Community psychologists express concerns about an emphasis on CBT and similar therapies.

by Jacqui Akhurst

During the Community Psychology UK conference, held in September 2007 at York St John University, delegates worked on a statement expressing their concerns about the impact of poverty and disadvantage on the mental health of individuals and communities. In the same month, Lord Layard's report was published, and shortly thereafter the Health Secretary announced that £170m would be made available by 2010 for *Improving Access to Psychological Therapies*, to be rolled out systematically over a three year period (Sainsbury Centre 2007).

Subsequent to the *Improving Access to Psychological Therapies* announcement, the community psychology online network refined their concerns and compiled a press release for 21 October 2007. The members of the online discussion group also circulated the statement to anyone they thought might be interested. The press release was met with resounding silence from the broad range of the editors to whom it was sent, however I was very encouraged by the response I received from a number of my occupational therapy colleagues at York St John University. Katrina Bannigan suggested that I should write an article for *Mental Health Occupational Therapy*, and I was further encouraged by Jane Clewes in our communications. I therefore appreciate this opportunity to describe the Community Psychology UK concerns.

The issues to be explored below have become even more pertinent following the release, earlier this year, of a number of reports related to *Improving Access to Psychological Therapies* by the Department of Health (DH); and a recent debate in the House of Lords (15 May 2008). The DH (2008) implementation plan notes that approximately six million people in the UK have mental health conditions related to depression and anxiety, i.e. approximately 10% of the population. The DH outlines the plans for roll-out and describes the training of healthcare professionals for both low- and high-intensity delivery of services. The Lords debate was introduced by Baroness Neuberger and focused on what was termed 'mental ill health in the workplace'. A common thread in both the DH reports and the debate is the emphasis on the economic costs of mental health difficulties. For example, Baroness Neuberger highlighted the total per annum costs of employee mental ill health as nearly £26 billion (equivalent to £1000 per employee in the UK), and noted that the staff costs to the NHS are over £1 billion, 'equivalent to a quarter of the entire mental health budget for England' (House of Lords 2008). These figures are calculated from the costs of sickness absence, staff replacement and reduced productivity of those present at work, but not well. Whilst the dramatic economic impacts have gained the attention of politicians and policy makers, as health professionals I believe our concerns relate to the effects of such levels of distress on individuals, their families and our communities.

I will present the CPUK press release in four sections (italicised below), with some commentary on each. The release begins:

> *We write in response to the Health Secretary's recent announcement that £170m is to be made available by 2010 to increase the availability of low intensity, high volume, psychological interventions. At present Cognitive Behaviour Therapy (CBT) is the preferred approach. While we welcome the belated recognition of widespread emotional distress in our community, and applaud the government's willingness to spend public money on it, we have a number of serious reservations about the approach adopted.*

All those who work in mental health are aware that many forms of distress, with multiple causes, have a dramatic impact on people's functioning, resulting in difficulties at work and home. The fact that the economic costs of increased levels of absenteeism and the costs of benefits have been the driver for seeking solutions, rather than primary concerns for citizens' wellbeing, highlight the nature of our materialist culture. However, it is encouraging that the government is beginning to roll out new programmes focussed on assisting people with issues related to their mental health rather than only threatening more punitive approaches (such as the withdrawal of benefits). What is also encouraging is that the DH (2008) reports that special interest groups have been set up to explore ways of accessing people in the sectors of our communities that have been harder to reach. However this work is still in relatively early stages in comparison to the approaches being prescribed.

CBT has been emphasised as the treatment approach of choice in many of the documents and statements, in particular for the proposed high-intensity interventions. This preference may be partially due to CBT having an established evidence base, whereas other therapeutic approaches such as humanistic counselling, family and systems-based therapy have not established the evidence for success that conform to National Institute for Health and Clinical Excellence (NICE) criteria. It is possible that CBT is better suited to measurement, but this raises questions about the nature of the evidence, likely to have been gathered from randomised controlled trials. Since it is acknowledged in the DH (2008) documents that only one quarter of those with depression and anxiety are likely to have sought help, it is possible that the evidence has not been based on work with the 75% of people being targeted through the new initiatives. The vested interests in particular modalities of intervention of certain

powerful lobbying groups also raise questions.

The community psychologists network is thus concerned about the emphasis being placed on one-to-one 'talking' treatments, in particular those that strive to 'correct faulty cognitions' or 'tackle errors in thinking'. One fundamental criticism relates to approaches trapped within the medical paradigm. Labelling challenges to mental health as 'disorders', focuses attention on the individual, without thorough attention being given to the influence of the many social and environmental pressures people face in the UK of the 21st century. This runs the risk of individuals seeing their 'disorder' as some sort of pathology within themselves, and treatments being prescribed without due consideration of the broader societal issues related to rampant materialism, the power of capitalism, and the forces that fragment communities (Walker 2008). The members of the community psychologists network express their concerns as follows:

> *CBT, and all like treatments, individualise social problems, draw attention away from the more important social, economic and material causes of distress and propose individual cognitive dysfunction as both the cause of people's problems and as the most appropriate site for intervention. Using a medicalised metaphor of 'illness' to describe human misery distracts attention away from the noxious effects on persons of structural poverty, unemployment, job insecurity, violence, abuse, racism, sexism, inequality and consumerism (among others) which are the root causes of human distress.*

Whilst there is no doubt that CBT and similar therapies are effective as treatments for some people, some of the time, members of the network are concerned that the proposed focus enables politicians to believe that widespread distress will be alleviated through these. We acknowledge that the short-term efficacy of these treatments has been reported in the literature, but are not convinced of the long-term benefits. Furthermore, there are also risks that in striving to cut costs, simplistic applications of CBT treatment will be instituted, without due consideration of the person's context. In the DH (2008) documents for example, there are references to bibliotherapy, telephone and online counselling. Whilst again these may be helpful to certain people with access to resources, good communication skills and familiarity with technology; such approaches may lead to people feeling a greater sense of failure because they have not felt supported, and may turn them away from seeking further assistance. Even optimistic accounts of the potential benefits of *Improving Access to Psychological Therapies* are that almost 50% of people needing help will not respond to the approaches being proposed (DH 2008). The Community Psychologists UK press release continues:

> *Briefly, the scale of socially caused distress is so vast, and growing so rapidly, that it is impossible to 'treat it better', let alone 'cure' it, as Mr Johnson and Lord Layard have suggested, by training more therapists. It is, simply, not feasible to treat all those in distress, one at a time, with any therapeutic technique.*

The above paragraph might seem to be very pessimistic, however members of the network are striving to emphasise the need to look at the root causes of distress. There is a growing body of research evidence showing that the income inequalities in the UK appear to correlate with the elevated levels of substance abuse, criminal activity and violence in comparison with other countries in Western Europe (see for example Wilkinson and Pickett 2006, and Walker 2008). Community psychologists recognise the need for far greater attention to programmes that work at community level rather than at CBT and similar therapies, and believe that resources should be directed at these:

> *The approach announced is, we argue, not only conceptually misguided, but also likely to be socially and economically wasteful of scarce resources. Even assuming therapeutic success, when 'treated' many or most distressed people will return to the same psychologically toxic environments that produce distress and will be subjected to the same causes of distress all over again. Primary prevention of distress at a society-wide level – not the 'cure' of individuals – is the only way to substantially reduce socially, economically and materially caused miser. Contemporary research shows that reducing income inequality in our society would be one of the most effective ways to reduce psychological distress and physical ill health – not just for the disadvantaged – but across society in general.*

The last sentence of the press release underlines the need to find ways of engaging policy makers in greater investment in impoverished and disadvantaged sectors of our society, but this may leave us unsure of ways to move forward. One of the ways that people working in mental health programmes in communities can make a contribution is by collecting evidence of the impact of their interventions. There is an urgent need for forms of participatory action research (and other more progressive research forms) to be embedded in community-based work. McKenzie and Harpham (2006) have collated an excellent record of work related to the concept of 'social capital', and emphasise the importance of a better 'understanding of the social factors that cause or perpetuate psychological problems ... if preventive strategies are to be developed' (p.12). They include a number of chapters from different parts of the world (the Netherlands, USA, UK, Southern Africa and Colombia), where community spirit, neighbourliness and mutual assistance have enabled people to overcome many odds, and the authors reflect on the importance of the 'fabric of society – the way in which communities are set up and people live' (p.11).

I have been encouraged to read of some of the initiatives reported in some of the recent issues of *Mental Health Occupational Therapy*. People working in settings and programmes more firmly rooted in communities have reported enabling the empowerment of others. Successful interventions emphasise partnership with service users, where professional skills are 'given away' and the local knowledge of participants is valued as equal to expert knowledge. Having recently returned from the

area of south Mississippi that was overwhelmed by the eye of Hurricane Katrina (where I left behind eight of our students engaged in community-based rebuilding projects), I was humbled by examples of resilience in the people there. It is the ongoing solidarity between individuals and groups that is enabling them to rebuild, to some extent, the towns and areas devastated by the tidal surge. People there report that it will take the area up to 20 years to recover from the events of August 2005, and some communities have begun the rebuilding more effectively than others.

The challenge for all of us is to work towards the more vulnerable in society being included and supported, to feel that they have a place and contributions to make. In our very individually-focused society, we need to look for ways to develop a greater culture of concern and encouragement of others, because in collaboration with others we can do so much more than is possible on our own.

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'Happiness is inversely related to income at higher levels of income because of the declining marginal utility of getting richer,' says Layard.

Reported by Stuart Jeffries in *The Guardian* on Tuesday 24th June 2008, Lord Richard Layard is given the title 'the government's happiness tsar'. 'He thinks he knows why we're all so miserable – it is because we're overpaid, over-materialistic and lonely.

His calls for cognitive behavioural therapy (CBT), for school lessons in emotional intelligence, and other allegedly happiness-causing reforms have been greeted warmly by education secretary Ed Balls, health secretary Alan Johnson, the health guideline-setting National Institute for Clinical Excellence and by local authorities up and down the country.

What is happiness, Layard asked in his 2003 lecture series Happiness: Has Social Science a Clue? His answer was simple: "By happiness I mean feeling good – enjoying life and feeling it is wonderful. And by unhappiness I mean feeling bad and wishing things were different."

In 2005, such was his access to government, that he presented a paper called Mental Health: Britain's Biggest Social Problem? to the No 10 Strategy Unit. There he argued that the scourge of unemployment had been replaced by that of depression. He pointed out that more mentally ill people were drawing incapacity benefits than there were unemployed people on Jobseeker's Allowance. One in six people suffered from depression or chronic anxiety, but only a quarter of sufferers were receiving treatment – mostly drugs. Layard recommended that CBT was as effective as drugs and was preferred by most patients.

But CBT, and Layard's support of it, has been derided. Typical was the GP, Mike Fitzpatrick who, writing in the British Journal of General Practice, charged that Layard was committing a fallacy similar to that of his predecessor William Beveridge, whose 1942 report predicted that improvements in health resulting from better health services would rapidly result in a reduced demand for health and welfare services and hence in a declining burden on the exchequer. It did not. "The notion that a few weeks of CBT will transform miserable people languishing in idleness and dependency into happy shiny productive workers is embarrassing in its absurdity," added Fitzpatrick.

What does Layard make of such criticisms? "Nobody claims that CBT is going to cure everybody. There will still remain roles for medication, family therapy. And for some personality disorders it won't be relevant either. But for many people currently suffering depression it will." Isn't CBT overrated? "No. CBT takes great trouble to evaluate itself. Other forms of treatment such as psychodynamic ones haven't evaluated their methods."'

Reference

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