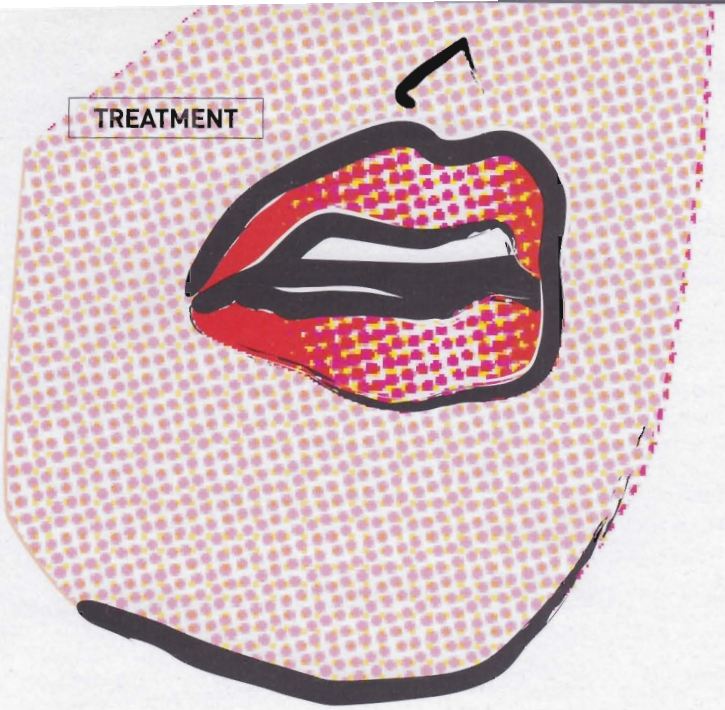

With rises in the number of people experiencing problems with powder and rock cocaine, access to psychological therapies is fast becoming a pivotal issue in the drugs sector. **Marcus Roberts** reports.

We really do need to talk

Back in July, the Mental Health Foundation of New Zealand launched a campaign called 'We Need to Talk'. Its aim is to survey and promote the use of 'talking treatments' in both 'mental health and addiction services'. The New Zealand campaign is inspired by, and borrows its name from, something closer to home. In October 2006, the five big mental health charities in England and Wales launched a report entitled *We need to talk – The case for psychological therapies on the NHS*. A year later, on 22 October 2007, they handed in a mass petition to the government, calling on it to make good on its manifesto promise to improve access to clinically proven and cost effective psychological therapies.

This campaign has not yet brought together the mental health and drug treatment sectors to the same extent as the work in New Zealand – although it is supported by both DrugScope and Alcohol Concern. So, where is the UK campaign at and what is its significance for the drug and alcohol sector?

Access to talking treatments on the NHS – especially access to Cognitive Behavioural Therapy (CBT) – is a fairly hot political issue at the moment. At the 2005 election, New Labour's manifesto promised better access. There has been progress on this pledge in the past two years, notably the Department of Health's *Improving Access to Psychological Therapies* programme. The Layard Report on Depression – published by the London School of Economics in June 2006 – has been particularly influential. This report calculated that unemployment due to depression and chronic anxiety costs £7 billion a year, while lost output amounts to £12 billion. Lord Layard argued that CBT would 'lift at least half of those affected out of their depression or chronic fear' at a cost of only £750 per person and called for a 'New Deal for Depression and Anxiety' with 10,000 extra therapists delivering CBT in 250 teams right across the country.

However, something very unexpected happened in October 2007 – the Department of Health announced £170 million for its *Improving Access to Psychological Therapies programme*. The plan is to have 20 'new areas' of psychological services next year, before increasing services to cover the whole country over the next few years. It will be interesting to see how this money is implemented and, more specifically, given that those with a dual diagnosis often fall between substance misuse services and mental health services, how people with concomitant problems will benefit from the extra cash.

Until the recent announcement from Alan Johnson, progress had been limited. Alan Johnson acknowledged to the New Health Network – in his first major speech as Health Secretary – that current provision is still 'too patchy whilst waiting times are too long'. In 2005, 27.7 million antidepressant prescriptions were written in England at a cost of £338 million. A study by the Mental Health Foundation reports that 78 per cent of GPs have prescribed anti-

depressants despite believing that it would be better to do something else. It is not surprising that many GPs rely on drug treatments. When the *We need to talk* report was published in 2006, it took an average of six to nine months to get an appointment with a therapist or counsellor, and waiting lists of up to two years were not uncommon. The *We need to talk* group is currently conducting fresh research, but all the anecdotal evidence suggests that waiting lists remain long – shockingly so in many parts of the country.

Access can be particularly difficult in some settings, such as prisons, and for some sections of the community: black people, for example, are less likely to be offered talking treatments. Alarmingly, a 2005 Healthcare Commission survey of people in hospital-based mental health services in England found that only 39 per cent had received any kind of psychological therapy.

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The *We need to talk* campaign was set up to support and develop the Layard Agenda. While recognising the strength of the economic arguments, it has placed a strong emphasis on the rights of patients to access treatments recommended by the National Institute of Clinical Excellence (NICE). As Mind's Chief Executive Paul Farmer said at the time: "The NHS would never be allowed to fail to provide a drug or operation that was mandated in NICE guidance, yet that is exactly what is happening with talking therapies." The argument applies to all NICE recommended therapies – not only CBT – and to the use of psychological therapies for people with a spectrum of mental health and related problems – not only depression and chronic anxiety. This clearly includes people with drug and alcohol problems.

The role of psychological therapies in drug treatment has received considerably less attention in the drug policy debate than the prescribing of substitute drugs – for example, methadone and buprenorphine – or the development of harm reduction services – such as needle exchange and advice and information services. This is surprising given the high levels of co-morbidity of substance misuse and mental health problems, the routine use of counselling and other 'talking treatments' in many drug treatment services, and the evidence-base for the effectiveness of psychological therapies in drug treatment.

In June 2005, the NTA published a research briefing on *The effectiveness of psychological therapies on drug misusing clients*. This briefing looked at the evidence on the use of psychological treatment 'to assist individuals to make changes to their substance using behaviour'. It concluded that 'there is a good evidence base for the effectiveness of psychological treatments for substance misuse'. It found evidence for the effectiveness of CBT approaches, including motivational interviewing and relapse prevention, for tranquilliser users, stimulant users, cannabis users and alcohol users. In other words, psychological therapies were found to be effective in areas of drug treatment where no substitute treatments are available. The NTA concludes 'with stimulant and cannabis users, psychological interventions are currently the only effective treatment option for clients' – this alone should push the issue of the availability of talking treatments up the drug and alcohol policy agenda.

But there is another obvious reason why drug and alcohol policy specialists should be behind a campaign to improve access to psychological therapies. A 2002 NTA survey found that the overwhelming majority of people in substance misuse services were also experiencing mental distress. It estimates that 83 per cent of substance misuse clients in Bromley had a co-existing mental health problem. A more detailed assessment of clients with dual diagnosis found that 55 per cent had generalised anxiety, 43 per cent agoraphobia and 41 per cent current depression. The NTA report concluded that 'most substance misuse clients would not have sufficient mental health problems for eligibility at community mental health teams .... the majority with mild and moderate mental health problems should be managed by specialist substance misuse services and/or primary care or by counselling services'. This group are experiencing precisely those forms of mental distress which are at the core of the Layard agenda and the *We need to talk* campaign for better access to psychological therapies on the NHS. If the NTA estimates still hold good, they represent roughly eight out of every ten clients of drug treatment services.

Drug and alcohol workers will encounter clients with a dual diagnosis in a range of particular settings. As mentioned above, prisons are a prime example. A 2005 Prison Reform Trust report estimates that as many as two thirds of male prisoners have both a mental health problem and recent misuse of cannabis, and one third a mental health problem and recent misuse of heroin. Yet, the *British Journal of Psychiatry* still needs to tell its readership in June 2007 that 'drug and alcohol misuse and dependency need to be a core focus of ... clinical interventions in prison.' Access to clinically proven psychological therapies in prisons remains poor and patchy. There is also a high rate of dual diagnosis in secondary mental health services, with the Department of Health's 2002 guidance stating that 'substance misuse is usual rather than exceptional amongst people with severe mental health problems'.

Access to talking treatments is not a peripheral issue for the drug and alcohol sectors, it is an absolutely pivotal one – psychological therapies may be the only evidence-based intervention available for people seeking treatment for some drug problems such as crack cocaine and cannabis. Around eight out of ten clients of drug services will have co-existing mental health problems – many of them need access to CBT and other psychological therapies. Substance misuse specialists can also provide an important corrective to a debate about talking treatment that has some times skirted around the issue of complex need. How many of the people that drug treatment services work with would be fit for entry into or return to the mainstream economy after a £750 course of CBT? But above all, we need to be clear in our campaign work that access to psychological therapies is not only the right of people experiencing mental distress, it is also, in very many cases, a pre-requisite for tackling substance misuse problems effectively.

The *We Need to Talk* campaign is a joint initiative of the Mental Health Foundation, Mind, Rethink, the Sainsbury Centre for Mental Health and Young Minds. You can download the report, find out about and help to support the *We Need to Talk* campaign at /www.weneedtotalk.org.uk – or contact Emily Wooster, Mind, 15-19 Broadway, Stratford, London E15 4BQ (e-mail: e.wooster@mind.org.uk). Information about the New Zealand version of *We Need to Talk* is at www.mindnet.org.nz

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