INTRODUCTION

Reducing the silent burden of impaired mental health

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SUMMARY

Mental and behavioural disorders account for about one-third of the world’s disability due to all ill health amongst adults, with unipolar depressive disorders set to be the world’s number one cause of ill health and premature death in 2030, affecting high- and low-income countries alike. There is a range of evidence-based cost-effective interventions that can be implemented in parenting, at schools, at the workplace and in older age that can promote health and well-being, reduce mental disorders, lead to improved productivity and increase resilience to cope with many of the stressors that are facing the world. These facts need to be better communicated to policy makers to ensure that the silent burden of impaired mental health is adequately heard and reduced.

Key words: mental health; mental health promotion; public health

SILENT BURDEN OF IMPAIRED MENTAL HEALTH

Leading up to the 2011 UN High Level Meeting on Non-Communicable Diseases (NCDs) (http://www.un.org/en/ga/president/65/issues/ncdiseases.shtml), it has been pointed out that the spread of NCDs, principally, heart disease, stroke, diabetes, cancers and chronic respiratory diseases, presents an ongoing global crisis (Beaglehole et al., 2011). Further, there are four simple highly cost-effective policy interventions in both low- and well-resourced countries that can have a high and immediate impact in averting ill health and premature deaths from NCDs, as well as reducing inequalities. These include reductions in alcohol, salt and tobacco intake, as well as the promotion of a diet low in saturated and trans fats and sugar, and physical activity.

However, there is another group of NCDs and disorders, often co-morbid with physical diseases, that are often neglected and far larger in terms of their impact on impaired health and disability. The World Health Organization uses a summary measure of health status, the disability-adjusted life year (DALY), which includes potential years of life lost due to premature death and equivalent years of ‘healthy’ life lost by virtue of being in states of poor health or disability (Murray and Lopez, 1996). One DALY can be thought of as one lost year of ‘healthy’ life, and the burden of disease can be thought of as a measurement of the gap between current health status and an ideal situation where everyone lives into old age, free of disease and disability. DALYs for a disease or injury cause are calculated as the sum of the years of life lost due to premature mortality (YLL) in the population and the years lost due
to disability (YLD) from the disease or injury, weighted for the severity of the disability. Unipolar depression makes a large contribution to the burden of disease, being at third place worldwide and eighth place in low-income countries, but at first place in middle- and high-income countries (World Health Organization, 2008). More important is that it is estimated that by the year 2030, unipolar depression will become the number one cause of ill health and premature death, contributing to 6.2% of all the world’s DALYs.

Years lived with disability (YLD) measure the equivalent years of healthy life lost through time spent in states of less than full health. When all the years of life with reduced capability for all the sufferers of each condition are added up and weighted for disability, a total of YLD for each condition is obtained. YLD estimates are restricted to loss of health experienced by individuals, and do not take into account other aspects of quality of life or well-being, or the impacts of a person’s health condition on other people (except as far as they experience directly assessed losses of health themselves). In all regions of the world, the World Health Organization notes that mental and behavioural disorders are the most important causes of disability, accounting for around one-third of YLD among adults aged 15 years and over (Table 1).

The disabling burden of mental and behavioural disorders is almost the same for males and females, but the major contributing causes are different. Whilst unipolar depression is the leading cause for both males and females, the burden of depression is 50% higher for females than males. In contrast, the male burden for alcohol and drug use disorders is nearly seven times higher than that for females, and accounts for almost one-third of the male burden from mental and behavioural disorders. In both low- and middle-income countries, and high-income countries, alcohol use disorders are among the 10 leading causes of YLD. This includes only the direct burden of alcohol dependence and problem use. The total attributable burden of disability due to alcohol use is much larger.

**MENTAL HEALTH, THE ECONOMY AND UNEMPLOYMENT**

Impaired mental health costs society and businesses and impacts on productivity. Taking England as an example, it has been estimated that the economic and social costs of mental ill health were over £105 billion in 2009, of which some £30 billion were the costs of output losses resulting from the adverse effects of mental health problems on people’s ability to work (Centre for Mental Health, 2010). The annual cost of mental ill health to employers in the UK is significant, estimated at £25.9 billion in 2006 or £28.3 billion at 2009 pay levels (National Institute for Health and Clinical Excellence, 2009). The £25.9 billion can be broken down as £8.4 billion a year for sickness absence, £15.1 billion a year for reduced productivity at work and £2.4 billion a year for turnover, replacing staff who leave their jobs because of impaired mental health.

Furthermore, evidence dating back over 80 years and from a variety of different regions of the world suggests that mental health problems have a significant impact on productivity. For example, in 1994, it was estimated that mental ill health cost employers £10.4 billion in the UK, with £4.9 billion for sickness absence, £5.4 billion for reduced productivity at work, and £0.1 billion for turnover (National Institute for Health and Clinical Excellence, 2009). The impact of mental ill health on productivity is likely to be even greater today, given the increasing burden of mental health problems in the population.

**Table 1: Leading cases of YLD, world, 2004 (World Health Organization, 2008)**

<table>
<thead>
<tr>
<th>Males</th>
<th>Females</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Cause</strong></td>
<td><strong>YLD (millions)</strong></td>
</tr>
<tr>
<td>1 Unipolar depressive disorders</td>
<td>24.3</td>
</tr>
<tr>
<td>2 Alcohol use disorders</td>
<td>19.8</td>
</tr>
<tr>
<td>3 Hearing loss, adult onset</td>
<td>14.1</td>
</tr>
<tr>
<td>4 Refractive errors</td>
<td>13.8</td>
</tr>
<tr>
<td>5 Schizophrenia</td>
<td>8.3</td>
</tr>
<tr>
<td>6 Cataracts</td>
<td>7.9</td>
</tr>
<tr>
<td>7 Bipolar disorder</td>
<td>7.3</td>
</tr>
<tr>
<td>8 COPD</td>
<td>6.9</td>
</tr>
<tr>
<td>9 Asthma</td>
<td>6.6</td>
</tr>
<tr>
<td>10 Falls</td>
<td>6.3</td>
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COPD, chronic obstructive pulmonary disease.
the world shows that an adverse economic climate, such as recession and consequential unemployment, is associated with poorer mental health. For example, in the member states of the European Union, between the years 1970 and 2007, a more than 3% rise in unemployment increased the risk of death from suicides 4-fold and deaths from dependence on alcohol 28-fold (Stuckler et al., 2009). Younger populations were found to be more sensitive to the negative health effects of rising unemployment than were those older than 60 years. For men, death rates from suicide and ischaemic heart disease at ages 30–44 years were positively related to unemployment. For women, there were significant associations with suicides at ages 15–29 years. However, the association between unemployment and mortality is not fixed and can be modified by social protection. In the European Union, between the years 1970 and 2007, for every US$10 higher investment in active labour market programmes, there was a 0.04% lower effect of a 1% rise in unemployment on suicide rates in people younger than 65 years. And, when this spending was greater than US$190 per head per year (adjusted for purchasing power parity), rises in unemployment were found to have no adverse effect on suicide rates (Stuckler et al., 2009).

Mental Health Promotion

Mental health is crucial in today's society not only to identify and realize aspirations, to satisfy needs and to change or cope with the environment (World Health Organization, 1986, Ottawa Charter for Health Promotion), but also to stimulate growth and development and to contribute to prosperity, solidarity, social justice and increased quality of life. The huge burden of impaired mental health for individuals, families, society and the economy calls for action to prevent mental ill health and to promote mental health and well-being. The profound burden and costs of the health, social and economic impacts of impaired mental health necessitate public mental health actions, not only to treat, but also to prevent impaired mental health and to promote positive mental well-being. Promoting mental health is also fundamental to managing global challenges, such as climate change, conflict and economic crises (World Health Organization, 2009, Nairobi Call to Action).

This supplement is based on systematic reviews prepared for the Dataprev project, a 3-year project financed by the Research Directorate of the European Commission, updating and documenting the evidence base for mental health promotion and disorder prevention for four population groups, infants, children, working age and elder populations. The papers in this supplement summarizes the evidence for actions to prevent disorders and to promote positive mental well-being through parenting, at schools, at the workplace and in older age, supported by economic analyses, and a commentary on strengthening the evidence base for decision-making.

Healthy Start in Life

A healthy start is crucial for mental health and well-being throughout life, with parenting being the single most important factor. Parents provide for their children's basic needs for food and protection, they also care for them when sick, teach them language and help them master the basic skills of living in the community and society in which they are born. Without such care, babies and children do not survive. It is, however, in the more subtle aspects of parenting, including the quality of parent–child relationships and different approaches to socialization and discipline, that the origins of mental well-being and mental illness lie.

Based on a systematic review of 51 systematic reviews, Stewart-Brown and Schrader-McMillan (Stewart-Brown and Schrader-McMillan, 2011) identify a range of low-cost practices that if widely implemented could promote mental health throughout life. McDaid and Park (McDaid and Park, 2011), noting that the economic consequences of poor childhood mental health are profound and can last into adulthood, also find that investing in parenting interventions can be highly cost-effective, with the costs of parenting interventions being modest in comparison to the potential avoidable lifetime costs of poor mental health that some children may experience.

Health Promoting Schools

Children and young people spend a large amount of time in schools and the school
represents an easy access environment with direct day-to-day contact with children, young people and, often, their families. Schools not only establish the competencies for learning, they are an important setting for mental health promotion and, indeed, health promotion in general, through their role in helping to establish identity, interpersonal relationships and other transferable skills. The school has for sometime now been seen as a unique community resource to promote and foster mental, emotional and social well-being, and calls for it to be more active in this respect are growing.

The past two decades have seen a significant growth of research and good practice on mental health prevention and promotion in schools. Across the world, an increasing number of schools are engaging in a wide range of mental health-related initiatives and policies, which in many places are showing promising results. Activities operate under a variety of headings, not only ‘mental health’ but also those such as ‘social and emotional learning’ ‘emotional literacy’, ‘emotional intelligence’, ‘resilience’, ‘life skills’ or ‘character education’.

Based on a systematic review of 52 systematic reviews, Weare and Hind (Weare and Hind, 2011) find well-designed programmes with a very wide range of positive impacts, including aggression and depression; reduction of commonly accepted risk factors, such as impulsiveness, and antisocial behaviour; and development of the competences that promote mental health such as cooperation, resilience, a sense of optimism, empathy and a positive and realistic self-concept. Programmes have also been shown to help prevent and reduce early sexual experience, alcohol and drug use, and violence and bullying in and outside schools, promote pro-social behaviour and in some cases reduce juvenile crime. Children who receive effective and well-designed mental health and social and emotional learning programmes are more likely to do well academically, in some cases achieving higher marks in subjects such as mathematics and reading, to make more effort in their school work, and to have improved attitudes to school, with fewer exclusions and absences.

McDaid and Park (McDaid and Park, 2011) identify favourable return on investment ratios for school-based programmes. For example, the Caring School Community scheme can be delivered at a cost of $16 per pupil over 2 years, and potentially generate a return on investment of 28:1, even when just looking only at benefits of reduced drug and alcohol problems alone (even before placing monetary value was placed on the significant improvements seen in mental and emotional health) (Aos et al., 2004).

**WELL-BEING AT WORK**

Occupational stress and work-related mental health problems have a number of major socio-economic consequences such as absenteeism, labour turnover, loss of productivity and disability pension costs (Dewe and Kompier, 2008). Personal costs include lower self-esteem, physical conditions (e.g. heart disease) and negative impact on family life. For these reasons, the workplace is considered to be one of the most important settings for mental health promotion.

Actions can be implemented at both an organizational level within the workplace and targeted at specific individuals. The former include measures to promote awareness among managers of the importance of mental health and well-being at work and to improve their skills in risk management for stress and poor mental health, for instance looking at job content, working conditions, terms of employment, social relations at work, modifications to physical working environment, flexible working hours, improved employer–employee communication and opportunities for career progression.

Actions targeted at individuals can include modifying workloads, providing cognitive behavioural therapy, relaxation and meditation training, time management training, exercise programmes, journaling, biofeedback and goal setting.

The results of the systematic review of Czabala et al. (Czabala et al., 2011) suggest a mismatch between what is being done by many businesses, particularly the larger and multinational ones in promoting mental health and a lack of published evaluations. McDaid and Park find that while the costs to business and to the economy in general of dealing with poor mental health caused by work has been the focus of attention by policy makers in recent years, less attention has been given to evaluating the economic costs and benefits of promoting positive mental health in the workplace. In part, this may be due to a lack of incentives for business to undertake such evaluations, as well as issues of commercial sensitivity. Nevertheless, it has
been estimated that effective management of mental health in an UK organization with 100 employees could save £250 000 per year (National Institute for Health and Clinical Excellence, 2009). Enhancing the well-being of workers and educating them about mental health issues has a beneficial impact on their families and friends as well as helping to reduce the harmful stigma that can accompany mental illness.

MENTALLY HEALTHY OLDER PEOPLE

Among the ageing population, anxiety and depressive disorders are the most prevalent mental health problems, with around 12% of adults aged 65 or older currently affected by depressive syndromes in Europe (Copeland et al., 1999). Given the growth of the older adult population, depression in older adults is set to become an increasingly important health issue.

In their systematic review, Forsman and Wahlbeck (Forsman and Wahlbeck, 2011) note that associations exist between social capital in the ageing population and mental health. Crucial components of the individual-level social capital concept, such as social support, and social network size were shown to be negatively associated with depressive symptoms and depression, while loneliness showed a positive association with depressive symptoms and depression. They note that research has highlighted that civic mistrust and lack of reciprocity or of social participation (i.e. low individual-level social capital) are associated with depressive symptoms among older adults.

Forsman and Wahlbeck (Forsman and Wahlbeck, 2011) identity evidence that indicates that depressive symptoms and depression in older people can be prevented by psychosocial interventions. Policies that support access to social activities, peer support and skill training will protect mental health. In all policy arenas, the possible impact on mental health determinants of older people needs to be considered. Design of care services for older people needs to recognize the importance of providing access to meaningful social activities and possibilities for peer group support. McDaid and Park (McDaid and Park, 2011) report that programmes to reduce social isolation, including befriending schemes, can be cost-effective.

FROM EVIDENCE TO PRACTICE

Finally, Jané-Llopis et al. (Jané-Llopis et al., 2011) reflect on what all of this means in terms of strengthening the evidence base for decision-making on promotion and prevention in mental health. They note evidence from research studies will be only one of a number of factors taken into account in the decision-making process. Some policy decisions and interventions may be considered worth doing on the basis of social justice, political, ethical, equity issues, reflecting public attitudes and the level of resources available, rather than be based on health outcomes alone.

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