Making the case for investment in mental health promotion and mental disorder prevention activities in Europe

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Mental Health Policy in Europe
- Promoting mental health and preventing mental disorders - Article 152
- Mental health impacts in other sectors
- Lisbon Process - European Competitiveness
- Promoting Social Inclusion
- Commission & MS response to WHO Declaration
- New Mental Health Pact

The impacts of poor mental health range far and wide
One in four (132.4 million) Europeans affected every year
- €436 billion in 2006
- €2,271 per EU household per year
- Social and personal costs profound:
  - Prejudice and discrimination
  - Less likely to be employed
  - Less likely to be in relationship
  - Great risk of homelessness
  - More likely to be in contact with criminal justice system

Cost of Suicide

Costs per completed suicide (£s 2005)

Ireland New Zealand Scotland

Intangible Indirect Direct

 Sources: (Ire) Kennelly et al 2005; (NZ) O’Dea & Tucker 2005; (Sco) McDaid et al 2006

Total Costs of Depression in EU

Lost Productivity Hospitalisation Pharmaceuticals Outpatient Care

€41 billion direct costs
€77 billion productivity losses
€35 billion productivity losses for cardiovascular disease

Sobocki et al, J Mental Health Policy & Econ, 2006
Leal et al, European Heart Journal, 2006
Costs of schizophrenia in England

- Total cost to public purse 2004/05 €10.4 billion
- Unemployment 39%
- Premature Mortality 13%
- Social Security 9%
- Other health and social care 13%
- Informal Care 9%
- Institutions 17%

Mangalore & Knapp, J Mental Health Pol & Econ, 2007

Disability Benefits GB 2007

- € 3.9 billion per annum
- Plus reduced tax receipts €14 billion

Source: Department of Work and Pensions, 2007

Social Welfare Expenditure

- France - 25% of illness-related social security expenditure due to stress
- Finland - 1990 - 2003 disability benefits for mental health problems increased by 93% - 42% of all benefits paid
- Spain - General Workers Union estimate that 50%-60% of sick leave and disability claims due to stress at work
- Netherlands - steady increase over last 30 years. By 2003 - 35% of those leaving work due to MH problems

Presenteeism

- Significant economic costs associated with ‘presenteeism’
  - Five times greater than absenteeism (Kessler 1997)
  - Stewart et al. (2002) Major depression associated with 7.2 hours per worker per week of lost productive time, or 86% of total time losses
  - WHO Instrument to measure presenteeism available but only used for migraine in Europe?

Objective

- To collate and assess quality of data on what is known about the cost effectiveness of mental health promotion / disorder prevention interventions in Europe (and elsewhere)

- Look at ways in which evidence base might be further strengthened

Methods

Systematic review - health and non health databases (Zechmeister et al 2007)

Subsequently augmented by grey literature - consultation with other networks e.g. IMPHA

Bespoke questionnaire for MHEEN network to identify additional and future evaluations
Inclusion Criteria

Specific goal of well-being or avoidance of mh disorders in universal and targeted populations plus suicide prevention

Excluded:

Pharmaceutical interventions
Alcohol and substance abuse interventions
Used checklist on economic evaluations (subsequently relaxed)

Economic evaluation - pure simplicity ...

The effectiveness question:
Does this intervention work?

The economic question:
Is it worth it?

Two Basic Needs: (A) Costs and Outcomes; (B) 2+ Alternatives
Results

Remarkably despite profound impact of poor mental health, evidence supporting the economic case for prevention/promotion limited

Limited scope for meta-analysis of studies

What is available suggests may be highly cost effective

Huge potential to use economic evidence to help strengthen the case even further for investment in promotion/prevention

Source: Zechmeister, Kilian, McDaid & MHEEN Group, BMC Public Health 2007
Financial costs of social exclusion: long term follow up of antisocial children

Early Years Interventions can be effective and cost effective

Mean total costs age 10 to age 28 €'s 2002 prices

- Scott et al BMJ 2002
- Early Years Interventions can be effective and cost effective
- Low cost parenting interventions can help tackle behavioural problems in childhood (Prime Minister’s Strategy Unit 2006)
- If total lifetime QALY gain just 0.1 then cost per QALY €10,000 - €50,000 (Dretzke et al, Health Technology Assessment 2005)
- Early Childhood Interventions
  - Aos et al. (2004)
    - Long-term net benefit for 38 out of 61 programmes
    - Highest net benefit for juvenile offender programmes
  - Pre-school programmes: favourable long-term net benefits (Karoly et al 2005)
  - Perry Pre-School Programme 8:1 benefit cost ratio at age 27

Suicide Prevention is cost effective

- National universal strategies in Scotland & England
- Targeted strategies in universities and ethnic minorities
- CBT for deliberate self harm
- Suicide awareness training course

Most use modelling based approach and indicate potentially highly cost effective (and often low cost)
Educational intervention for health professionals to prevent suicide

<table>
<thead>
<tr>
<th>Reduction in suicide rates</th>
<th>1%</th>
<th>2.5%</th>
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<tbody>
<tr>
<td>Suicided prevented</td>
<td>0.34</td>
<td>0.85</td>
</tr>
<tr>
<td>Life year gained</td>
<td>9.9</td>
<td>25</td>
</tr>
<tr>
<td>Cost£/suicide prevented</td>
<td>249,400</td>
<td>99,700</td>
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<tr>
<td>Cost£/life year gained</td>
<td>8,600</td>
<td>3,400</td>
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Source: (Appleby et al. Psychological Medicine, 2000)

Potential Cost Effectiveness of Suicide Prevention Strategy in Scotland

Promoting the well-being of older people

- RCT of participation in regular 2 year physical exercise programme in Sheffield
- Physical & mental health (SF-36)
- Small but significant reduction in overall health decline
- €17,172 (€4,739 - €32,533) per QALY gained

Source: Munro et al., Journal of Epidemiology and Community Health, 2004
Training to help long term unemployed return to work

- Short training courses – mental health promotion
- Reduce depressive disorders (39%-25%)
- Help facilitate employment

[Graph: JOBS programme implementation costs vs. costs avoided]

Source: Vinokur et al., Journal of Applied Psychology 1991

Academic evidence largely from US

But some European evidence:
- Psychological therapy
- Early identification, management, job modification
- Physical exercise programmes

Major caveat: limited information on quality of many company funded evaluations

Workplace

Employee Assistance Programmes

Numerous and long standing US literature

McDonnell Douglas EAP helped reduce work loss days by 25% and turnover by 8% of people with mental health problems (Alexander 1990)

Many other US programmes focusing on health as a whole deemed to be cost effective (Pelletier 2005)

But incentives for employers differ in US

Source: Dewa, McDaid & Etter, Canadian Journal of Psychiatry, 2007
Workplace screening & early treatment


Recovery linked to lower work disability and possibly lower future health care costs.

Early identification at work:
Electricité de France

- APRAND (Action de Prévention des Rechutes des troubles Anxieux et Dépressifs)
- Early identification of anxiety and depressive disorders in 140,000 employees
- 10% to 20% increased probability of remission/recovery
- Now looking at impact on productivity underway

Source: Goddard et al, European Psychiatry (2006)

Stress Reduction

CBT designed to help participants understand the effects of stress and establish a healthier approach to work and life. Often also used as part of a graded return to work.

Resulted in absence reduction, savings of £455,000 - a return on investment of 8:1

Evidence of improved productivity and company culture

Source: IDS Human Resources, 2007
Stress Management

- Holistic stress policy at Somerset Council
- Survey to identify triggers
- Guidelines on stress management; restructuring skill mix for workers; counselling

Source: Somerset Council, 2007

<table>
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<tr>
<th>Implementation Cost</th>
<th>Productivity Losses Avoided</th>
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<tbody>
<tr>
<td>0</td>
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<td>0.5</td>
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Source: Somerset Council, 2007

Stress Management

- Pharmaceutical company - high rates of stress related absence
- Stress management course for those at risk; training of management in identification of stress
- Absenteeism decreased by only 1%
- Net gain €600,000

Source: Polemans, 1999

Challenges in workplace mh promotion

- Sensitivity to employers/ees of mental health issues
- Differing incentive structures for European employers i.e. not responsible for health care costs of employees
- Poor co-ordination between EU Occupational Safety and Health and EU Public Health agencies
- Limited robust evaluation data
- Evaluators may have commercial interest in interventions
What do we know?

- Economic evidence limited but promising
- Still US dominated - generalisability
- Early years interventions strong - potentially very long term benefits
- Suicide prevention strategies need only very modest benefits to be C/E
- Interventions in workplace can be of benefit to employee’s, employers and the tax payer

Where do we go?

- Potentially many C/E interventions
- Context, transferability and implementation
- Economic modelling /threshold for C/
- Retrospectively assess economic case for interventions of proven effectiveness
- Partnership working with employers
- Look at how economic incentives can be used to overcome silo budgets and fragmented structures

What can be done at EU level?

- Much responsibility for action rests with Member States
- Multi-sectoral response by EU-DGs
- Exchange/augment information on what works, in what context and at what cost
- Facilitate co-operation between Member States and others (including employers)