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Policy Brief 2
Tackling the Crisis in Mental Health

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COVID has revealed one of the great underlying injustices of our age – the huge scale of untreated mental illness. This is a major cause of misery as well as of economic loss. Good treatments exist, but only a minority of those who need treatment receive it. Good services exist and they should be copied more widely.

The scale of the problem

According to the latest Global Burden of Disease estimates, 3.8% of the world's population suffers from diagnosable depression and 4.0% from diagnosable anxiety disorders (like PTSD, OCD, panic attacks, social phobia and general anxiety).1 In fact depression is amongst the world's biggest single illnesses. Rates of depression and anxiety disorder are quite similar across world, and in all regions the rates are higher for women than men. Further, many people suffer from schizophrenia, bipolar disorder or substance use disorders. Though the numbers here are smaller than for depression and anxiety disorders, these conditions have enormous impact on people's economic and social lives, and are associated with human rights violations, especially when care is in institutions. Many of these problems have likely gotten worse due to COVID-19.

The effects

Mental illness has devastating effects on people's happiness, on their physical health and on the economy. When researchers study the causes of misery, they find that the biggest single explanatory variable is a record of mental illness.[2] This is much more important than either poverty or unemployment. So, it is not surprising that most people who die by suicide are mentally ill[3] - and suicides account for more than 1 percent of all deaths worldwide.

What is less well known is that mental illness has big effects on physical health. For example, there are follow-up studies that show that depression makes one 50% more likely to die in each subsequent year – the same effect as smoking.[4] It also makes people with given health problems to use around 50% more healthcare.[5] People with severe mental health conditions die on average 10-20 years younger than the general population.[6]

Mental illness also affects the economy directly, by stopping people working or reducing their productivity. It has been estimated that 42% of all disability and all absenteeism in the OECD is due to mental illness[7], and the OECD estimate that mental illness typically reduces a country's GDP by 4%.[8] So, if we can treat or prevent mental illness, we can get huge savings, which help to offset the cost. And good treatments exist, both for depression and anxiety disorders.

Good treatments

Brief psychological therapies are recommended for both depression and anxiety and 50% of people who get treated recover.[9] Recommended treatments include cognitive behavioural therapy (CBT) and, interpersonal therapy.

Medication is also recommended for moderate and severe depression and for some anxiety conditions – with similar results. For anxiety disorders, few people relapse once they have recovered. And for depression both psychological therapy and medication (if continued) reduce relapse rates by around a half.[10] These are the results when people are treated by well-trained specialists. Poorer countries do not have and may not be able to afford so many specialists as rich ones (even though their wages will be lower). In such cases well-trained and supervised lay workers (e.g., community workers) can produce good results.[11] Medication and psychosocial interventions are also recommended for people with psychoses.

WHO has produced a practical guide to what should be provided in primary health care, called the mhGAP Intervention Guide, and associated psychological intervention manuals, such as CBT-based Problem Management Plus as well as Group Interpersonal Therapy for the management of depression.

Wherever possible, people should be offered psychological therapy (with or without medication). This is not only recommended in terms of outcome but, in many countries, it is what many people want.[12]

The shocking shortfall

But the tragedy is that these excellent therapies reach only a fraction of those who need them. In no rich country do more than 40% of people with depression/anxiety disorders receive treatment (even “medication only”). This would be considered an outrage for most physical conditions, even if these are less disabling than depression or anxiety.[13] In poorer countries treatment coverage is even worse (see Table 1).

Most resources for mental health are poorly distributed and, in most countries, go towards large mental hospitals,[14] which means that most people with severe mental health problems receive either inappropriate institutional care or no mental health care at all in their communities.

Table 1. Percentage of people with depression and anxiety being treated

High-income countries	24
Upper middle-income countries	18
Lower middle-income countries	12
Low-income countries	6

Source: WHO (2015).[15]

Parity of esteem

There ought to be a simple principle of parity of esteem between physical and mental health. In any country **a person with mental health problems should be as likely to receive evidence-based treatment as a person with physical health problems**. This is a matter of elementary justice. It is also a matter of economic common sense. For depression and anxiety affects every age group, especially those of working age. When someone is treated successfully, the following savings arise:

- Savings on disability, absenteeism, and 'presenteeism'
- Savings on physical healthcare.

In a typical rich-country calculation, each type of saving is roughly enough to cover the cost of the psychological treatment[16] And WHO has estimated a 5 in 1 return on investment for depression treatment globally.[17] So the case for a widespread roll-out of these therapies is overwhelming.

Some examples

There are numerous examples where psychological therapy has been made much more available in a short period of time. To be successful this requires three things.

1. A good training programme for therapists in the evidence-based treatments to be provided.
2. An effective service for delivering therapy (e.g., either within primary or secondary care)
3. An effective system for supervising therapists and for collecting routine data on the outcome of the therapy.

An example of this is England's programme for Improving Access to Psychological Therapy (IAPT). This was launched in 2008 and by 2021 it was treating over 600,000 people a year, with over 50% recovering. (Recovery is known because each person's mental state is measured before every session). This service is provided mainly within secondary care. At least 10 advanced countries have shown interest in learning from the initiative.

Among middle income countries, a major initiative was undertaken in Chile in 2001. That year Chile launched a National Depression Detection and Treatment Program.[18] Detection is the responsibility of any healthcare professional engaged in regular medical consultations. Treatment is then organised by the primary-care physician, and consists of medication and individual or group psychotherapy. Severe cases are referred to a mental health specialist. The expansion of the service is impressive.

In less developed countries, most major initiatives are more recent. Six countries (including India and South Africa) belong to the EMERALD consortium.[19] Treatment is given by non-specialist general healthcare workers, who are given special short courses on the treatment of mental health problems, especially depression. WHO colleagues have proposed a basic minimum effort (target) from every country in their models.[20] This is that **by 2030 an additional 25% of people suffering from depression/anxiety should be in treatment** (on top of the numbers in Table 1). The cost of this would be about 0.1% of GDP in 2030 – surely an absolute minimum.

Child and adolescent mental health

Much (though not all) of mental illness begins before the age of 18. This is especially true of anxiety disorders. Typically, 14% of adolescents have a mental health problem.[21] Again in rich countries, only up to 40% may be in treatment, but in poor countries very few. Obviously, we need at least as large an expansion of child and adolescent mental health services as that of adults.

Digital treatments

One of the most exciting developments in mental health is digital treatments. These are especially effective for anxiety disorders, and for all conditions they work best if accompanied by brief telephonic contact with a live therapist. There should be a major programme to produce and translate digital treatments worldwide for depression/anxiety/conduct disorder for children and as well as adults. WHO has developed a CBT-based e-mental health programme called Step-by Step,[22] which has proven effective for depression in Lebanon and will be made available to countries globally.

Prevention

Of course, we would ideally prevent mental illness before it occurs. Though this is impossible in every case, there are some key changes which could help.

1. First, schools. The mental wellbeing of the children should be a formal goal of every school. Schools should teach socio-emotional life-skills as an explicit skill, to be learned through formal teaching of at least one hour a week. High-quality materials should be developed for teaching life-skills, and teachers trained to use these materials.

2. Workplaces. Employers should have a duty of care for the mental health of their employees. Line managers should know how to ask 'Are you OK?' and know what help can be provided if the answer is 'No'. And the organisation of work should not be so harsh or pressured as to cause problems of mental health.

3. Parents. The WHO-UNICEF nurturing care framework for early child development should be widely applied.[23]

Conclusions

This is a massive agenda, but hugely urgent. We can summarise the main steps that are needed.

1. Reorganization of services
   Countries whose resources for mental health are mainly in institutions need to reorganize their services so that people can access quality, affordable care near where they live.

2. Parity of esteem.
   It should be a principle that people with mental health problems are as likely to receive evidence-based treatment as people with physical health problems. This will undoubtedly require that expenditure on mental health should grow faster than on physical health.

3. Evidence-based care
   Treatments should be based on evidence. There should be large-scale programmes to train psychological therapists and healthcare workers to provide mental health interventions, and well-organised services for them to work in.

4. Digital approaches
   There should be a major funding of digital treatments and their deployment worldwide.

5. Schools and society at large
   The mental wellbeing of children should be an explicit goal of every school (with the necessary backup from the government). And line-managers and parents should be offered training in how to promote mental health.

COVID-19 has provided a wake-up call. We need not only better public health but also a revolution in mental health.

Endnotes

[1] IHME estimates for 2019. Institute for Health Metrics and Evaluation.

[2] For example Clark et al (2018) Table 16.1.

[3] Williams (2001).

[4] Mykletun et al (2009).

[5] Katon (2003). Hutter et al (2010). Naylor et al (2012).

[6] Gronholm et al (2021).

[7] OECD (2012) Figures 2.17, 2.18. 2.19.

[8] OECD (2012).

[9] Layard and Clark (2014).

[10] Dobson et al (2008).

[11] Singla et al (2017).

[12] McHugh et al (2013).

[13] 40% was the figure for the UK in 2014. McManus et al (2016).

[14] Saxena et al (2011).

[15] WHO (2015). See also Chisholm et al. (2016). For major depressive disorder, Thornicroft, Chatterji, et al. (2016) report higher treatment rates, but these include visits to religious advisers and traditional healers.

[16] See for example Layard and Clark (2014) Chapter 11.

[17] See Chisholm, Sweeney et al (2016).

[18] Araya, Alvarado, Sepulveda, & Rojas (2012).

[19] Semrau et al. (2015). See also Chisholm, Burman-Roy et al (2016).

[20] Chisholm, Sweeny et al (2016).

[21] IHME estimates for 2019

[22] Carswell et al (2018).

[23] Ante-natal classes can help parents to become better parents and better partners to each other e.g., using Family Foundations. See Harold et al (2016).

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