially, cannot (yet) be diagnosed via a unique set of symptoms or an accurate diagnostic test (unlike many other medical conditions).

3. NHS Brighton and Hove CCG; NHS Wiltshire CCG; NHS Dartford, Gravesham and Swanley CCG; NHS Bristol CCG; NHS Scarborough and Ryedale CCG; Thameside and Glossop CCG; NHS West Essex CCG

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At the same time, successful diagnosis will also be challenged if GPs rigidly restrict themselves to the average eight to ten-minute appointment time. This is particularly problematic where patients present with physical symptoms (e.g. back pain, chest pain and headache) that may derive from mental illness (LSE, 2012). A more holistic mind-body understanding by General Practice is certainly needed. The Chief Medical Officer has accordingly recommended a period of specific mental health training in GP training, as well as supporting training posts in psychiatry for Foundation Year doctors (CMO, 2014).

New referral opportunities?

Increasing service contact between the mentally ill and the NHS is vital to parity of esteem. New opportunities for diagnosis and IAPT referral could derive from the five-year health check at General Practice (or other provider), available to those aged 40–74. Also untapped are the work capability assessments carried out by health professionals for those applying for Employment and Support Allowance (ESA), which could be a timely opportunity for signposting.

Recommendation	Action to be taken by:
1. Publication of IAPT workforce recruitment data to identify whether targets have been met: both High Intensity Therapists and (low intensity) Psychological Wellbeing Practitioners. With recruitment now commissioned locally, data should include a breakdown of therapists by CCG. Data to be published on the IAPT website and by HSCIC.	DH CCGs

4. Considering depression

4.2.4 Medication: use and effectiveness

Antidepressants help many people function in their day to day lives. The medicine can play a vital part in the individual's care pathway, whether or not taken in combination with talking therapy. Some people opt for drug therapy alone, perhaps due to busy lifestyles or an aversion to talking therapy. However, combined pharmacological and psychological therapies may lead to better outcomes than single treatments. One study reported response rates for patients receiving drug therapy alone of 53–55%; for psychological therapy alone of 50–52%; and for combined therapy of 75–85% (Petersen, 2006).

NICE recommends the continuation of antidepressants for at least six months after remission of an episode of depression (NICE CG90). For various reasons, including adverse side effects and lack of perceived benefit, antidepressants are often discontinued after remission or recovery from an acute episode, which frequently leads to relapse or recurrence. This, in turn, increases the risk of subsequent poor treatment response and lifelong depressive chronicity (Nutt, 2010).

There are approximately thirty different kinds of antidepressant, belonging within the following categories:

- Selective serotonin reuptake inhibitors (SSRIs)
- Serotonin-norepinephrine reuptake inhibitors (SNRIs)
- Serotonin modulators and stimulators (SMSs)
- Serotonin antagonists and reuptake inhibitors (SARIs)
- Norepinephrine reuptake inhibitors (NRIs)
- Tricyclic antidepressants (TCAs)
- Tetracyclic antidepressants (TeCAs)
- Monoamine oxidase inhibitors (MAOIs)
- Others

Of these, SSRIs and SNRIs are the most widely used. Antidepressants are usually prescribed for moderate to severe depression. They are also prescribed for other common mental illnesses, including severe anxiety and panic attacks, OCD, eating disorders and PTSD. Side effects are common; this is even true of the newer medicines (SSRIs and SNRIs), although for most people these are mild and wear off over a couple of weeks as the body gets used to the medication (RCPsych, 2014). For a proportion, however, side effects such as headaches, dizziness, insomnia or flu-like symptoms, prove unbearable and lead to treatment discontinuation (HHP, 2010).

4. Considering depression

It is not exactly known how antidepressants work. It is thought that they increase levels of a group of chemicals in the brain called neurotransmitters, which pass signals from one brain cell to another. Certain neurotransmitters, such as serotonin and noradrenaline, can improve mood and emotion (NHS Choices).

Around 50–65% of people treated with an antidepressant for depression see improvement, compared to 25–30% of those taking placebo (RCPsych, 2014). On the one hand this suggests effective treatment for the majority in need of medication; on the other, given the high prevalence of depression in the UK, it suggests an enormous number of people failing to respond well to antidepressants, particularly at the first line of treatment. In fact, even with good compliance, one third of patients do not adequately respond to treatment and up to 20% are considered non-responders (EMA, 2013).

It is important to also bear in mind that for most sufferers, depression recurs. According to the Mental Health Foundation (2007):

More than half of people who have one episode of depression will have another, while those who have a second episode have a further relapse risk of 70%. After a third episode, the relapse risk is 90%. For about 1 in 5 people, the condition is chronic.

Due to the high prevalence of depression and current limitations of medication, the European Medicines Agency is encouraging pharmaceutical companies:

to foster development of new antidepressants and not only focus on the treatment of acute symptoms and maintenance of the effect during the index episode, but explore also the potential of their compounds in the prevention of new episodes called recurrence prevention' (EMA, 2013).

Antidepressant medication still has significant scope for improvement. Pharmaceutical companies therefore need to be incentivised to take the economic risks of research and development (R&D). How much the UK encourages them to do this for depressive illness will be examined in Section 7.

5. The funding gap

Mental ill health represents nearly 40% of all disability and up to 23% of the total financial burden of ill health in the UK

World Health Organisation 2008

Despite this startling fact by the WHO, the NHS spends only 13% of its budget on mental health services. The disproportional burden–spend appears all the more perplexing given the eye-watering costs of mental illness to the wider economy. The Centre for Mental Health has calculated the cost of mental illness in England at around £52 billion annually, taking into account expenditure through health and social care, and reduced economic output through presenteeism and absenteeism. If including the monetised ‘human cost’ – the reduced quality of life through disability, suffering and distress, as calculated at £30,000 per Quality Adjusted Life Year (QALY)⁴ – the figure rises to £105 billion (CMH, 2010).

In this section we briefly describe recent NHS funding activity and then examine specific implications for the treatment of depression.

5.1 NHS: investment vs cuts

NHS spending on mental health has risen by over one third (35.5%) in the past decade. Between 2003/4 and 2008/9 funding for mental health services saw yearly increases from £8.97bn to 11.17bn; in the two years following expenditure rose by another £1bn, to £12.16bn. However to put this in context, NHS total net expenditure increased from £64.17 billion in 2003/04 to £109.72 billion in 2013/14 – a 71% increase.

Data indicates that PCT funding of NHS mental health services fell by 2.5% in real terms from 2011 to 2013; NHS funding for independent sector providers rose significantly during the same period, while voluntary sector and local authority providers saw slight cuts to budgets (Nuffield Trust, 2014).

One of the casualties of NHS cuts is Early Intervention in Psychosis (EIP), which each year helps more than 10,000 young people aged 14–35 to recover from a first episode of psychosis. Research by Rethink Mental Illness found that 50% of EIP services had seen budgets decrease in the past year, some by as much as 20%. 58% of EIP services had lost staff over the previous 12 months, and 53% reported a reduced quality of service for the same period

Rethink 2014

4. A Quality Adjusted Life Year (QALY) is a measure of the state of health of a person or group in which the benefits, in terms of length of life, are adjusted to reflect the quality of life (NICE).

5. The funding gap

An investigation by Community Care and BBC News in 2013 showed that budgets for ‘crisis resolution teams’ that year fell 1.7% in real terms compared to 2011/12, while the average monthly referrals to these teams rose 16% (CC/BBC 2013).

The most recently published national surveys of investment for mental health indicate real terms reductions of 1% for working age adults and 3.1% for older people in 2011/12. Provisional data from foundation trusts suggest a fall in real terms of funding for mental health services for 2013/14.

Services for children and adolescents have not been protected either: research indicates that as much as three quarters of CCGs have either frozen or cut their CAMHS budgets between 2013/14 and 2014/2015 (CYPN, 2014).

Central government may espouse the principles of parity of esteem, but as the Minister Norman Lamb recently acknowledged, ‘mental health is often disadvantaged in local spending plans’. The irony is that with austerity measures introduced around 2010, which have been felt acutely in social services and social care, came increased unemployment, housing benefit reductions, increased debt and social deprivation – problems expected to lead to lower wellbeing and resilience, more mental health needs and alcohol misuse, higher suicide rates, greater social isolation and worsened physical health (Knapp, 2012). There was a strong argument for increasing mental health resources at this time to support prevention and early intervention, as well as meeting increased need. Instead, we saw the opposite.

Investment for early intervention

An encouraging development for early intervention services is the promised £120m investment that will bring into force new waiting-times standards. This is a landmark moment for mental health. According to NHS England (8 October 2014), the new standards introduced from 2015/16 will mean:

- 75 per cent of people referred for talking therapies for treatment of common mental health problems, such as depression and anxiety, starting their treatment within six weeks and 95 per cent starting within 18 weeks.
- At least 50 per cent of people going through their first episode of psychosis getting NICE-approved help within two weeks of being referred.

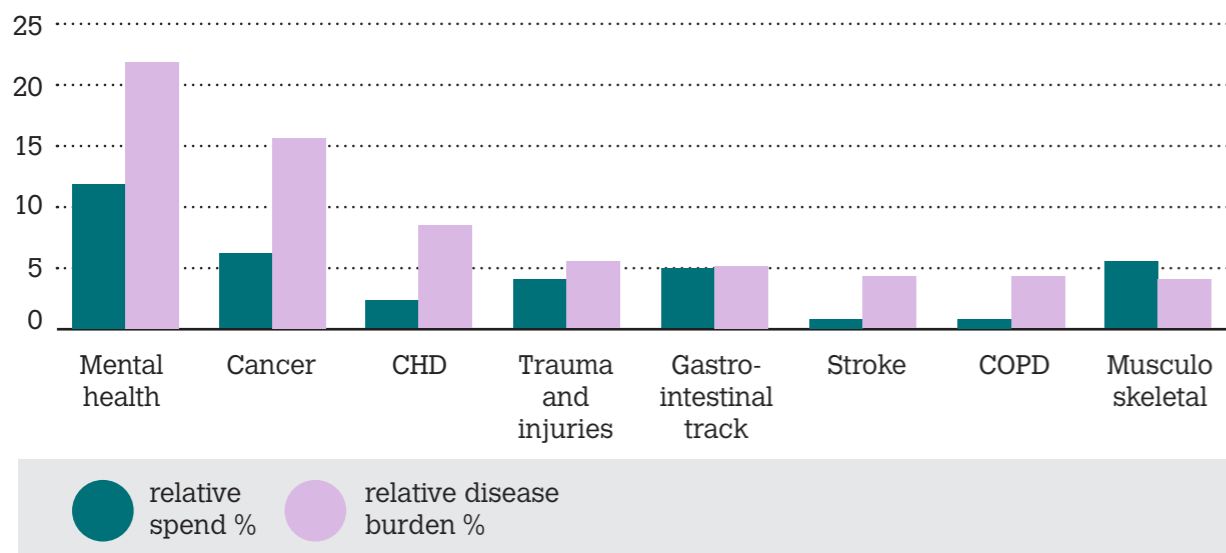
Only with robust oversight and scrutiny will the new standards have their desired impact. It is easy to imagine that introducing maximum waiting times will deter some CCGs from encouraging appropriate numbers of referrals into therapy in the event of inadequate local service provision (see Section 4.2.2). It is also important to bear in mind that IAPT, even working at planned capacity, is not sufficiently funded to meet the needs of the general population (CMO, 2014).

5. The funding gap

5.2 Proportional spend: implications for depression

Few would argue that NHS spend should be accurately proportional to the relative burden of particular diseases, since there is little benefit in spending a lot of money on a high-burden disease if the available interventions are not particularly effective (Monitor, 2013). At the same time, this very point forces a reconsideration of mental health spend, since available, low-cost interventions demonstrate a comparably high degree of success.

Graph 5a: Comparison of NHS spend and disease burden



Monitor: 'Closing the NHS funding gap', 2013. Data from WHO, 2009; NHS Programme Budgets 2010/11

It is important to note, within the inequalities displayed by graph 5a, that the majority of NHS mental health spend supports those with severe mental illness (e.g. schizophrenia and bipolar), who make up just 1% of the population (LSE, 2012). Reports of inadequate services for severe mental illness, particularly hospital services (Community Care, 2014), mean that even this group is clearly in need of better care.

NHS spend on treatments for common mental illness is but a small proportion of the whole, even if recent years have seen a sharp rise in NHS spend on antidepressants (prescribed for a range of mental illnesses). Not all prescribing may be appropriate to clinical need, although the rise may be attributable in part to the effects of economic downturn on mental health, as well as a growing recognition among GPs of the dangers of early discontinuation of drug treatments. NHS spend on antidepressants totalled £282m in 2013, with prescriptions increasing by 6% over the previous year to 53 million (HSCIC, 2014c).

5. The funding gap

Funding for IAPT in 2011/12 was under 2% (£213m) of the entire NHS spend on mental health services, equating to about 0.2% of total NHS annual spend (MHS, 2012).

We saw in Section 4 how funding for the IAPT programme ranges from £1.76 to £14.55 per head of population across CCG areas (Pulse, 2013a). Proportional spend disparities are not confined to IAPT: a 2014 FOI by Luciana Berger MP, Labour's shadow public health minister, revealed that around two-thirds of CCGs are spending less than 10% of their NHS budget on mental health services – some as little as 7% (Guardian, 2014). Bradford City, for example, spends just 8.85% of its budget on services to treat psychological conditions: though we do not know its IAPT budget, HSCIC experimental data suggest Bradford City's IAPT service is severely limited in terms of access and outcomes, with just 210 people (0.26% of the CCG population) completing treatment for common mental illness and only around one quarter of these people seeing recovery.

As already noted, we must be careful in placing too much emphasis on HSCIC 'experimental' data. But the question remains: how can CCGs, and indeed other stakeholders, be encouraged to invest more in IAPT?

A greater awareness among commissioners of the close links between mental and physical illness is a good place to start. The LSE in its report *How Mental Illness loses out in the NHS* estimates NHS costs of extra physical healthcare caused by mental illness to total at least £10 billion. The authors argue that there is a point to which increasing capacity to treat depression and anxiety disorders would very probably cost nothing in real terms, given the reduction in physical healthcare costs (LSE, 2012).

The DH in its earlier IAPT Impact Assessment, 2011, was more cautious in its estimates, suggesting £0.68 healthcare savings for every £1 spent on services expansion. In healthcare terms these figures are still attractive and the DH maintained that the programme represented 'excellent value' to commissioners (DH, 2011).

It is important to recognise that recent research suggests costs of IAPT services to be markedly more than original DH estimates (Griffiths and Steen, 2013). For example, Radhakrishnan et al (2012) indicate the costs of therapy to be three times higher than earlier DH estimates published in the Impact Assessment (£99 vs £33 for low intensity; £177 vs £55 for high intensity). However, even using these figures as a basis, the report authors claimed that the programme remained cost-effective.

Recent IAPT analyses have been limited in methodology and unable to establish true and absolute RoI – that is, taking into account wider societal data. This is a much needed analysis. As the DH's Impact Assessment made clear, IAPT promises significant RoI at the national level, counting NHS efficiencies, savings to the Department of Work and Pensions (reduced unemployment and ESA payments), savings to Local Authority (reduced housing benefits, increased council tax revenues) and to businesses (reduced presenteeism, absenteeism and increased profitability) and thus increased revenue to the Exchequer.

5. The funding gap

5.2.1 Moving forward

We urge the DH to commission a new independent study of IAPT to demonstrate wider RoI. Meanwhile the department should commission and disseminate case studies of the most successful programmes, perhaps facilitated by regional GP IAPT champions. As the report by Radhakrishnan et al, cited above, concluded:

It is likely that improvements in current IAPT practice cannot occur until current practice is scrutinised and treatment approaches that are both effective and financially viable are identified, studied, and highlighted.

Further evidence for IAPT should be emanating from the ongoing IAPT Payment by Results (PbR) pilot. Indeed IAPT PbR, which is looking at an outcomes-based payment and pricing system, may well incentivise improvement if implemented. The government is also seeking to incentivise CCGs to increase access to psychological therapies through the Quality Premium scheme, which provides additional funding to those that meet key goals (DH, 2014).

Perhaps most crucially for parity of esteem, we urge the consideration of integrated social and health service funding of IAPT with pooled budgets: IAPT is surely one of the greatest and most obvious opportunities for this much supported (but little implemented) strategy. Funding arrangements would need to involve CCGs and LAs as well as central government, most importantly the DWP.

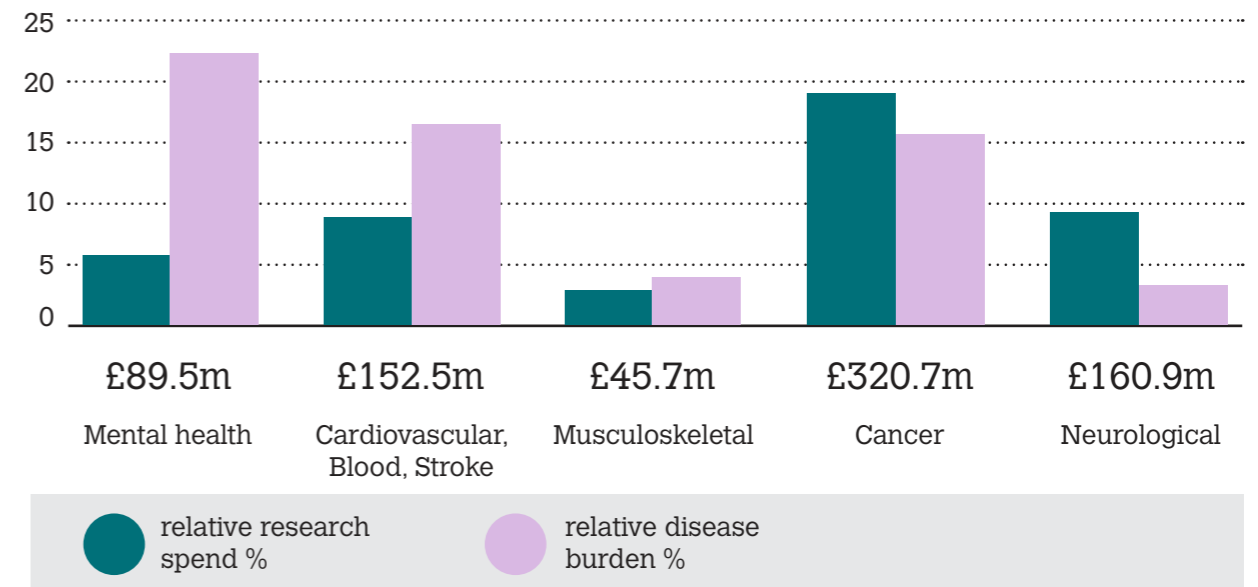
Recommendations	Action to be taken by:
2. CCG spend on IAPT, proportional to CCG population, to be published on IAPT website to bring greater transparency and accountability to the programme.	NHS England CCGs
3. Area Teams to appoint regional GP-IAPT Champions to disseminate best practice among CCGs, using case studies of the most successful and cost-effective IAPT programmes.	NHS England Area Teams
4. IAPT to be funded by both health and social services with one pooled budget (for each locality), in appropriate recognition of the programme's potentially significant and wide-ranging societal benefits. Commissioning plans to involve national and local stakeholders.	NHS England Department of Work and Pensions (DWP) Local Authorities CCGs

5.3 Publicly-funded research

An account of funding disparities has also to recognise the field of publicly-financed research. As with NHS spend, research funding in the UK is by no means proportional to disease burden, and the gulf is nowhere greater than in the case of mental health. Graph 5b, drawing on the main UK public and charitable funders of health research, shows data on a selection of major disease areas, highlighting relative research spend and disease burden.

5. The funding gap

Graph 5b. Comparison of UK research spend and relative disease burden



Data sources: UK Clinical Research Collaboration (UKCRC) 2012; WHO, 2009; NHS Programme Budgets, 2010/11.

The UK has particular strengths in MH research, for example in the fields of genetics and genomics, developmental biology, neural systems and translational neurobiology, and epidemiology. It also has a strong reputation for clinical trials. The Medical Research Council has identified some specific opportunities for increased UK mental health research, many relevant to depression at the primary care and community level, including:

- Understanding the life-course determinants of mental illness and wellbeing
- Primary preventive strategies based on early detection of high risk state
- Identifying the cognitive and neurobiological basis of wellbeing and health development
- Promoting good mental health at key life stages
- New treatments through investment in experimental medicine
- Promoting recovery including cognitive remediation and social rehabilitation

The UK is supremely positioned to support health research: the NHS is after all the largest publicly-funded health service in the world; it can facilitate recruitment of representative samples of patients, service users and carers to clinical trials far more easily than many providers in other countries (MHF, 2010). If health equality is to emerge, the UK needs to better match its research funding to the relative disease burden. There is no logical reason to be giving such little priority to mental health.

6. Depression and the workplace

Mental ill-health, such as depression and anxiety, costs British businesses over £1,000 per employee every year

DH/Deputy Prime Minister's Office

There are both social and economic reasons for promoting mental health awareness, understanding and best practice in the workplace. Whilst businesses and organisations should be mindful of the mental wellbeing of their workforce on humanitarian grounds alone, the economic reason has to be pushed hard to ensure that even the most indifferent line-manager takes note: the mental wellbeing of employees is critical to optimal productivity.

Self-reported depression is the single most important cause of workplace absenteeism in the UK. It has been estimated that depression accounts for lost productivity costs 23 times higher than the direct cost to the NHS (MHF, 2010). The opportunities for prevention and early intervention in the workplace are considerable: depression (and stress and anxiety) may or may not be related to the workplace itself, but even simple, low-cost precautions and interventions have the capacity for substantial improvements to employee wellbeing and corporate profitability.

6.1 Presenteeism, absenteeism and unemployment

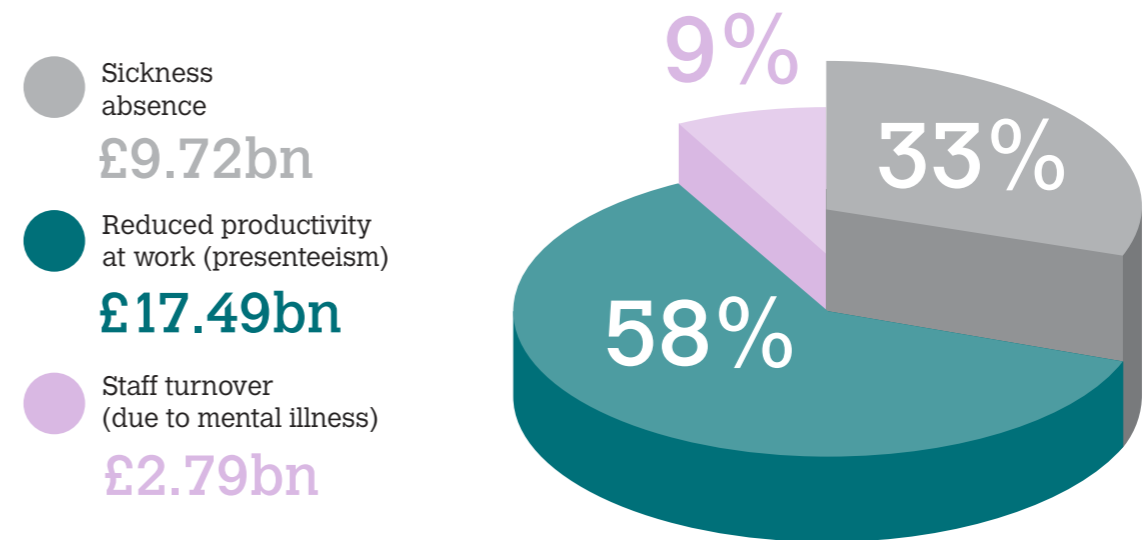
Around one in six employees suffers mental ill health at any one time and one in four will experience a common mental illness during the course of a year (MHF, 2007). With two-thirds to three-quarters of those people untreated, common mental illness is estimated to cost the UK business economy around £30 billion a year (DH/Deputy Prime Minister's Office).

Mental illness accounted for 70 million working days lost in 2013 (CMO, 2014); some 15.2 million of those were lost as a direct result of workplace stress, anxiety or depression (ONS, 2014).

The Sainsbury Centre for Mental Health has analysed the proportional costs of mental illness to business (SCMH, 2007). Updating their figures to the £30 billion estimate of the DH/Deputy Prime Minister's office, we arrive at the following breakdown:

6. Depression and the workplace

Graph 6a: Costs to business of mental ill health



As the chart shows, 'presenteeism' – working whilst ill – is to be feared by employers more than absenteeism: businesses lose 50% more working time through presenteeism than absenteeism. It also costs substantially more to employers due to its more common occurrence among higher-paid staff (SCMH, 2007).

During an episode of depression, cognitive symptoms – concentration difficulties, indecisiveness and forgetfulness – are present up to 94% of the time (Conradi et al, 2011). Businesses will experience, on average, more than 4½ hours per week of lost productivity time through the presenteeism of each employee with depression (Stewart et al, 2003). Then there are the often substantial costs of misjudgement in the workplace caused by depression. A period of presenteeism will often precede a period of prolonged absenteeism – sometimes launched by a nervous breakdown.

The out-of work population is to be considered here also. Around 46% of ESA and IB claimants had a mental illness in 2013 and approximately 44% of those claimants (nearly 500,000 individuals) had depression as their primary condition (DWP, 2014a; DWP, 2014b). These figures comprise individuals who have recently withdrawn from the workplace due to mental illness, through to the long-term unemployed.

6.2 Support for returning to / finding work

Work can play an important role in developing and maintaining good mental health (Blustein, 2008); employment can also be important to the process of recovery from mental illness (CMO, 2014). However people with mental health conditions have among the lowest employment rates of all disadvantaged groups. They are also at greater risk than most of falling out of work (DWP, 2014c).

6. Depression and the workplace

It is vitally important that the government supports businesses and organisations in helping both recovering employees and the unemployed back into work. The DWP programme Work Choice is designed to help some of the most disadvantaged in this respect, although its job-start rates for even those with mild to moderate mental health conditions have been reported as disappointing (CMH, 2013). The figures for the Work Programme, which uses a payment scheme to incentivise providers to take on former ESA claimants, also show limited success (HCCPA, 2013), with clients who need more specialist support typically sidelined (Rees et al, 2014).

In 2011 the DWP extended their Access to Work programme to include a new Mental Health Support Service, delivered on Access to Work's behalf by Remploy and offering support for those with mental ill health moving into work, or those needing help to retain their current employment (DWP 2014d). The number of people with mental health problems helped by Access to Work is still small – 1,410 (4% of the total helped) – although use of the service by this group has more than doubled in two years.

For those with severe mental illness, Individual Placement Support (IPS) has demonstrated significant success. The model adopts a form of apprenticeship, taking a 'place then train' approach, rather than vocational training and sheltered work, and includes individualised support for the individual and their employer. The outcomes for clients have proved particularly successful, including reduced hospitalisations, although implementation in the UK is patchy and only a few places have closely adhered to the best-practice model (CMH, 2014). IPS needs to be studied and made more widely available: funding for the service should be a joint concern of CCGs, local authorities and the DWP.

6.3 Workplace learning: Time to Change

Since 2009 the number of sick days lost to 'stress, depression and anxiety' has increased by 24%; the number lost to 'serious mental illness' has doubled.

CMO, 2014

With growing recognition of the costs of mental illness to productivity, organisations and businesses are being invited to combat the rising tide of sickness absence and invest in support for a healthier workforce.

'Time to Change' is a partnership initiative between the charities MIND and Rethink Mental Illness. Working in schools, workplaces and public arenas, it is England's largest programme to end the stigma and discrimination faced by people with mental health problems.

Time to Change has proved particularly effective among businesses and organisations. It demands from signees an organisational pledge to end stigma and discrimination in the workplace. It runs workshops on a range of campaigning and engagement topics and has for around 50 organisations offered a free 'Organisational Healthcheck' audit to identify areas where improvements can be made to the practical application of mental health related policies. Time to Change has also

6. Depression and the workplace

launched an Organisational Learning Peer Network – a forum for organisations to share good practice, learning and peer support on issues surrounding the effective management of mental health problems in the workplace.

Case Study 6a: Croydon Council

Both private and public sector organisations are reaping the benefits of mental health awareness, promotion and support in the workplace.

Croydon Council had in place a mental health policy before signing the Time to Change pledge, but many staff members knew nothing about it, and around two-thirds felt the authority did not prioritise staff wellbeing. Signing the pledge, Croydon Council completed an action plan for improvements to staff mental wellbeing, with specific goals identified.

The action plan included the initiation of Mental Health First Aid training across the organisation. The Council also began to promote a holistic approach to mind and body by running physical health-related programmes, such as fitness classes and cholesterol testing, in conjunction with mental health activities, including one-to-one stress management consultations.

This activity has sent a clear message that the organisation is committed to reducing stigma around mental health. Since signing the pledge, the council has seen stress-related absences fall by 47%.

Source: Speakout Issue 4 (Spring 2014) – Time to Change

Case Study 6b: BT

The telecoms giant BT is one of the country's leading organisations in the promotion of mental wellbeing in the workplace. It has developed a three-tiered mental health framework:

- **Level one** – promoting employee wellbeing and preventing distress; including tips on the company intranet and management training.
- **Level two** – identifying distress and intervening early through online stress risk assessment and companion training for line managers.
- **Level three** – support and treatment for people experiencing mental health problems, including producing 'advance directives' to identify early warning signs and establish a plan of action for how someone can be supported if becoming distressed.

BT runs a stepped care cognitive behavioural therapy (CBT) service for staff. Course completion stands at 80% of those entering treatment – nearly 2,000 people since 2010. Of these cases, 98% have been resolved, with just 5% returning to restricted duties initially. The average satisfaction rating of the service is 94%.

The company also runs a 'managing mental health' programme that has trained over 7,900 of its people managers. BT has seen sickness absences fall by 15% overall since 2010.

Sources: Time to Change case study (Accessed 24 Nov, 2014). 2020health correspondence with BT (Nov/Dec 2014). BT employee wellbeing webpage (Accessed 8 December 2014).

6. Depression and the workplace

It has been estimated that for every £1 invested in early diagnosis and treatment of depression at work there is a cross-sector return of £5 (IDEA Survey, 2012). Investment may take many forms, from mental health first aid courses for line managers and stress-management consultations, to the direct funding of talking therapies or counselling – bearing in mind currently restricted access via the NHS.

Increased investment may also be necessary for flexible working hours and locations: such arrangements empower employees and have demonstrated significant mental health benefits (CMO, 2014). And it is of considerable importance that organisations are flexible in their return to work policies: a graduated return (in hours, pace and complexity) for someone recovering from mental illness may be far more effective than immediate immersion in former duties. The setting of short-term milestones can be key.

Small and medium size businesses may not feel they have the resources to provide optimal levels of support. However, Time to Change has a range of tools and resources via its website (www.time-to-change.org.uk) from which organisations of any size can benefit. Workplace best practice compiled by Harvey et al (2014) also shows that any organisation can take inexpensive, vital steps to a mentally healthy workplace by:

1. Increasing awareness of mental illness and reducing stigma
2. Designing and managing work to minimise harm
3. Promoting protective factors at an organisational level to maximise resilience
4. Enhancing personal resilience
5. Promoting and facilitating early help-seeking
6. Supporting workers' recovery from mental illness

It is hard not to overstate the importance of No.1 in the above list: increasing awareness within the workplace is itself a major strategy of prevention and early intervention. As the Time to Change programme makes clear, reducing stigma is the gateway to the realisation of best practice in the workplace, in all its forms. Other significant organisations supporting workplace mental health include the Chartered Institute of Personnel and Development (CIPD) and Business in the Community (BITC) Workwell Mental Health Champions Group. The Health and Safety Executive (HSE), together with DH and DWP, have also published a Line Manager's Resource – 'a practical guide to managing and supporting people with mental health problems in the workplace' (<http://www.hse.gov.uk/stress/pdfs/manage-mental-health.pdf>).

We suspect that this guidance and help has not yet impacted the vast majority of businesses and organisations across England – statistics do not suggest otherwise (although significant rises in sick days lost to stress, depression, anxiety and severe mental illness since 2009 will be attributable in part to the economic downturn). To support government, third sector and voluntary group initiatives, local authorities, CCGs and the DWP should consider the joint-funding of specialist Workforce Mental Health Consultants (WMHCs) to promote prevention and early intervention – and employer responsibility – among workplaces in the local community. This would be particularly

6. Depression and the workplace

valuable to small to medium size businesses that may well be unmindful of mental health best practice. The WMHC should also support employers in the safeguarding of jobs of people who become ill, especially through close working with primary care / IAPT services.

Recommendations	Action to be taken by:
5. Independent analyses of 'Time to Change' interventions and outcomes to be commissioned, so to increase the evidence base and help ensure organisational buy-in.	DH DWP
6. Individual Placement Support (IPS) employment specialists to be instated within each IAPT service across England, joint-commissioned by LAs and CCGs with additional support from the DWP.	Local Authorities CCGs DWP
7. Appointment of local Workforce Mental Health Consultants (WMHC) to promote prevention and early intervention, particularly targeting small to medium size businesses. WMHCs to support employers in the safeguarding of jobs of those experiencing illness by close working with primary care / IAPT services.	Local Authorities CCGs DWP

6.4 Reflection

It was noted in our workshop (24 November 2014) that, working to the objective of parity of esteem, it is perhaps time for the Health and Safety Executive (HSE) to bring legal force to the protection of workers' mental health. The Health and Safety at Work Act, 1974, states: "It shall be the duty of every employer to ensure, so far as is reasonably practicable, the health, safety and welfare at work of his employees." The Act by implication thus recognises workplace malpractice that may be injurious to mental health. By enforcing mental health considerations the HSE would support the welfare rights of employees of all companies – importantly those working for employers that are otherwise little incentivised to proactively protect, let alone promote, the mental wellbeing of their workforce

Recommendations	Action to be taken by:
8. HSE to bring legal force to the protection of workers' mental health through employer obligations already enshrined in the Health and Safety at Work Act, 1974.	Health and Safety Executive
9. High-profile dissemination of employer obligations under the Health and Safety at Work Act to be undertaken to support mental wellbeing in the workplace.	DH Public Health England DWP

7. How can NICE encourage parity of esteem?

The National Institute for Health and Care Excellence (NICE) is an independent public body that provides national guidance and advice to improve health and social care. Their Health Technology Appraisal (HTA) process considers the recommendation of new and existing medicines/treatments within the NHS. The technology itself may be a medicine, medical device, diagnostic technique, surgical procedure or health promoting activity, and recommendations are based on both clinical efficacy and value for money. If NICE recommends the use of a technology within the NHS, the public has a legal right of access to it, where clinically appropriate (NICE: technology appraisal guidance).

For some treatments and medicines NICE issues ‘guidelines’ only, which are advisory rather than compulsory. The guidance ‘does not override the responsibility of healthcare professionals and others to make decisions appropriate to the circumstances of each patient’. At present, advisory guidelines appear to apply to all treatments (including medicines) for depression, as well as service access and treatment pathways (see NICE guidelines [CG90]).

7.1 Opportunities for recommendations?

Since NICE guidelines are commonly perceived to carry little legal force, the close-to-default position of NICE to issue only guidelines for mental health treatments may be seen as a potential barrier to parity of esteem. As the Royal College of Psychiatrists points out:

A greater proportion of mental health treatments than physical health treatments have undergone a clinical guideline assessment process rather than a technology appraisal process. This means that they are in practice less available to service users, as there is not the same legal imperative for mental health service providers to make them available.

The potential legalities of NICE guidelines have received some recent attention under law – see Case Study 7a. However the case highlighted nonetheless reflects the perception that NICE guidance does not have to be followed to the letter. Such perception may be valid in certain cases: after all, some guidelines appear more forceful than others due to the available evidence base. However, the room for subjective responses to guidelines only adds fuel to postcode lotteries. This problem crosses both physical and mental healthcare, but mental health services, already chronically underfunded, are particularly exposed.

Parity of esteem stands little chance unless the force of law compels the reduction of inequalities. Is now the time, therefore, for NICE to begin considering some legally-binding recommendations around access and treatment, to make headway to this vital objective?

7. How can NICE encourage parity of esteem?

Case Study 7a: potential legalities of NICE guidelines

To what extent are NICE guidelines legally binding? And do some guidelines carry more weight than others? A recent case illustrates the confusion. A woman requesting oocyte cryopreservation before beginning chemotherapy was denied treatment by Thanet CCG on the grounds that there was not enough evidence to demonstrate its effectiveness. NICE guidance, however, confirms the treatment as appropriate to women of reproductive age who are preparing for medical treatment for cancer that is likely to make them infertile. A court ruled that the CCG

was under an obligation in public law to have regard for the NICE guidance; the only basis for disregarding NICE guidance was where there was legitimate disagreement with NICE on matters concerning the current state of medical science.

Sir Andrew Dillon, Chief Executive of NICE, responded: ‘This court ruling highlights that CCGs cannot simply ignore NICE guidelines without having a clear clinical case for doing so.’

Sources: NICE 6 May, 2014

7.1.1 Waiting times

The announcement by NHS England to introduce maximum waiting times (from 2015/16) for referral into therapy gives NICE an opportunity to consider quality standards on this issue. As soon as possible, waiting times and rights of access should be also reflected in the NHS Outcomes Framework. The public should be given legal opportunity to seek alternative provision at the expense of the NHS where maximum waiting times are exceeded.

7.1.2 Services

NICE has produced guidelines in strong support of talking therapy, particularly CBT, which is advised as a treatment for depression, generalised anxiety disorder, panic disorder, OCD and, in modified form, PTSD (NICE Pathways). Despite recognition of CBT as a useful and cost-effective treatment, there is no legal requirement for CCGs to make it available. Perhaps more importantly, there is no legal requirement for CCGs to follow NICE guidance in giving service users choice of therapy.

The case for NICE-mandated services – and choice – is stronger still considering that in 2013 more than half of all CCGs were not offering a service that GPs could refer to for severe mental illness (Pulse, 2013a); and we have noted (Sections 4 & 5) how the quality of IAPT services appear widely variable across the country.

An unequivocal message is needed from NICE: CCGs need to feel legal pressure to fund an adequate range of services to meet local population needs, particularly the needs of the most vulnerable groups.

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7.1.3 Medication

NICE's position does not preclude the possibility of a Health Technology Assessment (HTA) on an antidepressant – a process that could bring a legally-binding recommendation for its use in the NHS. To date, only a relatively small number of new medicines for mental health have been through a Single Technology Assessment process. Whilst 'clinical guidelines' is not a default position on mental health treatments as such, they are typically picked up within the guideline process, which systematically reviews current evidence (NICE, 2014a).

Moving forward in the interests of parity of esteem, NICE should conduct HTAs on all new medicines to treat mental illness, giving opportunity for careful and informed discussion where there will inevitably be greater uncertainty around incremental cost-effectiveness ratios (ICERs).⁵ The HTA process offers the chance of rebalancing the current inequity of very few treatments for mental illness having a legally binding recommendation.

7.1.4 HTAs: further considerations

NICE's current HTA methods for measuring quality of life (QoL) centre on the EQ-5D questionnaire, which defines health in terms of five dimensions: mobility, pain/discomfort, self-care, anxiety/depression and usual activities. These dimensions are specific and limited: for example, they do not appropriately consider the individual's subjective wellbeing; the QoL of those living with, and perhaps caring for, the individual; or productivity gains enabled by treatment.

It is important that QoL gains afforded by treatment include such wider societal considerations. In some treatments these considerations will be minor, in others, such as those for depression, the issue is vital to the understanding of true cost-effectiveness – as we now explore.

7.2 NICE and 'wider societal benefit'

In July 2013, the Department of Health (DH) asked NICE to consider additional terms of reference in the appraisal of new health technologies as part of its 'value-based assessment' (VBA) process. Included in the requests was a proportionate system for taking account of wider societal benefits (WSB), the implication being that by ignoring the 'net resource impact' of a successful treatment, NICE were liable to refuse technologies that were actually cost-effective.

However, NICE was uncomfortable with the proposal, pointing out that consideration of WSBs was liable to discriminate against the elderly. That is, since the net resource impact of older people (65+) was on average less than that of working age people, appraisals factoring in WSBs would typically see technologies as more cost-efficient where the majority users were younger adults.

5. Incremental cost effective ratio (ICER): the ratio of the change in costs to incremental benefits of a therapeutic intervention or treatment.

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A public consultation followed with NICE in 2014, during which an alternative VBA method was explored. However, following the consultation, NICE acknowledged that many respondents had argued that 'productivity effects... should be allowed and considered', even though the original WSB model was not generally supported (NICE, 2014c). The Board of NICE subsequently issued recommendations for next steps, two of which state:

- The desirability and practicality of incorporating wider societal benefits into the appraisal methodology should be reviewed, in conjunction with the Department of Health.
- The further consideration of burden of illness and wider societal benefits should be taken forward in the context of the broader consideration of the way in which new treatments are developed, evaluated and supported for adoption in the NHS... NICE should explore ways of stimulating this review in conjunction with its partners and with the Department of Health.

A patient's net resource contribution (or net production) is the amount of resources the patient contributes, or produces, net of the amount they use or consume.

If a treatment changes either the patient's production or consumption of resources, it will change the amount available for the rest of society to consume – whoever they may be. Resource production and consumption extends to unpaid activities such as parental child care and domestic work.

Source: Methodology for estimating 'Wider Societal Benefits' as the net production impact of treatments. Department of Health, 2013

We next ask the question: can NICE take into consideration WSB without undermining the principles of the NHS Constitution?

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7.2.1 WSB: an ethical dilemma

The WSB debate has certainly shone a spotlight on some key NHS principles and values enshrined in its Constitution of 2013 (see Appendix B). On the one hand, the NHS is committed to promoting ‘equality through the services it provides’ (First Principle) and an equitable⁶ service to the health needs of the population, recognising that ‘some people need more help [than others]’. On the other hand, the NHS is committed to providing the ‘best value for taxpayers’ money and the most effective, fair and sustainable use of finite resources’ (Sixth Principle). The problem is that these principles and values are not always fully reconcilable.

It is possible that in the pursuit of ‘equality’ and (though not termed as such) ‘equity’, NICE is in danger of failing to uphold the Sixth Principle of the NHS Constitution. If a treatment represents an efficient use of taxpayers’ money under the additional calculations of wider societal benefit, should it be denied on account of apparent bias to a particular cohort of people?

Older-age groups have potential quality of life to gain with the more efficient use of NHS resources for the working-age population. Thus to deny effective and cost-efficient treatment to a population that is predominantly of working-age is potentially to deny increased quality of life to all individuals, young to old.

In summary, values of equality and equity need to be contextualised within the broader framework of the NHS. After all, NICE routinely ‘discriminates’ against individuals where treatments are not considered cost-effective. Since NHS budgets are fixed, not everyone can access best possible care free at the point of use. Healthcare otherwise simply becomes displaced, with one person effectively taking healthcare away from another. NICE therefore needs to undertake a detailed equality analysis to best understand the right trade-offs.

Subjective wellbeing

Though not a component of the DH’s WSB model, subjective wellbeing is a further important consideration for HTA evaluations and should perhaps feed into a new conceptualisation of ‘wider societal benefit’.

It is noteworthy that HM Treasury now recognises subjective wellbeing in its own evaluations (DWP, 2013). However, the preference-based, health-related QoL (EQ-5D) assessment tool favoured by NICE does not appropriately recognise subjective wellbeing (NIHR, 2014). Further, as with many mental health conditions, the burden of illness of depression is sometimes borne as much by those living with and caring for the person directly affected (Fujiwara & Dolan, 2013). These are vital issues of wellbeing that need to be considered by NICE.

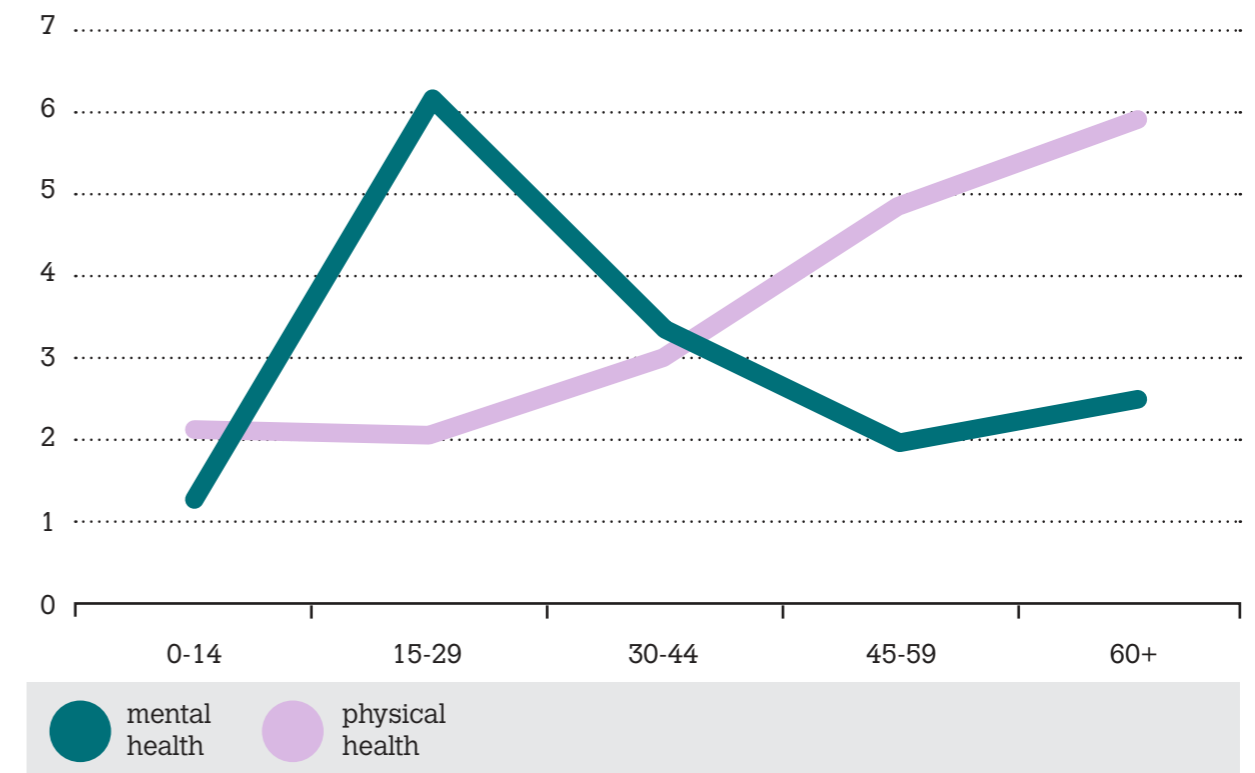
6. The term ‘equity’ itself does not appear in the constitution, although as a value it is implied.

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7.2.2 Implications for depression

Value-based assessment and WSBs have significant relevance to common mental illness, which as diagram 7a shows is most prevalent in younger adults.

Diagram 7a. Reproduced from *How Mental Illness loses out in the NHS*. LSE, 2012. The units on the vertical axis measure ill-health by the average % reduction in the quality of life, spread over the whole population of each age group.



During the aforementioned VBA public consultation with NICE, Claxton et al (York University) cited depression as one of the most cost-effective conditions⁷ to treat per QALY gained under WSB considerations (with estimated net production per QALY at £23,500).⁸ We have noted already that mental illness increases the costs of physical healthcare by ‘at least £10 billion’ (LSE, 2012); successful treatments have the potential to reduce spend elsewhere in the NHS – avoiding or limiting the effects of ‘healthcare displacement’⁹ – while at the same time distributing the wider social and economic advantages of a healthier working-age population.

7. The selective list (by Claxton et al) cited Rheumatoid arthritis (1); Diabetes (2); Ankylosing spondylitis (3); Depression (4)

8. Claxton et al were demonstrating the WSB considerations, not endorsing the concept

9. Healthcare displacement: where improvements to quality of life for one group typically means reduced quality of life for another group, due to the constraints of fixed NHS budgets.

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Treatments that enable people to remain socially integrated and emotionally balanced as partners, parents and carers, and which enable people to stay in or return to work, introduce a societal and cost-efficiency factor that needs to be considered in NICE appraisals. It should also be remembered that where medicine enables productivity and social inclusion, this in turn supports (and can expedite) the recovery process. Any impact on families and carers also needs to be considered. These factors could give a new treatment a lower incremental cost-effectiveness ratio (ICER) – making it more cost-effective.

If the ‘end-of-life modifier’ has been implemented to allow greater proportional spend on treatments society apparently values more highly, should not a ‘WSB modifier’ be introduced where benefits both to the patient and to the wider public – cradle to old age – are demonstrable? One wonders how the public would respond to this concept: would they support specific recognition of productivity gains in order to realise best value for taxpayers’ money?

7.3 Support for innovation

The Government has a responsibility to support a pricing, tax and patent environment that encourages high quality research and development. Its Strategy for UK Life Sciences, launched in 2011, is designed to improve the wider conditions for pharmaceutical innovation, in part through tax relief and by encouraging venture capital opportunities, including increased support for small and medium-sized enterprises (BIS, 2011).

The new Pharmaceutical Price Regulation Scheme (PPRS) arrangements are also designed to support R&D. The PPRS was introduced as a voluntary agreement between government and the pharmaceutical industry to control the prices of branded drugs sold to the NHS. The current agreement requires industry to reimburse the Department of Health if NHS spending on branded medicines exceeds the allowed growth rate (DH, 2014c). In theory this should mean that doctors at the frontline have no inhibitions over prescribing new drugs to patients.

PPRS rebate.

The total rebate payable to the Government each year is divided between companies in proportion to their sales, except when a company launches a new product during the term of the current agreement (2014–18). In this event, as a measure to encourage innovation, sales of the new product are included in the rebate to the Government but excluded from the sales figure that determines the proportion of the rebate to be borne by the company. Approximately 130 companies have voluntarily signed up to the PPRS.

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We suspect that many frontline clinicians are unfamiliar with the PPRS, which was claimed at the time of the new agreement in 2013 to ‘ensure NHS patients will receive the best and most advanced medicines in the world while managing the cost’ (Pulse, 2013b). We have found no articles explaining the new PPRS arrangements in the BMJ or Pulse (two of the most widely-read medical publications in the UK) since the announcement of the 2013 agreement.

It could be argued that if industry has committed to reimburse any above-budget spending on branded (the latest) medicines, there is a case for NICE to allow for greater degrees of uncertainty around ICERs in their decision making process for depression and other mental health conditions.

7.3.1 Antidepressants

The disincentives presented by a pervasive generics market in the UK are very real. For pharmaceutical companies there is notable difficulty in manufacturing a cost-effective medicine that is (typically) only incrementally better than others in its class. Further, antidepressants carry inherent R&D risks due to the high and variable placebo response in drug trials (EMA, 2013) and the more subjective outcomes-assessment process associated with treatments for common mental illness. These factors make the demonstration of cost-effectiveness all the more challenging.

In light of these challenges, the recognition of ‘wider societal benefits’ by NICE could be valuable to the incentivising of antidepressant R&D in the longer term. NICE needs to reward the value of incremental progress; such has been the trajectory of many a health technology after all – penicillin is a famous example.

NICE also needs to bear in mind that if incremental progression is not rewarded and the generics market over time increases, new and more advanced technologies will be further beyond the reach of NHS services users. Such a scenario could exacerbate inequalities for those who suffer depressive illness.

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Recommendations	Action to be taken by:
NICE: parity of esteem	
10. Quality Standards on maximum waiting times and access to evidence-based treatments within mental health services; clear statement of public right to alternative providers (with fees chargeable to the NHS) where targets are missed.	NICE
11. Mandatory recommendation for CCGs to provide range and choice of evidence-based treatments for common mental illnesses.	NICE
12. CCGs to be alerted to obligations to observe NICE guidance on mental health services, with clarification where existing 'guidelines' carry legal implications.	DH Healthwatch
13. Health Technology Assessments (HTAs) to become standard on all new mental health pharmacological treatments.	NICE
14. Changes to be made to the HTA process to capture wider costs and benefits, recognising 'subjective wellbeing' (of patients, families/carers) and productivity gains.	NICE
Pharmaceutical Price Regulation Scheme (PPRS)	
15. To ensure understanding among CCGs and frontline clinicians of the implications of the 2014 PPRS agreement.	DH
16. NICE to consider a greater degree of flexibility around ICER uncertainty for depression and other mental health conditions in recognition of current PPRS arrangements (requiring pharma to reimburse NHS overspend on branded medicines).	NICE
17. Publication of local uptake on NICE-approved branded drugs (perhaps via the Innovation Scorecard) to support public access to latest treatments.	DH Healthwatch

8. Conclusion

Everyone who works in the NHS must ask not only how efficiently the sector is spending NHS resources, but also whether the areas chosen to spend on yield the greatest health value for the people the NHS is here to serve.

Monitor, 2013

In this report we have indicated limited progress of parity of esteem for mental health 'on the ground'. Whilst IAPT has undoubtedly been expanding, the past three years have seen the parity agenda battling the gales of austerity and losing ground in local spending plans. Localism is well placed to understand and respond to local need: it can only be assumed, therefore, that many CCGs and Local Authorities do not want to hear central government's arguments for increased proportional spend on mental health.

Do local commissioners doubt the evidence base? Possibly; but they will certainly (still) be feeling the pressures of austerity targets, and evidence points to the tendency to prioritise acute needs at times of economic downturn (CMO, 2013).

NICE has a further role to play in challenging local health inequalities and postcode lotteries: we hope to see more forceful messages from NICE around mental health to bring greater legal bearing to the parity of esteem agenda. We also hope to see NICE supporting health equality by considering subjective wellbeing and productivity benefits of treatments of mental illness, and to this end conducting Health Technology Assessments on medicines and other interventions for common mental illness and rewarding incremental progress.

We are optimistic about Time to Change and other workplace initiatives, which appear to be reducing stigma and discrimination and increasing opportunities for mental health support in the workplace. Currently, however, such embryonic initiatives have limited scope and are making little impact on national trends, bearing in mind the significant rise in work days lost to mental illness over the last few years. We have yet to see prevention and early action strategies working at scale in the manner of the musculoskeletal disorder (MSD¹⁰) workplace programme, which has seen a general downward trend in MSD-related sick days since 2001, even if figures show a spike for 2013/14 (HSE, 2014).

Politicians and policy implementers, together with businesses and wider society, need to be ever mindful that the working-age population is decreasing in ratio to older people. With the greater prevalence of long term conditions that accompany an ageing population, society is set to become increasingly dependent on a health-optimised workforce. Policy needs to recognise this issue as a national priority.

10. MSD, including back pain and neck pain, is the leading cause of work-related sick days.

8. Conclusion

Mind and body are inseparable: mental health affects physical health; physical health affects mental health. This fact alone should be enough to galvanise the parity of esteem agenda. But in the final analysis we are left with a simple moral imperative: the public should not be subject to stigma and inferior NHS treatment when experiencing mental illness. And it is inevitably the more vulnerable members of our society who are subject to the greatest inequalities of all.

Appendix A: interviews and round table

Interviews (semi-structured interviews listed only)

Name	Position	Organisation
Sue Baker	Director	Time to Change
Andy Bell	Deputy Chief Executive	Centre for Mental Health
Professor Martin Knapp	Director	Personal Social Services Research Unit (PSSRU): London School of Economics and Political Science
Professor Allan Young	Director	Institute of Psychiatry, King's College London

Round table attendees

Name	Position	Organisation
Judy Abel	Executive Manager	2020health
Louise Aston	Workwell Director	Business in the City
Professor Dinesh Bhugra	Professor of Mental Health and Diversity	Institute of Psychiatry, King's College London
John Binns	Mental Health and Personal Resilience Adviser	Independent (Trustee, MIND; former Partner, Deloitte)
Alex Blacknell	Research Manager	2020health
Dr Gillian Bowden, MBE	National Assessor, Health and Social Care	Norfolk and Suffolk NHS Foundation Trust
Rt. Hon. Paul Burstow MP	MP for Sutton and Cheam	Liberal Democrats
Lee Evitt	Market Access Manager	Lundbeck UK
Paul Farmer	Chief Executive	Mind
Katherine Hall	Website and Communications Manager	Centre for Mental Health
Tracey Harding	Head of Health and Safety	UNISON
Carole Hirst	Clinical Director	Rotherham, Doncaster and South Humberside NHS Foundation Trust
Cynthia Joyce	Chief Executive Officer	MQ Transforming Mental Health

Appendix A: interviews and round table

Round table attendees (continued)

Name	Position	Organisation
Dr Paul Litchfield, OBE	Chief Medical Officer and Director Wellbeing Inclusion, Safety & Health	BT Group plc.
Julia Manning	Chief Executive	2020health
Emer O'Neill	Chief Executive	Depression Alliance
Jon Paxman	Senior Researcher	2020health
Richard Pemberton	Chair	British Psychological Society, Division of Clinical Psychology
Sarah Yong	Public Affairs Manager	Chartered Institute of Personnel and Development
Ramsay Young	Public Affairs Manager	Lundbeck UK

Appendix B: extracts from the NHS Constitution

The first principle:

The NHS provides a comprehensive service, available to all...it has a wider social duty to promote equality through the services it provides and to pay particular attention to groups or sections of society where improvements in health and life expectancy are not keeping pace with the rest of the population.

The third principle:

The NHS aspires to the highest standards of excellence and professionalism – in the provision of high quality care that is safe, effective and focused on patient experience...through its commitment to innovation and to the promotion, conduct and use of research to improve the current and future health and care of the population.

The sixth principle:

The NHS is committed to providing best value for taxpayers' money and the most effective, fair and sustainable use of finite resources. Public funds for healthcare will be devoted solely to the benefit of the people that the NHS serves.

NHS Values, including:

Everyone counts. We maximise our resources for the benefit of the whole community, and make sure nobody is excluded, discriminated against or left behind. We accept that some people need more help, that difficult decisions have to be taken – and that when we waste resources we waste opportunities for others.

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2020health's mission

Making health personal

2020health is an independent, social enterprise think tank whose mission is to "Make Health Personal". Through research, evaluation, campaigning and relationships we aim to both improve individual health and create the conditions for a healthy society.

2020health research and activity includes the following workstreams:

**Fit-for-school / Fit-for-work / Fit-for-later life:
Forgotten conditions / Integration / International
Innovation / Social Care**

Endorsements of 2020health's work

From one to many: The risks of frequent excessive drinking

"If the government was to heed this report - which might almost be re-named "one too many" - with its emphasis on education, statutory regulation of advertising and increased availability of Brief Interventions, we might see a significant impact on the harm caused by excessive drinking, thus benefitting both individuals and the wider society. Please read it Mr Lansley."

Baroness Hayter

Chair, All Party Parliamentary
Group on Alcohol Misuse

"GPs are well aware of the problems alcohol abuse can cause. We see the long term damage to individuals and their families probably more than any other group of healthcare professionals in the UK. I hope this guidance will help GPs and their patients make informed decisions that will prevent serious ill health in the future."

Dr Clare Gerada

Chair, RCGP

Head of Wellbeing: An essential post for secondary schools?

"The central recommendation of the recent parliamentary Health Committee inquiry into Children and Adolescents' Mental Health Services, was the value of investing in prevention and early intervention for mental illness in young people. I welcome this thoughtful report and support the proposal to pilot Heads of Wellbeing within secondary schools and to explore their potential to improve wellbeing across the whole school community."

Dr Sarah Wollaston MP

Chairman, Health Select Committee

"This report begins to form an evidence base about an issue rarely high up the national agenda - the wellbeing of pupils and staff. As such, it makes a valuable contribution to this debate and raises issues that teachers and school leaders will want to consider."

Baroness Morris of Yardley

Former Secretary of State for Education

Healthcare without Walls: Delivering telehealth at scale

"Addressing the strategic challenge of the rising tide of people with long term conditions lies in patient centred care. Personalising care with care planning, integrated working by sharing the medical record and introducing immediacy using telehealth monitoring and telemedicine will transform patient care, improve outcomes and achieve more for less. This report adds considerable value to the debate on how services can be transformed using telehealth in the future."

Dr Shalid Ali

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NHS Yorkshire and the Humber

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