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Conclusions, discussion and recommendations

Introduction

This review has:

- made estimates of the number of people with specific mental health problems in England
- estimated the costs associated with these conditions
- assessed the impact that specific interventions may have on cost.

This chapter summarises the findings, draws out their implications and makes a number of recommendations.

Limitations

Although we regard the data in this report as representing reasonable estimates of the costs of mental health disorders there are naturally a number of limitations.

We consider that perhaps the main limitation is that of the availability of data. We obtained data on prevalence from a mixture of national surveys and published literature. While we have confidence in the robustness of these data, we were not able to obtain good estimates of how prevalence rates may change over time. However, the two Psychiatric Morbidity Surveys of 1993 and 2000 show little change in prevalence rates and epidemiologists we consulted generally do not feel that rates are changing.

Data on service use and costs were also limited. We have attempted to take a comprehensive approach to costing but the data did not allow this as we would have liked. One area where the costs are underestimated is for forensic mental health care. For example, the cost data for schizophrenia were obtained from community studies and while inpatient data were from the Hospital Episode Statistics these will not capture stays in private sector secure units.

Finally, there were limitations with the intervention modelling. We confined ourselves to those for which there was reasonable data on effectiveness, but other interventions such as employment schemes, court diversion programmes and anti-stigma initiatives could potentially also have a noticeable economic impact.

Conclusions

This report has estimated that there are currently 8.65 million people with the mental health problems analysed (see Table 14, overleaf). This number is projected to increase by 14 per cent by 2026. Figure 112 (see p 119) shows the distribution of service costs by agency. Clearly much of the cost falls on informal carers and social care agencies.

TABLE 14: NUMBER OF PEOPLE WITH SPECIFIC DISORDERS AND CURRENT AND PROJECTED COSTS

Disorder	Number of people (million)		Service costs (£ billion)			Lost earnings (£ billion)			Total costs (£ billion)		
	2007	2026	2007	2026 (2007 prices)	2026 including real pay and price effect ^c	2007	2026 (2007 prices)	2026 including real pay and price effect ^c	2007	2026 (2007 prices)	2026 including real pay and price effect ^c
Depression	1.24	1.45	1.68	2.03	2.96	5.82	6.31	9.19	7.50	8.34	12.15
Anxiety disorders	2.28	2.56	1.24	1.40	2.04	7.7	8.34	12.15	8.94	9.74	14.19
Schizophrenic disorders	0.21	0.244	2.23	2.52	3.67	1.78	1.94	2.83	4.01	4.46	6.5
Bipolar disorder/ related conditions	1.14	1.23	1.64	1.8	2.63	3.57	3.83	5.58	5.21	5.63	8.21
Eating disorders	0.117	0.122	0.016	0.016	0.024	0.035	0.036	0.052	0.051	0.052	0.076
Personality disorder ^a	2.47	2.64	0.7	0.78	1.13	7.2	7.65	11.16	7.9	8.43	12.29
Child/adolescent disorders ^b	0.61	0.69	0.14	0.16	0.24	0	0	0	0.14	0.16	0.24
Dementia ^b	0.58	0.94	14.85	23.88	34.79	0	0	0	14.85	23.88	34.79
Total	8.65	9.88	22.5	32.59	47.48	26.1	28.1	40.97	48.6	60.69	88.45

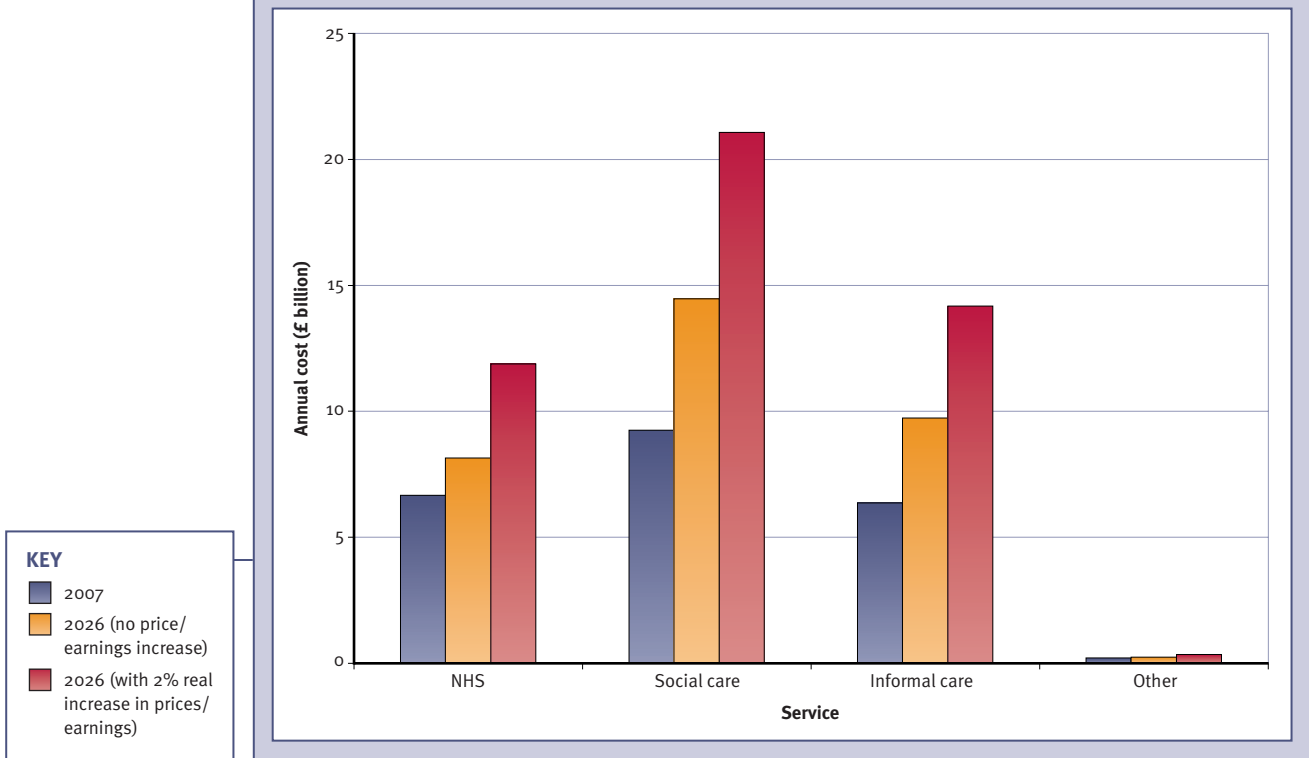
Notes: ^a The costs for personality disorders related to 64.6 per cent of people with the condition (see Chapter 9). ^b The total costs are the same as the service costs as we have assumed that there is no lost employment for people with these conditions. ^c It has been assumed that real pay and prices increase by two percentage points above the GDP deflator.

However, this is largely due to the impact of dementia – the NHS costs dominate the overall costs of care for other disorders. The costs to the NHS and social services (£16 billion) are slightly more than the £12.5 billion estimated by the Sainsbury Centre for Mental Health for 2002/3, while the lost employment costs shown in Table 14, above, (£26 billion) are very similar to the £23 billion reported in that report (Sainsbury Centre for Mental Health 2003b).

Mental health problems in England result in substantial costs in terms of service requirements, informal care and lost employment. This report concludes that they will continue to do so. The prevalence of specific mental disorders are likely to remain broadly stable over the next 20 years, but the costs are projected to increase substantially. Two main factors lie behind this increase – first, an estimated 300,000 increase in the number of people with dementia (accounting for 36 per cent of the increase in costs) and second the assumption of a real pay and price increase of 2 per cent per annum (accounting for 64 per cent).

The cost of lost employment is currently more than the cost of providing health and social care services. Although by 2026 it will have fallen proportionately to less than the costs of providing services (the increase in the number of people with dementia having little or no impact on lost employment) it will remain a significant drain on resources at some £28 billion (at 2007 prices).

112 ANNUAL SERVICE COSTS OF MENTAL ILL HEALTH BY SECTOR



The current service cost (£22.5 billion) is equivalent to 1.7 per cent of the Gross Domestic Product (GDP). The projected cost for 2026 including real changes in prices (£47.5 billion) is equivalent to 3.5 per cent of GDP. If we consider total costs (that is including lost employment), currently the costs of these mental health problems (£48.6 billion) are equal to 3.6 per cent of GDP, rising to 6.6 per cent (£88.5 billion) by 2026 with real changes in prices and earnings included. We need to be somewhat cautious with these figures as the costs of mental health care include unpaid informal care which is not typically included in GDP. (In our total cost estimates we included lost earnings which also are not part of GDP calculations.)

Summary of results from scenarios modelling

We have assessed the impact that a number of interventions might potentially have on service costs. For depression and anxiety disorders (Chapters 4 and 5), increasing the number of people who are currently in treatment and who receive evidence-based intervention (many people with mental disorders are either not in contact with services or are in contact but are not receiving any treatment) would increase service costs but could result in overall savings if effective treatment results in increased employment. This appears to be particularly the case if medication is prescribed to more of those who could benefit. Psychological therapies such as cognitive behavioural therapy (CBT) seem to produce similar gains compared to medication but are far more expensive and it is therefore much more difficult for these extra service costs to be offset by increased employment, the key issue here being the rate of increase in the real earnings from

employment. A 2 per cent increase (our basic assumption) would see long-term net savings; a 1 per cent increase would see initial savings but these would be lost by around 2020. However, therapy is often preferred to medication by patients and cheaper, though still effective, modes of delivery such as computer-based psychological interventions might result in greater savings.

With regard to schizophrenia and bipolar disorder and related conditions (Chapters 6 and 7) savings could also be realised by expanding the use of crisis intervention and early intervention services. For both of these there is reasonable evidence of reduced inpatient stays, particularly in the short term. We also examined the use of early detection services for psychosis. This is one of the few ways in which the prevalence of mental illness might actually be reduced. If this happens we have shown that cost savings will occur.

We also modelled the impact of reducing the rate of dementia (Chapter 11) in those aged 65–74 and 65–84. This could result in substantial cost savings (up to £5.2 billion by 2026).

We did not model the impact of specific interventions for eating disorders, personality disorders and disorders affecting children/adolescents. This was primarily due to the lack

TABLE 15: POTENTIAL ANNUAL SAVINGS FROM INTERVENTIONS TO TREAT DEPRESSION, ANXIETY DISORDERS, SCHIZOPHRENIA, BIPOLAR DISORDER AND DEMENTIA

Condition and interventions	2007	2026
<i>Depression</i>		
Medication for those currently untreated	£5–36 million	£8–61 million
Medication plus psychological therapy for those currently untreated	£1–9 million	£2–16 million
<i>Anxiety disorders</i>		
Medication for those currently untreated	£8–66 million	£13–102 million
Medication plus psychological therapy for those currently untreated	£1–7 million	£2–11 million
<i>Schizophrenia</i>		
Expansion of crisis intervention teams	£4–22 million	£7–37 million
Expansion of early intervention services	£0 million	£13–65 million
Introduction of early detection services	£0 million	Up to £19 million
<i>Bipolar disorder</i>		
Expansion of crisis intervention teams	£2–10 million	£3–16 million
Expansion of early intervention services	£0 million	£8–31 million
Introduction of early detection services	£0 million	Up to £4 million
<i>Dementia</i>		
Reduction in prevalence among those aged 65–74	£0.2–0.6 billion	£0.4–1.2 billion
Reduction in prevalence among those aged 65–84	£0.8–2.4 billion	£1.7–5.2 billion

The range of potential savings depends on how many more patients are treated and how quickly new services come online

of robust data. However, we did show that there were potential cost increases in increasing the proportion of people with eating disorders who were in contact with services. One might assume that this would be offset by productivity gains, but we have not modelled this.

A summary of the potential cost savings from the various interventions we have modelled is shown in Table 15 opposite.

Discussion

Certain evidence-based interventions, such as increasing the number of people who take medication, crisis resolution teams and early intervention in psychosis, can reduce costs in the medium to long term and are worth pursuing for their clinical, social and economic benefits. However, only a reduction in incidence of mental disorders – leading over time to reduced prevalence – would have a significant impact on the future costs of mental health problems. This poses a considerable challenge to both the government and local service providers.

It became apparent that while all the interventions examined had the potential to reduce costs, in no cases would this account for a substantial amount of the overall total cost – an increase from £48.6 billion in 2007 to £88.45 billion in 2026 (including real pay and price increase of 2 per cent above the GDP deflator), about half of which will be due to an increase in the number of people with dementia. However, significant sums could still be released as a result of interventions, to reduce the prevalence rate of dementia and in schizophrenia and bipolar disorder and related conditions, for investment elsewhere in the system.

The cost of lost employment

Of the estimated £88.45 billion total cost of mental health in 2026, nearly half (£40.97 billion) is a result of lost earnings. Reducing this figure will require major efforts on behalf of service providers, employment agencies and employers. The government's announcement in October 2007 of substantial funding to increase access to psychological therapies is a step in the right direction but whether or not it leads to net savings through reducing the cost of lost employment depends on the rate at which real earnings increase over the next 20 years. We know, though, that employment (including voluntary work, part-time work and paid work) can bring great benefits to individuals experiencing mental health problems in terms of self-esteem, personal income and quality of life, and these are strong reasons for improving training and employment support over and above any anticipated cost benefits.

Who benefits?

There is the question of which organisations benefit from efforts to treat and support people with mental disorders. The cost of psychological therapies, for example, falls to the NHS through primary care trust (PCT) commissioning of such services. The benefits, however, may be largely felt by the Treasury and the Department for Work and Pensions in terms of reductions in lost employment costs, fewer benefits payments and increased tax revenue. The NHS may invest significant resources in reducing the prevalence of dementia in older populations, with local authorities taking the bulk of the benefit in reduced

pressure on residential and social care support services. The NHS may also commit resources to assertive outreach and crisis resolution services which could lead to savings within police forces and the criminal justice system. This suggests that there needs to be a discussion among all stakeholders (health and social care services, schools, local authorities, housing agencies, criminal justice services and so on) about how each might contribute towards cost-effective interventions for people with mental disorders, bearing in mind the financial benefits that can accrue to a range of organisations as a result of such interventions.

Reducing the prevalence rate

The prevalence rates of the disorders discussed in this report have been broadly stable in recent years and are estimated to remain broadly stable for the next 20 years. One way of looking at this is to be positive about the expectation that the prevalence of mental disorders will not rise (although absolute numbers of people with disorders will rise due to an increasing, and increasingly ageing, population).

Nevertheless, it is clear that efforts should be focused on how to reduce the prevalence rate, not only in terms of improving the overall mental health of people in England, but in terms of making some significant reduction to the enormous future costs of mental health care that this report sets out. Our review does suggest considerable savings in the costs of dementia care, for example, if prevalence rates could be cut.

In this respect, there are two developments which might, theoretically, produce the desired results. The first would need to involve a medical breakthrough in terms of the treatment (and even ‘cure’) of some, or all, of the disorders, leading to prevalence rates dropping. However, past experience suggests that the continuing progress made in terms of better, more effective treatments, with fewer side-effects, has had little or no impact on overall prevalence rates. Perhaps the area with most potential is that of dementia, where the development of new drugs that slow the progress of dementia and allow people to remain living independently with minimal informal or formal support, could have a substantial impact on costs.

The second development which might impact on prevalence rates would be the establishment of effective mental health promotion and prevention strategies and practice. This would also accord with the Prime Minister’s call for a ‘new drive for a more preventive health service’ and an NHS ‘focused on prevention as much as cure’ (Brown 2008).

The World Health Organization has pointed out the health, social and economic benefits of primary prevention and mental health promotion, stating that ‘In view of the high and increasing burden of mental and behavioural disorders and the recognised limitations in their treatment, the only sustainable method for reducing their burden is prevention’ (Saxena *et al* 2006). A sustained increase in effective mental health promotion and prevention initiatives – both for those who have not experienced a mental disorder as well as those who have – might lead, in time, to a reduction in both incidence and prevalence of mental disorders.

We noted the point made by those we interviewed in our consultation exercise (*see*

Appendix 1, pp 127–128) that much of mental health care – and therefore money – is concerned with addressing problems once they have occurred rather than preventing their occurrence in the first place and tackling the stigma that surrounds mental illness and acts as a barrier to recovery. There was a strong feeling that a more preventive approach, focusing particularly on social inclusion and children’s emotional well-being, linked to early detection and intervention services, should be adopted as a way of minimising the development of mental disorders. However, as noted in the introduction, very little NHS money is currently devoted to mental health promotion (around one-tenth of one per cent of NHS mental health spend for adults of working age). Initiatives to improve people’s emotional well-being have been made outside the NHS, such as the establishment of the emotional health and well-being strand of the Personal, Social and Health Education (PSHE) schools initiative (Department for Education and Employment 2000).

Some evidence for the cost-effectiveness of mental health promotion and prevention does exist. A study looking at the economic case for mental health promotion, commissioned by the Northern Ireland Association for Mental Health (Friedli and Parsonage 2007), states that ‘the scale of the economic benefits of preventing mental illness is considerable’ and suggests that preventing conduct disorders in children who are most disturbed would save £150,000 per case in lifetime costs and that promoting positive mental health in children with moderate mental health would produce a lifetime benefit of around £75,000 per case. The report concludes that investment in support for parents is the ‘best buy’ in promoting mental health.

A NICE evidence briefing (National Institute for Health and Clinical Excellence 2007b) looked at review-level evidence of effective ways to promote positive mental health and prevent mental disorders, and aimed to identify cost-effectiveness data for non-pharmacological interventions. Although it did not cover children and young people, it found some evidence for the cost-effectiveness of family interventions in cases of schizophrenia, compared to standard care. However, overall the briefing found significant gaps in the evidence base and little review-level evidence of the cost-effectiveness of mental health promotion interventions. It recommended further work to provide information on the impact and cost-effectiveness of mental health promotion interventions where evidence does not exist, and particularly interventions in primary care (targeting people who are not receiving medication), interventions in the workplace and interventions that aim to reduce social inequalities for individuals and communities (given the strong links between social deprivation and mental disorder).

Despite widespread acceptance that mental health promotion and prevention work should lead to medium- to long-term savings in terms of reduced service costs, the lack of a substantial body of published research on the cost-effectiveness of such work means that it has not been possible in this report to estimate the impact on future costs that such interventions might have.

Supervised Community Treatment

The Department of Health has estimated that savings may occur through the introduction of Supervised Community Treatment for some patients with serious and chronic mental disorders via the Mental Health Act 2007 (Department of Health 2007b). By the time a ‘steady state’ is reached in 2014/15, the potential annual savings to the NHS in England

through released bed days has been calculated at £45 million, although this would be offset by some £20 million of extra costs to the NHS and local authorities, making a potential annual net saving of £25 million. However, it is not known whether mental health trusts will in fact re-use the released bed days for other mental health patients or for other services, and accordingly we have not assumed such savings will in fact occur, and have not built them into our calculations.

Recommendations

On the basis of the findings in this study on the future costs of mental health we make the following recommendations.

- Future governments should ensure that funding for health and social care services for people with mental disorders is commensurate with expected future increases in mental health costs, including the real pay and price effect.
- Mental health and training and employment agencies should sustain and expand present efforts to support people with mental health needs of working age who are not in employment to return to work, including the use of evidence-based vocational support services. The Department of Health and Department for Work and Pensions should establish programmes designed to involve employers' understanding of mental health and the mental health of their workforce and to generate greater employment opportunities for people with mental health problems.
- Primary care trusts should commission more evidence-based interventions in primary care settings for people with depression and anxiety disorders, and providers should aim to treat more people who have these disorders but currently do not receive treatment. The reduction in lost employment costs should outweigh the cost of increased service provision. Psychological therapies are evidence-based and popular, and access to such services should be extended. However, depending on their success rate and the growth in real earnings among people who return to work as a result, they may be a costly option. As such, more focus should be placed on the most cost-effective ways of delivering such care (for example, through computer-delivered cognitive behavioural therapy).
- For people with schizophrenic and bipolar and related conditions, primary care trusts should maintain and expand the commissioning of crisis services in the community as these have been shown to provide good support while reducing expensive inpatient care.
- Early intervention services for psychosis have also demonstrated their effectiveness in helping to reduce costs and demands on mental health services in the medium to long term, and should be extended to provide care for people as soon as their illness emerges. Early detection services evaluated in research studies appear able to reduce the incidence of psychosis and these should be explored further in routine settings.
- Given the major cost impact of dementia, which underlies much of the estimated increase in mental health costs by 2026, health professionals, and in particular GPs, should make it a priority to establish better systems of early detection and treatment of

dementia, and pharmaceutical companies should maintain their efforts to develop cost-effective treatments that will help people remain independent for as long as possible.

- Health research funding bodies should commission research to establish better data on the cost-effectiveness of :
 - interventions for eating disorders and personality disorders
 - interventions in primary care settings for people with depression and anxiety disorders
 - interventions designed to delay the onset of dementia, allowing people to live independently for as long as possible.

- Echoing the NICE recommendation for further work to provide information on the impact and cost-effectiveness of mental health promotion interventions where evidence does not exist, health research funding bodies should also commission research to establish better data on the cost-effectiveness of mental health promotion and prevention initiatives in reducing the future incidence and prevalence of mental health problems, and on their impact on costs. In particular, the programme should prioritise research into:
 - interventions with children and young adults, given that many mental disorders experienced later in life result from problems in childhood
 - interventions in the workplace aimed at reducing mental health problems among employees.

- The Department of Health should, every three years, publish good-quality data on the incidence and prevalence of mental disorders and on services used by those with these conditions. While some data are available routinely, these are limited and access to information from some sources, for example the Mental Health Minimum Dataset, is not always straightforward.