

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

David McDaid on behalf of the MHEEN group
LSE Health & Social Care & European Observatory on Health Systems and Policies, London School of Economics

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

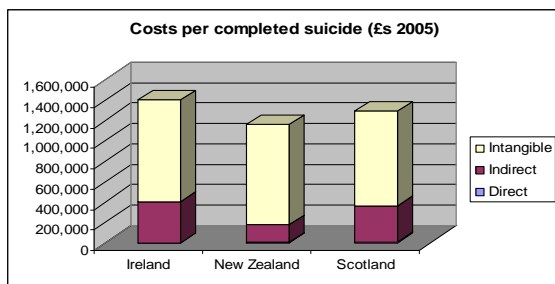
Context

The impacts of poor mental health range far and wide

Impact

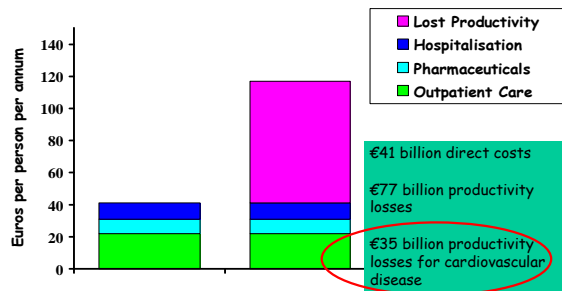
- One in four (132.4 million) Europeans affected every year
- €436 billion in 2006
- €2,271 per EU household per year
- Social and personal costs profound:
 - Prejudice and discrimination
 - Less likely to be employed
 - Less likely to be in relationship
 - Great risk of homelessness
 - More likely to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

Cost of Suicide



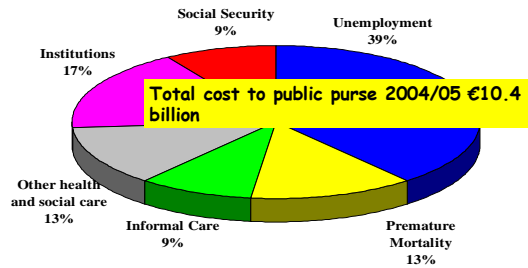
Sources: (Ire) Kennelly et al 2005; (NZ) O'Dea & Tucker 2005; (Sco) McDaid et al 2006

Total Costs of Depression in EU



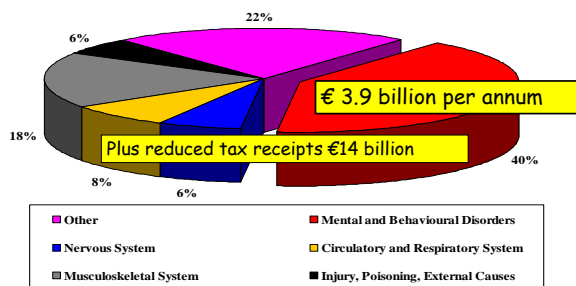
Sobocki et al, J Mental Health Policy & Econ, 2006
Leal et al, European Heart Journal, 2006

Costs of schizophrenia in England



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

Disability Benefits GB 2007



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

Source: Curran C, Knapp M, McDaid D, Tomasson K, MHEEN Group, *Journal of Mental Health* 2007

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

Costs for intervention Z

Costs for intervention X

Outcomes (e.g. suicide averted, quality of life, well-being, employment) for intervention Z

Outcomes (e.g. suicide averted, well-being, quality of life, employment) for intervention X

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

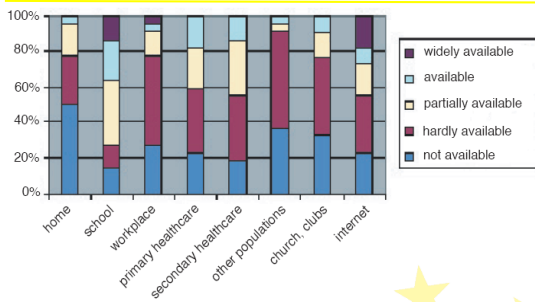
Huge potential to use economic evidence to help strengthen the case even further for investment in promotion/ prevention

Source: Zechmeister, Kilian, McDaid & MHEEN Group, BMC Public Health 2007

Promotion/Prevention are effective

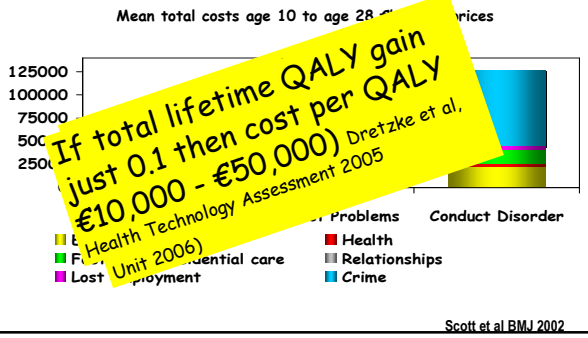


Availability of prevention and promotion in mental health in 22 European countries



Source: European Network for Mental Health Promotion and Mental Disorder Prevention, (IMPHA) 2006

Early Years Interventions can be effective and cost effective



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 for ethnic minorities
- CB (Most use modelling based approach and indicate potentially highly cost effective (and often low cost))
- Suicide awareness training course

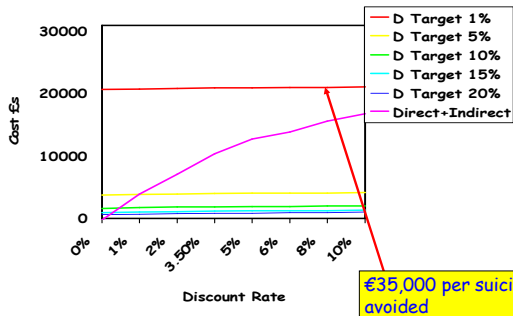
Most use modelling based approach and indicate potentially highly cost effective (and often low cost)

Educational intervention for health professionals to prevent suicide

	Reduction in suicide rates	
	1%	2.5%
Suicided prevented	0.34	0.85
Life year gained	9.9	25
Cost£/suicide prevented	249,400	99,700
Cost£/life year gained	8,600	3,400

Source: (Appleby et al. Psychological Medicine, 2000)

Potential Cost Effectiveness of Suicide Prevention Strategy in Scotland



Source: McDaid, Halliday, MacKenzie, Maxwell, McCollam, McLean, Platt, Woodhouse, 2006

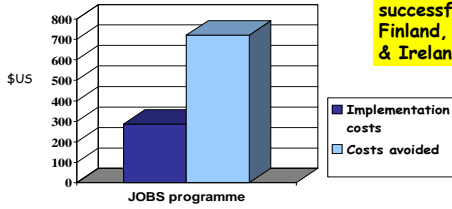
Promoting the well-being of older people

- 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



Implemented successfully in Finland, Netherlands & Ireland

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

Workplace

- Academic evidence largely from US
 - But some European evidence
- Psychological
E
management,
exercise programmes

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

Employee Assistance Programmes

Numerous and long standing US literature

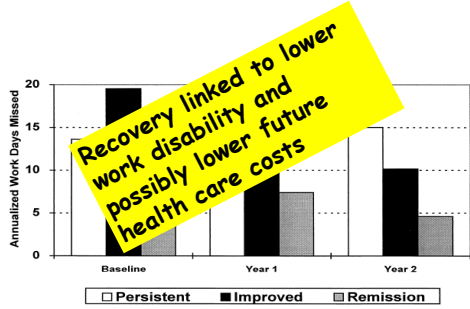
McDonnell Douglas EAP helped reduce work loss days by 25% and turnover by 8% of people with mental health problems (Alexander 1990)

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 & Ettner, Canadian Journal of Psychiatry, 2007

Workplace screening & early treatment



Source: Wang et al, JAMA, 2007

Early identification at work : Electricite 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.

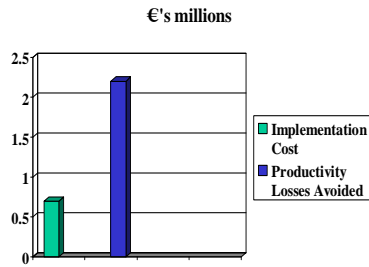
Resulted in absence reduction, savings of £455,000 - a return on investment of 8:1

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

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)
