

# 2011 WORLD MENTAL HEALTH DAY

## ***THE GREAT PUSH: INVESTING IN MENTAL HEALTH***



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# INTRODUCTION

**Vijay Ganju, Secretary General  
The World Federation for Mental Health**

The bottom line: Without adequate mental health services and supports, persons with mental illnesses cannot grow and prosper. Without the positive contributions of persons with mental illnesses, communities are thwarted and countries cannot achieve their full potential.

Across the globe, persons with mental illnesses are among the most vulnerable and the most poor. The neglect and discrimination they experience is unconscionable and a cause for international shame. To a large extent, that is the argument we have made over the last few decades: namely, that developing mental health services are the humanitarian thing to do, the right thing to do. We have demonstrated burden; we have identified needs and priorities; we've even identified effective and evidence-based interventions.

This has not proved sufficient. This year, for World Mental Health Day, we're addressing the economic argument. Building on emerging research, we are focusing on the payoffs to society, on affordability, cost effectiveness and "best buys". The essential point is that to move forward in the development front, and to be globally competitive, mental health must be addressed, frontally and substantively.

The argument is simple. Costs associated with mental illness are enormous and growing. Problems of mental illness affect physical health and chronic conditions. Mental illness is a major source of loss of productivity. We have the know-how and the interventions, and now even have models of mental health and development in practice. Investing in mental health is a "best buy."

A limitation that became apparent in development of these materials is that many of the studies in cost and projected impact have taken place in developed countries. Nevertheless, the findings and their implications, in a general way, apply more broadly.

The point we are trying to make this year: for societal advancement, mental health services are essential. The lack of mental health services is not just negligent; in economic terms, it is irrational.

Investing in mental health is not just a matter of dollars. It is a matter of sense--good, common sense!

## WORLD MENTAL HEALTH DAY 2011 FACT SHEET

- Mental illnesses are widely prevalent. The update of the *Global Burden of Disease* published in 2008 projected that by 2030 unipolar depressive disorders would be the leading cause worldwide of years of good health lost because of disability, ahead of heart disease, road traffic accidents, chronic obstructive pulmonary disease and HIV/AIDs. In 2004 the depressive disorders ranked third globally, but they are moving up toward the head of the list.<sup>i</sup>
- According to the World Health Organization, the vast majority of countries allocate less than 2% of their health budgets to mental health, leading to a treatment gap of more than 75% in many low- and middle-income countries.<sup>ii</sup>
- Mental disorders have economic consequences not only for national health care costs but for workplace operations, lost productivity, family budgets and individual incomes. Many young people are affected by these disorders, which can affect their lifelong prospects.
- The broad consequences of mental disorders should be considered in development planning. Interventions to support the mental health of infants, children and adolescents have been shown to reduce the risk of disorders in later life.
- Cost-effective treatments for mental illness are available for low-income countries. For example, a study of costs to treat schizophrenia and depression in Nigeria showed that effective treatment could be provided using older antipsychotic drugs and antidepressants rather than newer drugs, in combination with psychosocial treatment and case management.<sup>iii</sup>
- When incomes decline, there can be health consequences as well as economic ones. South Korea had an economic crisis in the late 1990s, and a recent study found a deteriorating trend in national mental health in the years following the crisis. Statistics for 1998 to 2007 suggest that the lowest income groups had the highest risk for depression, suicidal ideation and suicide attempts.<sup>iv</sup>

# INVESTING IN MENTAL HEALTH: WHY IT MAKES SENSE

Why invest in mental health?

The simple straightforward answer: **It is the right thing to do.** Unfortunately, these days this argument is not enough. Mental health is an integral part of good health, and yet, mental health and mental disorders never receive the same priority as physical health. Across the globe, there is a long history of stigma and neglect of persons with mental illnesses and their families. Care and services are lacking, and besides stigma, persons with mental illnesses and their families often face poverty, unemployment, and lack of adequate housing.

Policy makers and the general public often view mental health treatment and services as an expense to be avoided or minimized instead of an "investment" associated with economic development and productivity. The fundamental message of World Mental Health Day this year is: **Mental health is an essential component of economic productivity and well-being.**

There are several "no brainer" reasons major investments should be made in mental health. These are "economic" reasons with identified payoffs in terms of cost and productivity.

**Reason No. 1: The burden of mental health is huge and the costs of mental illness to society are enormous.**

Across the globe 450 million people suffer from a mental or behavioral disorder. The estimate is that one in five persons will suffer from a mental illness in a given year. Over a lifetime, one in two persons will experience mental illness. Four of the six leading causes of years lived with disability are depression, alcohol use disorders, schizophrenia and bipolar disorder. By 2030, depression is projected to be the leading cause of years lived with disability.

**Reason No. 2: Mental health is essential for economic development.**

The World Health Organization (WHO) recently released a report on mental health and development. This report is summarized on Page \_\_\_\_. It identifies the need for increased prioritization of mental health, the key argument being that economic development is impeded if the needs of the most vulnerable populations including persons with mental illness are not addressed. By including persons with mental illness explicitly in development efforts, especially those related to education and jobs, persons with mental illness can not only achieve their individual potential but also can contribute to development efforts in their communities and countries.

**Reason No. 3: Some mental health interventions are a "best buy."**

Through its Mental Health Gap Action Programme (mhGAP), the World Health Organization has identified priority conditions for which evidence based interventions can be readily scaled up and offer good value for money. Some of these interventions have been identified as "best buys." "Best buys" are strategies that are not only highly cost effective but also are feasible, affordable and appropriate.

**Reason No. 4: Without mental health interventions, costs of care and treatment increase.**

Interventions for mental illnesses make a difference; an early intervention makes a greater difference.

As in health care, we can wait until the problem is so severe there is no cure, or treatment becomes intensive and much more expensive. Research is beginning to show that appropriate care and treatment in the community can reduce costly care in hospitals and emergency rooms. That is, appropriate and timely mental health interventions reduce future higher costs of mental health care.

This is also true in terms of the life span: Interventions early in life reduce costs in adulthood. Early onset of mental disorders disrupts education in early careers. A study by Knapp and colleagues (2007) showed that children with conduct disorders generate substantial additional costs later in life. Interestingly these costs are not related to health as much as costs related to education and criminal justice.

The extent of the problem results in enormous costs to society. In countries where cost studies have been done, mental health problems account for 2.5 to 3.5 percent of the Gross National Product. For the U.S., the cost was U.S. \$148 billion; in Canada, the cost was \$14.4 billion. One of the most important findings is that the indirect costs associated with loss of productivity either match or exceed direct costs of mental health treatment and services. This loss of productivity is not only related to persons with mental illnesses but also based on family burden. Family members are often primary care givers and, besides bearing financial expenses of care, they have to bear the toll of emotional and physical support, as well as that of stigma and discrimination.

**Reason No. 5: Inaction related to mental health generates additional current and future costs.**

Given the pervasive nature of mental illnesses, inaction results in higher cost and lower productivity. Many corporations have identified mental illness and substance use issues as a major source of the loss of productivity. In many developed countries, 35 percent to 45 percent of absenteeism from work is due to mental health problems. In the UK, one survey showed that people with psychosis took an average of 45 days a year off work.

The bottom line: **NOT investing in mental health is very expensive!**

# Mental Health and Development

**Dr Michelle Funk**  
**Coordinator, Mental Health Policy and Service Development (MHP)**  
**Department of Mental Health and Substance Abuse**  
**World Health Organization, Geneva**  
*and*

**Ms. Natalie Drew**  
**Technical Officer, Mental Health Policy and Service Development (MHP)**  
**Department of Mental Health and Substance Abuse**  
**World Health Organization, Geneva**

*(Adapted from the WHO Report "Mental Health and Development: Targeting People with Mental Health Conditions as a Vulnerable Group." Geneva, 2010)*

## Introduction

Despite their vulnerability, people with mental health conditions have been largely overlooked as a target of development work. This is despite the high prevalence of mental health conditions, their economic impact on families and communities, and the associated stigmatization, discrimination and exclusion. The need for development efforts to target people with mental health conditions is increasingly gaining ground at the international level.

In 2010, WHO launched its Report on Mental Health and Development and later that year, the UN General Assembly adopted a Resolution on Global Health and Foreign Policy which, citing the WHO Report, for the first time highlights mental health as a major area for attention in development. This imperative is also reinforced in the United Nations Convention on the Rights of Persons with Disabilities (CRPD), which requires the mainstreaming of disability issues into strategies for sustainable development.

## People with mental health conditions comprise a vulnerable group

People with mental health conditions meet the major criteria for vulnerability as identified by an analysis of major development stakeholders' projects and publications. They are subjected to stigma and discrimination on a daily basis, and they experience extremely high rates of physical and sexual victimization. Frequently, people with mental health conditions encounter restrictions in the exercise of their political and civil rights, and in their ability to participate in public affairs. They also are restricted in their ability to access essential health and social care, including emergency relief services. Most people with mental health conditions face disproportionate barriers in attending school and finding employment. As a result of all these factors, people with mental health conditions are much more likely to experience disability and die prematurely, compared with the general population.

## Other vulnerable groups have high rates of mental health conditions

Looking at the situation from a different perspective, vulnerability can lead to poor mental health. Stigma and marginalization generate poor self-esteem, low self-confidence, reduced motivation, and less hope for the future. In addition, stigma and marginalization result in isolation, which is an important risk factor for future mental health conditions. Exposure to violence and abuse can cause serious mental health problems, including depression, anxiety, psychosomatic complaints, and substance use disorders. Similarly, mental health is impacted detrimentally when civil, cultural,

economic, political and social rights are infringed, or when people are excluded from income-generating opportunities or education. Addressing mental health problems in vulnerable groups more generally can facilitate development outcomes, including improved participation in economic, social, and civic activities.

### **Improving development outcomes: principles and actions**

A number of principles and actions developed from best practices and consistent with the CRPD, if integrated into national development and sectoral strategies and plans, can substantially improve the lives of people with mental health conditions and thus improve development outcomes for these individuals, their families, and their communities.

As a starting point, people with mental health conditions must be recognized by development stakeholders as a vulnerable group and consulted in all issues affecting them. Targeted policies, strategies, and interventions for reaching people with mental health conditions should be developed, and mental health interventions should be mainstreamed into broader poverty reduction and development work.

To make implementation a reality, adequate funds must be dedicated to mental health interventions and mainstreaming efforts and recipients of development aid should be encouraged to address the needs of people with mental health conditions as part of their development work. At country level, people with mental health conditions should be sought and supported to participate in development opportunities in their communities.

A number of different actions can be taken at country level to improve the development outcomes of people with mental health conditions. Mental health services are cost effective and affordable, and should be provided in primary care settings and mainstreamed within general health services. At a broader level, mental health issues should be integrated in countries' health policies, implementation plans, and human resource development, as well as recognized as an important issue to consider in global and multisectoral efforts such as the International Health Partnership, the Global Health Workforce Alliance, and the Health Metrics Network.

Other actions that can be taken at country level include the (re)construction of community-based mental health services (during and after emergencies), which can serve populations long beyond the immediate aftermath of an emergency situation. Strong links should be developed between mental health services, housing, and other social services, because mental health conditions often co-exist with a number of other problems such as homelessness.

Access to educational opportunities also is essential to improving the lives of people with mental health conditions. Development stakeholders have key roles in encouraging countries to enable access to educational opportunities, as well as supporting early childhood programmes that have been proven effective for vulnerable groups.

Because mental health conditions are associated with high rates of unemployment, people with these conditions should be included in income generating programmes. Grants and support for small business operations have demonstrated benefits, not only for people with mental health conditions, but also for their families and communities.

Development stakeholders also have an important role to play in catalyzing human rights reform through encouraging the formulation and implementation of human-rights-oriented policies and laws related to mental health. They can also help ensure that people with mental health conditions

have access to procedures that protect their rights including to complaints mechanisms and oversight bodies to monitor human rights conditions in mental health facilities.

Finally, development stakeholders have important roles to play in enabling people with mental health conditions to self-organize and advocate for their rights. They can encourage governments to support the establishment of self-advocacy groups, and provide financial resources for this purpose. Development stakeholders can also support initiatives by and for people with mental health conditions, aiming to build capacity of this group to understand their rights and develop the skills and knowledge necessary to influence decision-making processes on issues affecting them.

## **References:**

Funk M, Drew N, Freeman M, Faydi E, World Health Organization. *Mental health and development: Targeting people with mental health conditions as a vulnerable group*. Geneva, Switzerland: World Health Organization; 2010.

[http://www.who.int/mental\\_health/policy/mhtargeting/en/index.html](http://www.who.int/mental_health/policy/mhtargeting/en/index.html)

United Nations General Assembly, *Global Health and Foreign Policy*, Resolution A/RES/65/95, December 9, 2010

*International convention on the rights of persons with disabilities*. Adopted by the United Nations General Assembly in December 2006

<http://www.un.org/disabilities/documents/convention/convoptprot-e.pdf>

# INVESTING IN MENTAL HEALTH: BUDGETS, AFFORDABILITY, “BEST BUYS”

Prepared by Dan Chisholm, Tarun Dua, Taghi Yasamy and Shekhar Saxena on behalf of the Department of Mental Health and Substance Abuse, World Health Organization, Geneva

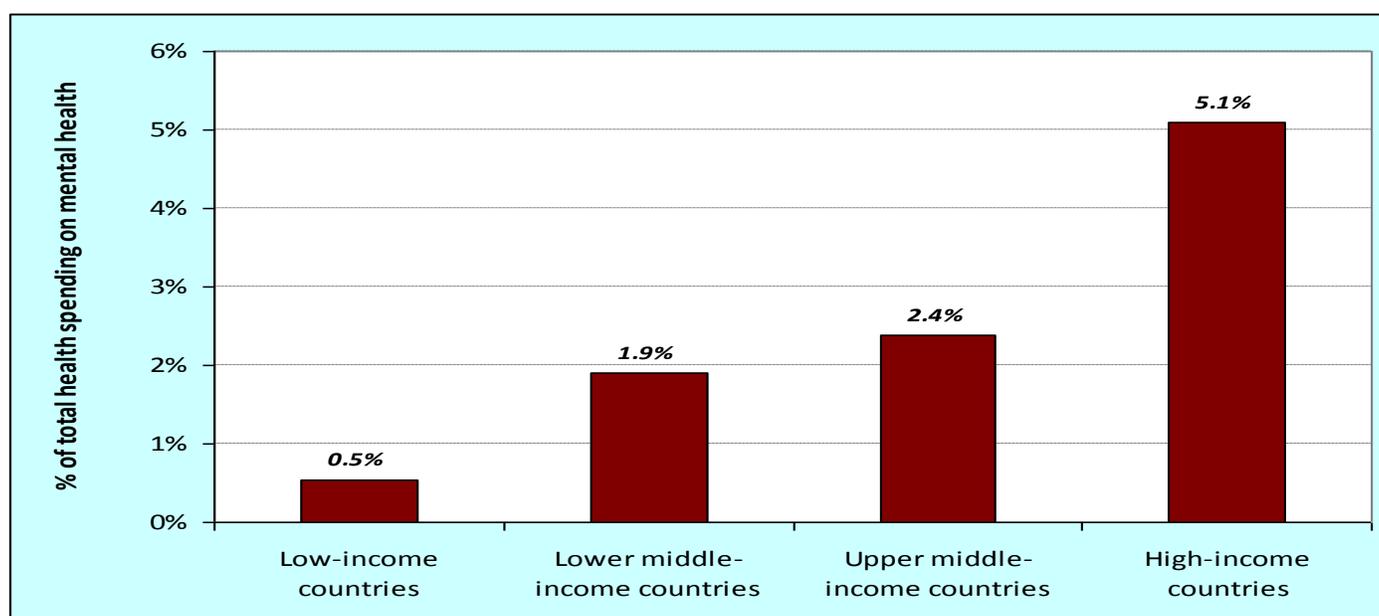
Mental, neurological and substance use disorders - henceforth referred to as mental disorders for convenience - remain an under-resourced element within health systems in low- and middle-income countries. This brief note addresses three questions around investment in mental health:

1. What is the current extent of under-resourcing or investment?
2. What is the justification for increased investment in mental health services?
3. What are the key components of renewed investment in terms of priority actions?

## The current state of investment

Many low- and middle-income countries currently allocate less than 2% - or even 1% - of the health budget to the treatment and prevention of mental disorders (see [Figure](#) below)<sup>1</sup>; this is not remotely proportionate to the burden they cause. The situation is particularly bleak in low-income countries, where on average there is only one psychiatrist per two million inhabitants. Most of the funds that are made available by governments get directed towards the running costs of mental hospital service provision; this inevitably curbs the development of (more equitable and cost-effective) community-based services.

**Figure** Mental health spending as a proportion of total health spending



<sup>1</sup> WHO mental health ATLAS (2011); WHO, Geneva, Switzerland.

It is not surprising that the result of this situation is a large treatment gap for these health conditions. A large multi-country survey supported by WHO showed that 35–50% of people with severe mental disorders in high-income countries and 76–85% in low-income countries did not receive any treatment in the previous 12 months.<sup>2</sup>

## **The case for investment**

The rationale or justification for an enhanced public health response to the existing burden of mental disorders can be made from a number of different perspectives:

- *Disease burden:* Mental disorders are major contributors to morbidity and premature mortality. 13% of the global burden of disease, measured in terms of foregone years of healthy life, can be attributed to these disorders; for example, 150 million people worldwide meet diagnostic criteria for major depression, and another 125 million meet criteria for alcohol dependence or harmful use. Almost three quarters of this burden is in low- and middle-income countries;
- *Economic losses:* Mental disorders are associated with high rates of unemployment and also under-performance while at work, which both exert a brake on labour participation and output (a critical component of economic growth); at least two-thirds of the considerable economic burden of mental disorders is typically attributed to these productivity losses. In addition, the chronic, disabling nature of mental disorders often places an catastrophic or impoverishing financial burden on individuals and households;
- *Unequal rights and opportunities:* Individuals with mental health problems (together with their families) are subjected to stigma, discrimination and victimization, and regularly encounter restrictions in the exercise of their political and civil rights, and in their ability to participate in public affairs. Also from an ethical perspective, the severity and vulnerability associated with certain mental disorders marks them out for particular concern and attention;

In short, the extent of the disease burden is large (and on current trends, set only to grow), so too the economic consequences of inaction, while the target population in need is vulnerable and unfairly treated (in life generally as well as in accessing appropriate care and support).

Given the compelling force of these arguments, why are mental disorders not already a public health priority? Arguably, the main culprit is the deeply embedded societal stigma attached to these health problems, which tends to get reflected in low levels of political prioritization and consequent resource allocation for mental health services. In the face of competing priorities, a further argument that has been used to limit the funding of mental health services relates to the perceived high cost and low cost-effectiveness of care, and the modest returns on that care in terms of recovery or restoration. The next section provides the evidence against this argument.

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<sup>2</sup> Demyttenaere K et al (2004). JAMA, 291:2581-90.

## "Best buy" interventions for investment

Since the range of mental disorders is wide and as resources for mental health are always finite - and usually very scarce - WHO's Mental Health Gap Action Programme (mhGAP) has selected a number of priority mental disorders on the basis of their large burden (in terms of mortality, morbidity or disability), their high economic costs, or their association with violations of human rights. The priority conditions are depression, psychosis, suicide, epilepsy, dementia, disorders due to use of alcohol, disorders due to use of illicit drugs, and mental disorders in children.

In terms of picking out specific, evidence-based interventions from this range of disorders that can be readily scaled-up and offer good value for money, information is required on cost-effectiveness; affordability and feasibility (see the [Box](#) for definitions of these terms). This information is available at the global level - that is, for countries at a range of different income levels - for alcohol use (as a risk factor for disease), epilepsy, depression and psychosis (see [Table](#)).

### Box Priority-setting criteria used to identify "best buys" in mental health

- **Cost-effectiveness** summarizes the efficiency with which an intervention produces health outcomes. A "very cost-effective" intervention is defined as one that generates an extra year of healthy life (equivalent to averting one disability-adjusted life year or DALY) for a cost that falls below average annual income or gross domestic product [GDP] per person.
- **Affordability** is defined in terms of the actual cost of implementing interventions, with US\$ 0.50 used as a threshold for considering an intervention to be very affordable / low cost, and US\$ 1 for quite affordable / low cost.
- **Feasibility** is defined by: (i) reach (the capacity of the health system to deliver an intervention to the target population); (ii) technical complexity (technologies needed for an intervention); (iii) capital intensity (the amount of capital required); and (iv) cultural acceptability. The latter includes wider issues around equity and human rights.

Out of this set of interventions, a number of "best buys" can be identified; that is, strategies that are not only highly cost-effective but also feasible, affordable and appropriate to implement within the constraints of the local health system.

**Epilepsy:** Diagnosis and treatment of epilepsy with first-line antiepileptic drugs is one of the most cost-effective interventions for non-communicable diseases. The treatment is very affordable and feasible to undertake in primary care, making it a "best buy."

**Depression:** Depression is among the leading causes of disability and is projected to be the top leading cause of disability and burden by 2030. The key interventions are treatment with (generically produced) antidepressant drugs and brief psychotherapy. Economic analysis has indicated that treating depression in primary care is feasible, relatively affordable (less than US\$ 1) and very cost-effective. It is another recommended "best buy."

**Psychosis:** Treating people with psychosis with older antipsychotic drugs plus provision of psychosocial support is quite a cost-effective public-health intervention. It is feasible to implement in primary care, although some referral support is required, making it less affordable. As such, it would constitute a "good buy" more than a "best buy." However, human rights considerations add to the imperative need to make these interventions available.

**Harmful alcohol use (as a risk factor for disease):** Harmful use of alcohol is a leading risk factor for disease globally, contributing not only to substance use and mental disorders, but also to injuries and non-communicable conditions such as liver cirrhosis, certain cancers and cardiovascular diseases. Taxation of alcoholic beverages and restricting their availability and marketing are among the identified "best buys."

An important next step in the accumulation of evidence in support of scaled-up action relates to the estimation of the human and financial resources needed to implement an integrated mental health package in different health system settings. Previous work showed that the annual cost per head of population of scaling-up an intervention package for psychosis, bipolar disorder, depression and harmful alcohol use was US\$ 2-3 in low-income countries and US\$ 3-6 in lower middle-income countries.<sup>3</sup>

## Conclusion

Faced with the yawning gap between the public health burden of mental disorders and the resources currently available to address this burden, this note clarifies the basis for renewed efforts to scale-up mental health services. In summary:

- A robust rationale exists for recognizing mental disorders as a public health priority;
- Feasible, affordable and cost-effective measures for mental disorders are available.<sup>4</sup>

As revealed by a recent survey of 'grand challenges in global mental health,'<sup>5</sup> such information and evidence can contribute importantly to renewed efforts to scale-up mental health services. However, knowledge alone is not enough; strong leadership, enhanced partnerships and the commitment of new resources are what is now needed to decisively move from evidence to action.

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<sup>3</sup> Chisholm D, Lund C, Saxena S (2007). *British Journal of Psychiatry*, 191:528-535.

<sup>4</sup> A range of effective measures also exist for prevention of suicide, prevention and treatment of mental disorders in children, prevention and treatment of dementia, and treatment of substance use disorders (alcohol use disorders and drug use disorders); more information is needed about their expected costs and impacts in different resource settings.

<sup>5</sup> *Nature*, 2011; 475:27-30.

**Table: Tackling the burden of mental disorders: identifying intervention "best buys"**

Notes: <sup>a</sup> Source of data: Chisholm D et al, *J Studies Alcohol*, 2004; Chisholm D et al, *British J Psychiatry*, 2004; Chisholm D, *Epilepsia*, 2005; Chisholm D et al, *WHO Bulletin*, 2008.

**Key: Cost-effectiveness:**

+++ (very cost-effective; cost per healthy life year gained < average income per person);

++ (quite cost-effective; cost per healthy life year gained < 3 times average income per person)

+ (less cost-effective; cost per healthy life year gained > 3 times average income per person)

**Affordability:**

+++ (very affordable; implementation cost < US\$ 0.50 per person);

++ (quite affordable; implementation cost < US\$ 1 per person);

+ (less affordable; implementation cost > US\$ 1 per person);

<b>Health condition</b>	<b>Interventions (* core set of "best buys")</b>	<b>Cost-effectiveness <sup>a</sup> (cost per healthy year of life gained)</b>	<b>Affordability <sup>a</sup> (cost per capita)</b>	<b>Feasibility (logistical or other constraints)</b>
<b>Epilepsy</b>	<b>Treat cases with (first-line) anti-epileptic drugs *</b>	<b>+++</b>	<b>+++</b>	<b>Feasible in primary care</b>
<b>Depression</b>	<b>Treat cases with (generic) anti-depressant drugs plus brief psychotherapy as required *</b>	<b>+++</b>	<b>++</b>	<b>Feasible in primary care</b>
<b>Alcohol use</b>	<b>Restrict access to retailed alcohol *</b> <b>Enforce bans on alcohol advertising *</b> <b>Raise taxes on alcohol *</b>	<b>+++</b>	<b>+++</b>	<b>Highly feasible</b>
	<i>Enforce drink driving laws (breath-testing)</i> <i>Offer counselling to drinkers</i>	<b>++</b>	<b>++</b>	<i>Feasible in primary care</i>
<b>Psychosis</b>	<i>Treat cases with (older) anti-psychotic drugs plus psychosocial support</i>	<b>++</b>	<b>+</b>	<i>Feasible in primary care; some referral needed</i>

## MENTAL HEALTH PROMOTION AND MENTAL ILLNESS PREVENTION: THE ECONOMIC CASE

The usual approach to dealing with mental disorders is to ***treat them*** but, in the case of many health problems, ***preventing them*** is better than cure. Within the spectrum of mental health interventions, prevention and promotion have become realistic and evidence-based, supported by a fast-growing body of knowledge. Prevention and promotion strategies can be used by clinicians to target individual patients, and by health program planners to target population groups – particularly children and adolescents and their families.

A major question is whether investment in the prevention of mental health disorders and the promotion of mental wellbeing is a wise use of available resources. As studies and projections have been made regarding the future costs of mental illness, they show a substantial increase of the impact of mental health problems on the economies of many countries under current treatment and care arrangements. That is, without prevention and promotion, costs related to mental health problems will impose a much greater strain on the economy in the future.

A team of British researchers led by Martin Knapp, David McDaid and Michael Parsonage looked at the economic case for mental health promotion and mental illness prevention in a study that was released in January, 2011. The team reviewed fifteen evidence-base interventions to estimate costs and potential savings for the National Health Service, other public agencies and the non-public sector. They drew attention to the need for such investments because of large increases in overall mental health care costs projected out to 2026.

The team's research to find “economic pay-offs” examined evidence for interventions such as those to reduce childhood conduct disorders, for early detection and treatment of psychosis, suicide prevention, and early treatment of depression associated with diabetes. The study had limitations because of the lack of data for medium- and long-term impacts, and because of the difficulty of ascribing reliable economic values to all evidence-based impacts. Results therefore are on the conservative end. They represent minimum economic benefits.

Excitingly, the return on investment for many of the interventions was quite high, even though the costs were often low. Some were self-financing over time (though not over very short periods). In some instances, the pay-offs accumulated over many years. For return on investment over time, the interventions that had the highest ratings are shown in the following table.<sup>6</sup>

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<sup>6</sup> Table adapted from Martin Knapp, David McDaid and Michael Parsonage. (2011) *Mental Health Promotion and Mental Illness Prevention: The Economic Case*. London: Personal Social Services Research Unit, London School of Economics and Political Science. P. 39. Report available for download at [www.pssru.ac.uk](http://www.pssru.ac.uk).

TOTAL RETURN ON INVESTMENT (ALL YEARS): ECONOMIC PAYOFFS FOR  
£1 EXPENDITURE

<b>INTERVENTION</b>	<b>RETURN ON INVESTMENT</b>
Prevention of conduct disorder through social and emotional learning programs	83.7
Suicide prevention by providing bridge safety barriers	54.5
Suicide prevention training provided to all general practitioners	44.0
Early interventions in psychosis	18.0
School-based interventions to reduce bullying	14.4
Screening for alcohol misuse	11.8
Early detection of psychosis	10.3
Early intervention for conduct disorder	7.9
Early diagnosis and treatment of depression	5.0

Assessing the economic value of mental health interventions requires long-range thinking about the savings that could accrue over a lifetime if an individual receives effective early help for difficulties. Government budgets often focus on short-term budget cycles and don't normally take that perspective. Also, projected savings might be made across government departments whose budgets don't intersect. For example treatment for problem behaviors diagnosed in the school system might result in better employment prospects later, and reduced future costs in the criminal justice system. In the present-day budget process, a government department might not see an economic case for investing in an intervention that could bring savings to another department far down the road, and it could be hard to persuade both departments to make an initial investment at a time of tight budgets.

This short-term view is beginning to change in line with the new interest in preventive policies and cost benefits. The principle of intervening at an early stage to reduce social problems is being recognized. Budget issues, however, will remain problematic at a time of rising austerity in many countries. The United Kingdom government recently commissioned an examination of the value of investing in early interventions for children and families at risk. A first report, "Early Intervention: The Next Steps," was published in January 2011 and contained detailed evaluations of evidence-based interventions for children, adolescents and families.<sup>7</sup> It was followed by "Early Intervention: Smart Investment, Massive Savings," released in July 2011.<sup>8</sup> In this second report Graham Allen, MP, chair of the research team, presented complex financial approaches to shift government spending towards early intervention, link payments to outcomes, and provide

<sup>7</sup> Graham Allen, M.P. Early Intervention: The Next Steps. An Independent Report to Her Majesty's Government. London: 19 January 2011. Report available for download at

[http://media.education.gov.uk/assets/files/pdf/g/graham%20allens%20review/20%of%20early\\_intervention\\_the\\_next\\_steps](http://media.education.gov.uk/assets/files/pdf/g/graham%20allens%20review/20%of%20early_intervention_the_next_steps)

<sup>8</sup> Graham Allen, M.P. Early Intervention: Smart Investment, Massive Savings. An Independent Report to Her Majesty's Government. London: 4 July 2011. Report available for download at

[http://www.cabinetoffice.gov.uk/resource\\_library/early\\_intervention\\_smart\\_investment\\_massive\\_savings](http://www.cabinetoffice.gov.uk/resource_library/early_intervention_smart_investment_massive_savings)

incentives for private investment. These funding measures are controversial and at the time of writing it is unclear how far the United Kingdom's government will go to adopt the financial recommendations, some of which represent a radical departure from accepted funding strategies.

Interventions target designed to reduce mental health problems in childhood and the teenage years include support for healthy pregnancies and the relationship between mothers and babies, education for mothers from impoverished backgrounds about the development of their toddlers, programs in school settings to address various social issues (conduct disorders, bullying and other behavior problems), programs to prevent child maltreatment in the home, and programs to support children in foster care. Other initiatives aim to improve parenting methods in families facing divorce, or promote the mental health of children who have parents with mental disorders.

The total cost of mental health problems in children and young people is high, affecting the individuals, their families, medical providers, schools and local communities. A 2009 report from the U.S. National Academy of Sciences on preventing disorders among children and adolescents placed the value of treatment, lost productivity and related costs in the criminal justice system in the United States in 2007 at US\$247 billion (mental health disorders and drug and alcohol abuse combined), or US\$2,380 for each young person in the age range 0-24.<sup>9</sup> At any particular point some 14%-20% of the country's young people have a mental, emotional or behavioral disorder.<sup>10</sup>

A recent report from Access Economics in Australia said that almost a quarter of Australians aged 12 to 25 years are affected by a mental disorder, and estimated the overall financial cost for this age group in 2009 at A\$10.6 billion, taking account of health system costs, caregiver costs, lost productivity, disability, welfare payments, tax revenues lost, and funeral costs from premature death. This amounted to A\$10,544 for each young person with a mental disorder.<sup>11</sup> The report, commissioned by Headspace (National Youth Mental Health Foundation) and Orygen Youth Health, focused on the economic value of improved mental health services for children and young people to age 25, with special attention to early intervention. Compared with current costs, large savings were projected if best practices were introduced universally.<sup>12</sup>

A report from the Canadian Institute for Health Information on "Return on Investment: Mental Health Promotion and Mental Illness Prevention" has found a return on investment for selected interventions, especially those targeting children and youth.<sup>13</sup>

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<sup>9</sup> National Research Council and Institute of Medicine. (2009). *Preventing Mental, Emotional, and Behavioral Disorders Among Young People: Progress and Possibilities*. Mary Ellen O'Connell, Thomas Boat, and Kenneth E. Warner, Editors. Board on Children, Youth and Families, Division of Behavioral and Social Sciences and Education. Washington, D.C.: The National Academies Press. P 239. Report available for download chapter by chapter at [http://books.nap.edu/openbook.php?record\\_id=12480&page=R1](http://books.nap.edu/openbook.php?record_id=12480&page=R1)

<sup>10</sup> Preventing Mental, Behavioral and Emotional Disorders Among Young People, p.17.

<sup>11</sup> Access Economics Pty. Limited. (2009) *The economic impact of youth mental illness and the cost effectiveness of early intervention*. P.ii. Report available for download at [www.accesseconomics.com.au/publicationsreports/getreport.php?report=226&id=286](http://www.accesseconomics.com.au/publicationsreports/getreport.php?report=226&id=286)

<sup>12</sup> Ibid., pp. iii-iv.

<sup>13</sup> Canadian Population Health Initiative of the Canadian Institute for Health Information. Return on Investment: Mental Health Promotion and Mental Illness Prevention. 29 September 2011. Available for download at <https://secure.cihi.ca/estore/productFamily.htm?locale=en&pf=PFC1658>

Another new report from the United Kingdom viewed early interventions from a different angle, that of wealthy philanthropists. A leading wealth management company teamed with a charity consultancy to find areas of private donor spending on social issues that would have an important impact. The resulting report started with 30 costly social problems which were winnowed down to three where “interventions can create economic benefits as well as improving lives.” The three priority areas were chaotic families with multiple issues, children with conduct problems, and employment difficulties due to mental health problems. The report listed effective interventions and cost data to show the long-term financial savings from early action to deal with problems.<sup>14</sup>

Thinking about the value of preventive expenditures and early treatment of disorders requires a mindset that considers both short- and long-term results, and broad thinking about government services and expenditures as well as expenditures within individual government departments. As the research base continues to grow, interest in implementing the prevention of social problems and mental health promotion will continue to expand.

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<sup>14</sup> Barclays Wealth, in co-operation with New Philanthropy Capital. (2011) Early Interventions: An Economic Approach to Charitable Giving. P.48. Report available for download at [www.barclayswealth.com/Early-Interventions.pdf](http://www.barclayswealth.com/Early-Interventions.pdf)

## **MENTAL ILLNESS AND SUBSTANCE ABUSE IN THE WORKPLACE: THE ECONOMIC IMPACT**

These days, in the era of global competition it's all about maximizing productivity. Mental illness and substance abuse services have a critical part to play.

The National Business Group on Health in the United States convened the national committee on employer-sponsored behavioral health services to develop recommendations to improve the design, quality, structure and integration of mental health and substance abuse services. Even though these findings were based on experiences in the U.S. they have broader application.

### KEY RESULTS IN THE COMMITTEE REPORT:

- Mental health and substance abuse service costs totaled \$104 billion and represented 7.6 percent of total healthcare spending. Indirect costs associated with lost productivity often met or exceeded direct treatment costs.
- Depression and other mental illnesses and substance abuse disorders are a major cause of lost productivity and absenteeism. Mental illnesses cause more days of work loss and work impairment than many other chronic conditions such as diabetes, asthma, and arthritis.
- Mental illness and substance abuse disorders are the fifth leading cause of short-term disability and the third lead cause of long-term disability for employers in the United States.
- While employers have focused their attention on the management of high cost, chronic medical conditions (e.g. heart disease and Type 2 diabetes), this does not usually include the significant additional burden of co morbid mental illnesses. Access to mental health and substance abuse services is critical to delivering effective disease management services for chronic medical problems and conditions.
- Without adequate mental health and substance abuse services medical costs are higher (by as much as 37 percent) and the number of sick days increases.

**THE BOTTOM LINE: To be competitive in the global economy mental health and substance abuse services *MUST* be included!**

# MENTAL HEALTH AND DEVELOPMENT: A MODEL IN PRACTICE

## BasicNeeds

BasicNeeds is an international development organization which works to bring about lasting change in the lives of people affected by mental illness and epilepsy. A unique feature of the organization is its innovative approach to tackling people's poverty and illness simultaneously. The work is based on the philosophy of building inclusive communities, where people with mental disorders – through development – realize their own rights. This innovative approach of working with poor people with mental disorders is called the Model for Mental Health and Development. BasicNeeds is currently active in ten countries and, to date has supported more than 85,000 people affected by mental illness and epilepsy, their families and carers. As Jeff Sachs, Director of the Earth Institute at Columbia University puts it,

Mental disorder and poverty go hand and hand. If a person with a mental disorder and his/her family are living in poverty, they're less able to seek and afford treatment or absorb the loss of a wage. They're less likely to perform socially and economically productive roles. Already marginalized, they're likely to experience further discrimination both in the job market and from their own community. Furthermore this link works in both directions, but the effect of poverty also considered to be a contributing factor to poor mental health. That poverty and mental illness are associated is a given, and any initiative that addressed both issues are welcomed.

## The Model

The model places people with mental disorders at its core and mental health firmly within a development context. Holistic in nature, it creates an environment in which people with mental disorders are able to address not only the illness but also their economic and social situation.

People with mental disorders do not exist in isolation. Their quality of life is greatly affected by the attitudes of the communities in which they live and the decisions made by the state that governs them. Therefore, through the model, these negative practices, beliefs about and behavior towards people with mental disorders are challenged. The model is formed of five separate but interlinked modules. These are:

- Capacity building
- Community mental health
- Livelihoods
- Research
- Management

The model is put into practice by mental health and development field programs, which operate within a defined geographical area where there are high levels of poverty. People accessing the programs may be male or female, adults or children. They will all have or be recovering from a mental disorder. Understanding that mental disorders affect more than just that individual, programs also work with their carers and family members. Increasingly BasicNeeds MHD programmes are also working with vulnerable populations such as vulnerable children and youth, orphans and populations affected by natural disaster or conflicts.

Mental health and development programs build the capacity of everyone involved in mental health and development processes. Organizations already involved in development are equipped with the necessary skills to support people with mental disorders. Carers and people with mental disorders join in self-help groups to provide encouragement, manage their illness and strengthen their voices. Community-based mental health services and facilities are also developed. By maximizing existing resources, diagnosis services, and treatment are made available on a regular basis and are extended into areas where previously there was nothing. State health providers commit to allocating human and financial resources and community workers provide the day to day ongoing support that is so vital for people recovering from mental disorders.

Measures are initiated to secure a sufficient economic livelihood for the whole family via opportunities to learn new skills or get an education, return to a previous occupation or access capital. In demonstrating the positive contribution that people with mental disorders can make, deeply ingrained prejudices in the community and wider society are challenged. Awareness raising and education activities expose myth and preconceptions about mental disorders still further.

Data is collected about the lives of people with mental disorders and the impact of the model. Key stakeholders involved in the programme implementation, including importantly persons with mental illness, have the opportunity to analyze the data, out of which new insights and knowledge emerge. Fueled by this body of evidence, mechanisms are introduced that empower people to advocate for change in policy and practice among individuals, communities and governments. The voices of people with mental disorders echo throughout. Pulling all these initiatives together are robust management and administration systems; these ensure the successful delivery of the model in practice.

Key crosscutting themes are:

- Working in partnership
- Programs rooted in their community
- Animation (inspiration; motivation; challenge)
- Participatory techniques
- Flexibility for local adaptations

This is an example of how the link between mental health and development is not just a theoretical notion. It's a model in practice and can be replicated elsewhere.

[This article was based on a book published by BasicNeeds: Mental Health and Development: A Model in Practice, 2008]

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<sup>i</sup> Global Burden of Disease: 2004 update, p.51. World Health Organization, Geneva, 2008. Available for download on the Internet at [http://www.who.int/healthinfo/global\\_burden\\_disease/2004\\_report\\_update/en/](http://www.who.int/healthinfo/global_burden_disease/2004_report_update/en/)

<sup>ii</sup> Foreword to mhGAP Intervention Guide for mental, neurological and substance use disorders in non-specialized settings. World Health Organization, Geneva, 2010.

<sup>iii</sup> Cost-effectiveness of an essential mental health intervention package in Nigeria. O. Goreje, D. Chisholm, L. Kola, V.Lasebikan, S. Saxena. World Psychiatry, February 2007: vol.6, no.1, pp.42-48.

<sup>iv</sup> J.Hong, M. Knapp, A.McGuire. Income-related inequalities in the prevalence of depression and suicidal behavior: a 10-year trend following economic crisis. World Psychiatry, February 2011: vol.10, no.1, pp.40-44.