

# Innovative Project Regulations Issued July 2015 (Effective October 1, 2015)

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## Article 2. Definitions

### **Adopt Section 3200.182 as follows:**

#### **Section 3200.182. Innovation Component.**

- (a) "Innovation Component" means the section of the Three-year Program and Expenditure Plan that consists of one or more Innovative Projects.

NOTE: Authority cited: Section 5846, Welfare and Institutions Code. Reference: Sections 5830 and 5847, Welfare and Institutions Code.

### **Adopt Section 3200.183 as follows:**

#### **Section 3200.183. Innovation Funds.**

- (a) "Innovation Funds" means the Mental Health Services Fund distributed to the County pursuant to Welfare and Institutions Code Section 5892, subdivision (a)(6).

NOTE: Authority cited: Section 5846, Welfare and Institutions Code. Reference: Section 5892, Welfare and Institutions Code.

### **Adopt Section 3200.184 as follows:**

#### **Section 3200.184. Innovative Project.**

- (a) "Innovative Project" means a project that the County designs and implements for a defined time period and evaluates to develop new best practices in mental health services and supports.

NOTE: Authority cited: Section 5846, Welfare and Institutions Code. Reference: Section 5830(b) and (c), Welfare and Institutions Code.

## Article 5. Reporting Requirements

### **Adopt Section 3510.020 as follows:**

#### **Section 3510.020. Innovative Project Annual Revenue and Expenditure Report.**

- (a) As part of the Mental Health Services Act Annual Revenue and Expenditure Report the County shall report the following:
- (1) The total dollar amount expended during the reporting period on each Innovative Project by the following funding sources:
    - (A) Innovation Funds
    - (B) Medi-Cal Federal Financial Participation
    - (C) 1991 Realignment
    - (D) Behavioral Health Subaccount
    - (E) Any other funding
  - (2) Total dollar amount expended during the reporting period for the administration of each Innovative Project by the following funding sources:

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- (A) Innovation Funds
  - (B) Medi-Cal Federal Financial Participation
  - (C) 1991 Realignment
  - (D) Behavioral Health Subaccount
  - (E) Any other funding
- (3) Total dollar amount expended during the reporting period for the evaluation of each Innovative Project by the following funding sources:
- (A) Innovation Funds
  - (B) Medi-Cal Federal Financial Participation
  - (C) 1991 Realignment
  - (D) Behavioral Health Subaccount
  - (E) Any other funding
- (b) The County shall within 30 days of submitting to the state the Mental Health Services Act Annual Revenue and Expenditure Report:
- (1) Post a copy on the County's website; and
  - (2) Provide a copy to the County's Mental Health Board

NOTE: Authority cited: Section 5846, Welfare and Institutions Code. Reference: Sections 5830, 5845(d)(6), and 5847, Welfare and Institutions Code.

### **Adopt Section 3580 as follows:**

#### **Section 3580. Innovative Project Reports.**

- (a) For each approved Innovative Project, the County shall submit to the Mental Health Services Oversight and Accountability Commission the following reports, as applicable.
- (1) For a continuing Innovative Project, an Annual Innovative Project Report as specified in Section 3580.010.
    - (A) The Annual Innovative Project Report is due no later than December 31 following the end of the fiscal year for which the County is reporting. The County may submit the Annual Innovative Project Report as part of the Three-Year Program and Expenditure Plan or Annual Update as long as the documents are submitted no later than December 31 pursuant to this subdivision.
    - (B) The County shall exclude from the Annual Innovative Project Report personally identifiable information as defined by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the Health Information Technology for Economic and Clinical Health Act (HITECH) and their implementing privacy and security regulations, the California Information Practices Act, and any other applicable state or federal privacy laws.
1. When the County has excluded information pursuant to subdivision (B) above, the County shall submit to the Mental Health Services Oversight and Accountability Commission one of the following:

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- a. A supplemental Annual Innovative Project Report that contains all of the information including the information that was excluded pursuant to subdivision (B). This supplemental report shall be marked "confidential".
  - b. A supplement to the Annual Innovative Project Report that contains the information that was excluded pursuant to subdivision (B). This supplement to the report shall be marked "confidential".
- (2) Upon completion of an Innovative Project, a Final Innovative Project Report as specified in Section 3580.020.
- (A) The County may submit the Final Innovative Project Report as part of the Three-Year Program and Expenditure Plan, Annual Update, or within six months from completion of the Innovative Project whichever is closest in time to the completion of the Innovative Project.
  - (B) The County shall exclude from the Final Innovative Project Report personally identifiable information as defined by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the Health Information Technology for Economic and Clinical Health Act (HITECH) and their implementing privacy and security regulations, the California Information Practices Act, and any other applicable state or federal privacy laws.
1. When the County has excluded information pursuant to subdivision (B) above, the County shall submit to the Mental Health Services Oversight and Accountability Commission one of the following:
- a. A supplemental Final Innovative Project Report that contains all of the information including the information that was excluded pursuant to subdivision (B). This supplemental report shall be marked "confidential".
  - b. A supplement to the Final Innovative Project Report that contains the information that was excluded pursuant to subdivision (B). This supplement to the report shall be marked "confidential".

NOTE: Authority cited: Section 5846, Welfare and Institutions Code. Reference: Sections 5830 and 5847, Welfare and Institutions Code.

**Adopt Section 3580.010 as follows:**

**Section 3580.010. Annual Innovative Project Report.**

**(a) The Annual Innovative Project Report shall include:**

- (1) Name of the Innovative Project
- (2) Whether and what changes were made to the Innovative Project during the reporting period and the reasons for the changes.
- (3) Available evaluation data, including outcomes of the Innovative Project and information about which elements of the Project are contributing to outcomes.
- (4) Program information collected during the reporting period, including for applicable Innovative Projects that serve individuals, number of participants served by:

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**(A) Age by the following categories:**

1. 0-15 (children/youth)
2. 16-25 (transition age youth)
3. 26-59 (adult)
4. ages 60+ (older adults)
5. Number of respondents who declined to answer the question

**(B) Race by the following categories:**

1. American Indian or Alaska Native
2. Asian
3. Black or African American
4. Native Hawaiian or other Pacific Islander
5. White
6. Other
7. More than one race
8. Number of respondents who declined to answer the question

**(C) Ethnicity by the following categories:**

1. Hispanic or Latino as follows
  - a. Caribbean
  - b. Central American
  - c. Mexican/Mexican-American/Chicano
  - d. Puerto Rican
  - e. South American
  - f. Other
  - g. Number of respondents who declined to answer the question
2. Non-Hispanic or Non-Latino as follows
  - a. African
  - b. Asian Indian/South Asian
  - c. Cambodian
  - d. Chinese
  - e. Eastern European
  - f. European
  - g. Filipino
  - h. Japanese
  - i. Korean
  - j. Middle Eastern
  - k. Vietnamese
  - l. Other
  - m. Number of respondents who declined to answer the question
3. More than one ethnicity
4. Number of respondents who declined to answer the question

**(D) Primary language used by threshold languages for the individual county**

**(E) Sexual orientation,**

1. Gay or Lesbian

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2. Heterosexual or Straight
  3. Bisexual
  4. Questioning or unsure of sexual orientation
  5. Queer
  6. Another sexual orientation
  7. Number of respondents who declined to answer the question
- (F) A Disability, defined as a physical or mental impairment or medical condition lasting at least six months that substantially limits a major life activity, which is not the result of a severe mental illness.
1. Yes, report the number that apply in each domain of disability(ies)
    - a. Communication domain separately by each of the following
      - (i) Difficulty seeing
      - (ii) Difficulty hearing, or having speech understood
      - (iii) Other (specify)
    - b. Mental domain not including a mental illness (including but not limited to a learning disability, developmental disability, dementia)
    - c. Physical/mobility domain
    - d. Chronic health condition (including but not limited to chronic pain)
    - e. Other (specify)
  2. No
  3. Number of respondents who declined to answer the question
- (G) Veteran status,
1. Yes
  2. No
  3. Number of respondents who declined to answer the question
- (H) Gender
1. Assigned sex at birth
    - a. Male
    - b. Female
    - c. Number of respondents who declined to answer the question
  2. Current gender identity
    - a. Male
    - b. Female
    - c. Transgender
    - d. Genderqueer
    - e. Questioning or unsure of gender identity
    - f. Another gender identity
    - g. Number of respondents who declined to answer the question
- (5) Any other data the County considers relevant.

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NOTE: Authority cited: Section 5846, Welfare and Institutions Code. Reference: Sections 5830, 5845(d)(6), and 5847, Welfare and Institutions Code.

**Adopt Section 3580.020 as follows:**

**Section 3580.020. Final Innovative Project Report.**

**(a) The Final Innovative Project Report shall include:**

- (1) Name of the Innovative Project
  - (2) Brief summary of the priority issue related to mental illness or to an aspect of the mental health service system for which the County chose to design and test the Innovative Project.
  - (3) Description of any changes that the County made to the Innovative Project during the course of its implementation and evaluation and the reasons for and impact of the changes, including any changes in the timeline.
  - (4) Program information collected during the reporting period as specified in Section 3580.010, subdivision (a)(4).
  - (5) Final evaluation results, including but not limited to:
    - (A) Description of the evaluation methodology;
    - (B) Outcomes of the Innovative Project including those related to the selected primary purpose, with a focus on whatever was new or changed compared to established mental health practices;
    - (C) Any variation in outcomes based on demographics of participants, if applicable;
    - (D) Assessment of which activities or elements of the Innovative Project contributed to successful outcomes;
    - (E) Explanation of how the evaluation was culturally competent;
    - (F) Explanation of how stakeholders contributed to the evaluation.
  - (6) Whether and how the County will continue the Innovative Project, the source of ongoing funding, if applicable, the reason for the decision, and how the County involved stakeholders in the decision.
  - (7) Whether the Innovative Project achieved its intended outcomes and a summary of what was learned.
  - (8) Description of how the County disseminated the results of the Innovative Project to stakeholders, and if applicable to other counties (e.g. as the County determined that the information would be of benefit to other counties).
  - (9) Any other data or information the County considers relevant.
- (b) The County shall include a copy of any presentations, reports, articles, manuals, CDs, DVDs, videos, or any other materials developed to communicate successful new or changed mental health practices, lessons learned and evaluation results of the Innovative Project.**

NOTE: Authority cited: Section 5846, Welfare and Institutions Code. Reference: Sections 5830, 5845(d)(6), and 5847, Welfare and Institutions Code.

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## Article 9. Innovation

### **Adopt Section 3900 as follows:**

#### **Section 3900. Rule of General Application.**

- (a) The use of Innovation Funds shall be governed by the provisions specified in this Article and Articles 1 through 5, unless otherwise specified.

NOTE: Authority cited: Section 5846, Welfare and Institutions Code. Reference: Sections 5830, and 5892(a)(6), Welfare and Institutions Code.

### **Adopt Section 3905 as follows:**

#### **Section 3905. Required Approval.**

- (a) The County shall expend Innovation Funds for a specific Innovative Project only after the Mental Health Services Oversight and Accountability Commission approves the funds for that Innovative Project.
- (b) The County shall expend Innovation Funds only to implement one or more Innovative Projects.

NOTE: Authority cited: Section 5846, Welfare and Institutions Code. Reference: Sections 5830(e), and 5892(a)(6), Welfare and Institutions Code.

### **Adopt Section 3910 as follows:**

#### **Section 3910. Innovative Project General Requirements.**

- (a) The County shall design and implement an Innovative Project to do one of the following:
- (1) Introduce a mental health practice or approach that is new to the overall mental health system, including, but not limited to, prevention and early intervention.
  - (2) Make a change to an existing practice in the field of mental health, including but not limited to, application to a different population.
  - (3) Apply to the mental health system a promising community-driven practice or approach that has been successful in non-mental health contexts or settings.
- (b) A mental health practice or approach that has already demonstrated its effectiveness is not eligible for funding as an Innovative Project unless the County provides documentation about how and why the County is adapting the practice or approach, consistent with subdivision (a)(2) above and with section 3930(c)(3). For example, the change can include specific adaptation(s) to respond to unique characteristics of the County or a community within the County such as an adaptation for a rural setting of a mental health practice that has demonstrated its effectiveness in an urban setting, or vice versa.
- (1) For purposes of this section, a mental health practice is deemed to have demonstrated its effectiveness if there is documentation in mental health literature of the effectiveness of the practice.

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- (A) “Mental health literature” refers to any report, published or online, including, but not limited to, peer-reviewed articles, nationally circulated (online or print) articles, reports of conference proceedings, program evaluation reports, and published training manuals.
- (c) Primary Purpose: The County shall select one of the following as its primary purpose for developing and evaluating the new or changed mental health practice referenced in subdivision (a) of this section.
- (1) Increase access to mental health services to underserved groups as defined in Title 9 California Code of Regulations, Section 3200.300.
  - (2) Increase the quality of mental health services, including measurable outcomes.
  - (3) Promote interagency and community collaboration related to mental health services or supports or outcomes.
  - (4) Increase access to mental health services.
- (d) Focus on Mental Health and Mental Illness: An Innovative Project may affect virtually any aspect of mental health practices or assess a new or changed application of a promising approach to solve persistent mental health challenges, including but not limited to, administrative, governance, and organizational practices, processes, or procedures; advocacy; education and training for services providers, including nontraditional mental health practitioners; outreach, capacity building, and community development; system development; public education efforts; research; services and interventions, including prevention, early intervention, and treatment.
- (1) “Persistent mental health challenge” means a priority issue related to mental illness or to an aspect of the mental health service system that the County, with meaningful stakeholder involvement, decides to address by designing and evaluating an applicable Innovative Project.
  - (2) The challenge addressed must be consistent with the selected primary purpose for Innovative Projects referenced in subdivision (c) of this section.

NOTE: Authority cited: Section 5846, Welfare and Institutions Code. Reference: Section 5830, Welfare and Institutions Code.

### Adopt Section 3910.010 as follows:

#### Section 3910.010. Time-Limited Pilot Project.

- (a) An Innovative Project shall have an end date that is not more than five years from the start date of the Innovative Project.
- (1) “Start date” means the date the County begins the implementation of the Innovative Project.
  - (2) “End date” means the date the County finalizes the decision whether to continue the Innovative Project.
- (b) The County designates the timeframe to complete the Innovative Project based on the complexity of the evaluation and the approach to be evaluated.
- (1) If, after the Innovative Project has been approved by the Mental Health Services Oversight and Accountability Commission, the County determines a need to extend the length of the Innovative Project, the County shall, within 30 days of the decision, notify the Mental Health

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Services Oversight and Accountability Commission of the new start date and/or end date of the Innovative Project. In no case shall the Innovative Project last longer than five years.

- (c) The County shall have a preliminary plan, from the outset, about how it will decide whether to continue an Innovative Project.
- (d) If applicable, the County shall have a plan about how to protect and provide continuity for individuals with serious mental illness who are receiving services from the Innovative Project at the conclusion of implementation with Innovation Funds.

NOTE: Authority cited: Section 5846, Welfare and Institutions Code. Reference: Section 5830(d), Welfare and Institutions Code.

### **Adopt Section 3910.015 as follows:**

#### **Section 3910.015. Continuation of an Innovative Project.**

- (a) After completion of the evaluation pursuant to section 3915 (i.e. when the evaluation questions are answered), the County, with meaningful involvement of stakeholders, shall decide whether and how Innovative Projects or elements of Innovative Projects, will be continued and incorporated into the local mental health delivery system and with what other funding sources, if funding is required.
- (b) An Innovative Project proven to be successful that the County, with meaningful stakeholder involvement, chooses to continue, in whole or in part, shall not be funded with Innovation Funds.
- (c) To continue a successful Innovative Project, the County shall transition the Project, or successful elements of the Project, if funding is required, to another category of funding. In some instances, the County may be able to incorporate successful practices demonstrated through an Innovative Project into existing mental health programs or services without the need for additional funds.

NOTE: Authority cited: Section 5846, Welfare and Institutions Code. Reference: Sections 5830(d) and 5848, Welfare and Institutions Code.

### **Adopt Section 3910.020 as follows:**

#### **Section 3910.020. Early Termination of an Innovative Project.**

- (a) The County, with meaningful involvement from stakeholders, may terminate an Innovative Project prior to the planned end date.
  - (1) The County shall notify stakeholders and the Mental Health Services Oversight and Accountability Commission within 30 days of the County's decision to terminate an Innovative Project prior to the planned end date, including the reasons for the decision.
    - (A) If the Innovative Project provides services for individuals with serious mental illness, the notification shall include a description of the steps the County took to protect and provide continuity of services for those individuals with serious mental illness who were being served.
  - (2) If applicable, the County, prior to terminating an Innovative Project, shall take all reasonably necessary steps to protect and provide continuity of services for individuals with serious mental illness.

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- (b) The County may, without involvement of stakeholders, terminate an Innovative Project prior to the planned end date, due to unforeseen legal, ethical or other risk-related reasons.
  - (1) The County shall inform stakeholders and the Mental Health Services Oversight Accountability Commission as soon as possible but in no case more than 30 days after the decision to terminate, including the reasons for the termination
    - (A) If the Innovative Project provides services to individuals with serious mental illness, the notification shall include a description of the steps the County took to protect and provide continuity of services for those individuals who were being served.

NOTE: Authority cited: Section 5846, Welfare and Institutions Code. Reference: Section 5848, Welfare and Institutions Code.

### **Adopt Section 3915 as follows:**

#### **Section 3915. Innovative Project Evaluation.**

- (a) The County shall design a method for evaluating the effectiveness and feasibility of the Innovative Project and shall conduct the evaluation according to the method designed.
- (b) The evaluation shall measure intended mental health outcomes selected by the County that are relevant to the risk of, manifestation of, and /or recovery from mental illness or to the improvement of the mental health system.
  - (1) The County shall select appropriate indicators to measure the intended mental health outcomes.
- (c) The evaluation shall include a measurement related to the selected primary purpose. For example, if the primary purpose is to increase access to mental health services, the evaluation must include a measurement of access.
- (d) The evaluation shall assess the impact of whatever element(s) of the Innovative Project are new and /or changed, compared to established practices in the field of mental health.
- (e) The evaluation shall use quantitative and/or qualitative evaluation methods to determine which elements of the Innovative Project contributed to successful outcomes in order to support data-driven decisions about incorporating new and/or revised mental health practices into the County's existing systems and services and disseminating successful practices.
- (f) The County shall collect and analyze necessary data to complete the evaluation.
- (g) The evaluation shall be culturally competent and must include meaningful involvement by diverse community stakeholders.

NOTE: Authority cited: Section 5846, Welfare and Institutions Code. Reference: Section 5830 and 5848, Welfare and Institutions Code; MHSA, uncodified Sections 2 and 3 of Proposition 63.

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## **Adopt Section 3925 as follows:**

### **Section 3925. Changed Innovative Project.**

- (a) If the County determines a need to change an Innovative Project that was approved by the Mental Health Services Oversight and Accountability Commission in one of the following ways, the County shall submit the Innovative Project Change Request pursuant to Section 3935 to the Mental Health Services Oversight and Accountability Commission and receive approval from the Mental Health Services Oversight and Accountability Commission before the change may be made.
- (1) Change the primary purpose.
  - (2) Change the basic practice or approach that the County is piloting and evaluating. Minor changes in how the approach is being implemented are expected and do not require prior approval from the Mental Health Services Oversight and Accountability Commission.
    - (A) Examples of minor changes that do not require submission of an Innovative Project Change Request and Commission approval include, but are not limited to, (a) changes in the design of the evaluation, including adding intended outcomes to be measured, (b) adding intended beneficiaries (e.g. population, demographics), (c) changing the methods to disseminate results of the Innovative Project, and (d) refining program methods based on interim evaluation results.
  - (3) Expend more Innovation Funds than previously approved.

NOTE: Authority cited: Section 5846, Welfare and Institutions Code. Reference: Section 5830, Welfare and Institutions Code.

## **Adopt Section 3930 as follows:**

### **Section 3930. Innovation Component of the Three-Year Program and Expenditure Plan and Annual Update.**

- (a) To request approval to use Innovation Funds for a specific Innovative Project, the County shall submit to the Mental Health Services Oversight and Accountability Commission an Innovative Project Plan for each new Innovative Project to be funded.
- (b) The Innovation Component of the Three-Year Program and Expenditure Plan or Annual Update shall include an Innovative Project Plan with the following general information for each new Innovative Project:
- (1) A description of how the County ensured that staff and stakeholders involved in the Community Program Planning process required by Title 9 California Code of Regulations, Section 3300 were informed about and understood the purpose and requirements of the Mental Health Services Act Innovation Component
  - (2) A description of the County's plan to involve community stakeholders meaningfully in all phases of Innovative Projects, including evaluation of the Innovative Project and decision-making regarding whether to continue the Innovative Project, or elements of the Project, without Innovation Funds.

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- (c) The Innovation Component of the Three-Year Program and Expenditure Plan or Annual Update shall include an Innovative Project Plan which shall include a description of the Innovative Project including but not limited to the following information:
- (1) Name of the Innovative Project
  - (2) The selected primary purpose as described in Section 3910, subdivision (c) and the reasons that this purpose is a priority for the County for which there is a need for the County to design, develop, pilot, and evaluate approaches not already demonstrated as successful within the mental health system.
  - (3) Whether and how the Innovative Project introduces a new mental health practice or approach; makes a change to an existing mental health practice that has not yet been demonstrated to be effective, including, but not limited to, adaptation for a new setting, population or community; or introduces a new application to the mental health system of a promising community-driven practice or an approach that has been successful in a non-mental health context or setting.
    - (A) The description shall include the key activities of the Innovative Project. Key activities are the activities the County plans to implement as part of the Innovative Project with the expectation that the activities will contribute to bringing about change and achieving the intended outcomes of the Innovative Project.
    - (B) The description shall address specifically how the Innovative Project is expected to contribute to the development and evaluation of a new or changed practice within the field of mental health.
  - (4) Description of the new or changed mental health approach the County will develop, pilot, and evaluate.
    - (A) Differentiate the elements that are new or changed from existing practices in the field of mental health already known to be effective.
    - (B) If applicable, describe the population to be served, including demographic information such as age, gender identity, race, ethnicity, sexual orientation, and language used if relevant to the specific Project.
    - (C) If applicable, describe the estimated number of clients expected to be served annually.
    - (D) Describe briefly, with specific examples, how the Innovative Project will reflect and be consistent with all relevant Mental Health Services Act General Standards set forth in Title 9 California Code of Regulations, Section 3320.
  - (5) Description of the method the County will use to evaluate the effectiveness of the Innovative Project including:
    - (A) Intended outcomes, including at least one outcome relevant to the selected primary purpose, and how those outcomes will be measured, including specific indicators for each intended outcome.
    - (B) Methods the County will use to assess the project elements that contributed to the outcomes.

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- (C) How the evaluation will assess the effectiveness of the element(s) of the Innovative Project that are new or changed compared to existing practice in mental health.
- (6) Description of how the County will decide whether and how to continue the Innovative Project, or elements of the Project, without Innovation Funds pursuant to the preliminary plan specified in section 3910.010(c).
- (7) If applicable, description of how the County plans to protect and provide continuity for individuals with serious mental illness who are receiving services from the Innovative Project after the end of implementation with Innovation Funds.
- (8) Specify the total length of the Innovative Project.
  - (A) Provide a brief explanation of how this time period will allow sufficient time for the development, time-limited implementation, evaluation, decision-making, and communication of results, including new effective practices and lessons learned.
  - (B) Include a timeline that specifies key milestones for development and refinement of the approach; ongoing assessment and final evaluation of the Innovative Project; decision-making, including meaningful involvement of stakeholders, about whether and how to continue a successful Innovative Project or parts of the project; and communication of the results and lessons learned with a focus of dissemination of successful Innovative Projects.
- (d) The Innovation Component of the Three-Year Program and Expenditure Plan or Annual Update shall include an Innovative Project Plan which shall include a budget which shall include but not be limited to the following information:
  - (1) The total Innovation Funds requested for each Innovative Project
  - (2) Estimated total mental health expenditures for the entire duration of each Innovative Project by fiscal year and the following funding sources:
    - (A) Innovation Funds
    - (B) Medi-Cal Federal Financial Participation
    - (C) 1991 Realignment
    - (D) Behavioral Health Subaccount
    - (E) Any other funding
  - (3) The County shall include a brief narrative to explain how the estimated total budget
    - (A) Is consistent with the time-limited, evaluation focus of the project
    - (B) Includes sufficient funds for the development, refinement, piloting, and evaluation; the decision-making process of determining whether to continue the Innovative Project without Innovation Funds; and dissemination of the Innovative Project results
  - (4) Estimated total mental health expenditures for evaluation for the entire duration of each Innovative Project by fiscal year and the following funding sources.
    - (A) Innovation Funds
    - (B) Medi-Cal Federal Financial Participation
    - (C) 1991 Realignment
    - (D) Behavioral Health Subaccount

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- (E) Any other funding
- (5) Estimated total mental health expenditures for the administration for the entire duration of each Innovative Project by fiscal year and the following sources of funding.
  - (A) Innovation Funds
  - (B) Medi-Cal Federal Financial Participation
  - (C) 1991 Realignment
  - (D) Behavioral Health Subaccount
  - (E) Any other funding
- (6) Total projected expenditures of Innovation Funds for each Innovative Project by fiscal year for
  - (A) Personnel expenditure, including salaries, wages and benefits
  - (B) Operating expenditure
  - (C) Non-recurring expenditures, such as cost of equipping new employees with technology necessary to perform MHSA duties to conduct the Innovative Project
  - (D) Training consultant contracts
  - (E) Other expenditures projected to be incurred on items not listed above and provide a justification for the expenditures
- (7) Document that the source of Innovation Funds is 5 percent of the County's PEI allocation and 5 percent of the CSS allocation.

NOTE: Authority cited: Section 5846, Welfare and Institutions Code. Reference: Sections 5830, 5845, and 5847, Welfare and Institutions Code.

### **Adopt Section 3935 as follows:**

#### **Section 3935. Innovative Project Change Request.**

- (a) If, after the Innovative Project has been approved by the Mental Health Services Oversight and Accountability Commission, the County determines the need to change the Innovative Project as described in 3925, the County shall submit a Change Request for approval by the Mental Health Services Oversight and Accountability Commission. The Change Request shall describe the change, the reasons for the change, and stakeholder involvement in the decision.
- (b) The County may submit the Innovative Project Change Request to the Mental Health Services Oversight and Accountability Commission as part of a Three-Year Program and Expenditure Plan, Annual Update, or as a separate request.
  - (1) If the County submits the Innovative Project Change Request as a separate request and not part of a Three-Year Program and Expenditure Plan or Annual Update, the County shall document how it complied with the community planning and the local review requirements in Title 9 California Code of Regulations sections 3300 and 3315.

NOTE: Authority cited: Section 5846, Welfare and Institutions Code. Reference: Sections 5830, 5845(d)(6), and 5847, Welfare and Institutions Code.

# **MENTAL HEALTH ACTION PLAN**

**2013 - 2020**



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## FOREWORD



Mental well-being is a fundamental component of WHO's definition of health. Good mental health enables people to realize their potential, cope with the normal stresses of life, work productively, and contribute to their communities.

Mental health matters, but the world has a long way to go to achieve it. Many unfortunate trends must be reversed—neglect of mental health services and care, and abuses of human rights and discrimination against people with mental disorders and psychosocial disabilities.

This comprehensive action plan recognizes the essential role of mental health in achieving health for all people. It is based on a life-course approach, aims to achieve equity through universal health coverage and stresses the importance of prevention.

Four major objectives are set forth: more effective leadership and governance for mental health; the provision of comprehensive, integrated mental health and social care services in community-based settings; implementation of strategies for promotion and prevention; and strengthened information systems, evidence and research.

Although the targets of this action plan are ambitious, WHO and its Member States are committed to fulfilling them.



**Dr Margaret Chan**

*Director-General*

*World Health Organization*

## SETTING THE SCENE

**01** In May 2012, the Sixty-fifth World Health Assembly adopted resolution WHA65.4 on the global burden of mental disorders and the need for a comprehensive, coordinated response from health and social sectors at the country level. It requested the Director-General, inter alia, to develop a comprehensive mental health action plan, in consultation with Member States, covering services, policies, legislation, plans, strategies and programmes.

**02** This comprehensive action plan has been elaborated through consultations with Member States, civil society and international partners. It takes a comprehensive and multisectoral approach, through coordinated services from the health and social sectors, with an emphasis on promotion, prevention, treatment, rehabilitation, care and recovery. It also sets out clear actions for Member States, the Secretariat and international, regional and national level partners, and proposes key indicators and targets that can be used to evaluate levels of implementation, progress and impact. The action plan has, at its core, the globally accepted principle that there is "no health without mental health".<sup>1</sup>

**03** The action plan has close conceptual and strategic links to other global action plans and strategies endorsed by the Health Assembly, including the global strategy to reduce the harmful use of alcohol, the global plan of action for workers' health, 2008–2017, the action plan for the global strategy for the prevention and control of noncommunicable diseases, 2008–2013, and the global action plan for the prevention and control of noncommunicable diseases (2013–2020). It also draws on WHO's regional action plans and strategies for mental health and substance abuse that have been adopted or are being developed. The action plan has been designed to create synergy with other relevant programmes of organizations in the United Nations system, United Nations interagency groups and intergovernmental organizations.

**04** The action plan builds upon, but does not duplicate, the work of WHO's mental health gap action programme (mhGAP). The focus of the latter was to expand services for mental health in low resource settings. The action plan is global in its scope and is designed to provide guidance for national action plans. It addresses, for all resource settings, the response of social and other relevant sectors, as well as promotion and prevention strategies.

**05** In this action plan, the term "mental disorders" is used to denote a range of mental and behavioural disorders that fall within the International Statistical Classification of Diseases and Related Health Problems, Tenth revision (ICD-10). These include disorders that cause a high burden of disease such as depression, bipolar affective disorder, schizophrenia, anxiety disorders, dementia, substance use disorders, intellectual disabilities, and developmental and behavioural disorders with onset usually occurring in childhood and adolescence, including autism. For dementia and substance use disorders, additional prevention strategies may also be required (as described, for example, in a WHO report on dementia issued in early 2012<sup>2</sup> and in the global strategy to reduce the harmful use of alcohol). Furthermore, the plan covers suicide prevention and many of the actions are also relevant to conditions such as epilepsy. The term "vulnerable groups" is used in the action plan to refer to individuals or groups of individuals who are made vulnerable by the situations and environments that they are exposed to (as opposed to any inherent weakness or lack of capacity). The term "vulnerable groups" should be applied within countries as appropriate to the national situation.

**06** The action plan also covers mental health, which is conceptualized as a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community. With respect to children, an emphasis is placed on the developmental aspects, for instance, having a positive sense of identity, the ability to manage thoughts, emotions, as well as to build social relationships, and the aptitude to learn and to acquire an education, ultimately enabling their full active participation in society.

<sup>1</sup> Annex II provides a glossary of main terms, links to other global action plans, strategies and programmes, international and regional human rights treaties, and selected WHO technical materials and resources on mental health.

<sup>2</sup> Alzheimer's Disease International. *Dementia: a public health problem*. Geneva, World Health Organization, 2012.

07 In the light of widespread human rights violations and discrimination experienced by people with mental disorders, a human rights perspective is essential in responding to the global burden of mental disorders. The action plan emphasizes the need for services, policies, legislation, plans, strategies and programmes to protect, promote and respect the rights of persons with mental disorders in line with the International Covenant on Civil and Political Rights, the International Covenant on Economic, Social and Cultural Rights, the Convention on the Rights of Persons with Disabilities, the Convention on the Rights of the Child and other relevant international and regional human rights instruments.

## OVERVIEW OF THE GLOBAL SITUATION

08 Mental health is an integral part of health and well-being, as reflected in the definition of health in the Constitution of the World Health Organization: "Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity." Mental health, like other aspects of health, can be affected by a range of socioeconomic factors (described below) that need to be addressed through comprehensive strategies for promotion, prevention, treatment and recovery in a whole-of-government approach.

### Mental health and disorders: determinants and consequences

09 Determinants of mental health and mental disorders include not only individual attributes such as the ability to manage one's thoughts, emotions, behaviours and interactions with others, but also social, cultural, economic, political and environmental factors such as national policies, social protection, living standards, working conditions, and community social supports. Exposure to adversity at a young age is an established preventable risk factor for mental disorders.

10 Depending on the local context, certain individuals and groups in society may be placed at a significantly higher risk of experiencing mental health problems. These vulnerable groups may (but do not necessarily) include members of households living in poverty, people with chronic health conditions, infants and children exposed to maltreatment and neglect, adolescents first exposed to substance use, minority groups, indigenous populations, older people, people experiencing discrimination and human rights violations, lesbian, gay, bisexual, and transgender persons, prisoners, and people exposed to conflict, natural disasters or other humanitarian emergencies. The current global financial crisis provides a powerful example of a macroeconomic factor leading to cuts in funding despite a concomitant need for more mental health and social services because of higher rates of mental disorders and suicide as well as the emergence of new vulnerable groups (for example, the young unemployed). In many societies, mental disorders related to marginalization and impoverishment, domestic violence and abuse, and overwork and stress are of growing concern, especially for women's health.

11 People with mental disorders experience disproportionately higher rates of disability and mortality. For example, persons with major depression and schizophrenia have a 40% to 60% greater chance of dying prematurely than the general population, owing to physical health problems that are often left unattended (such as cancers, cardiovascular diseases, diabetes and HIV infection) and suicide. Suicide is the second most common cause of death among young people worldwide.

12 Mental disorders often affect, and are affected by, other diseases such as cancer, cardiovascular disease and HIV infection/AIDS, and as such require common services and resource mobilization efforts. For example, there is evidence that depression predisposes people to myocardial infarction and diabetes, both of which conversely increase the likelihood of depression. Many risk factors such as low socioeconomic status, alcohol use and stress are common to both mental disorders and other noncommunicable diseases. There is also substantial concurrence of mental disorders and substance use disorders. Taken together, mental, neurological and substance use disorders exact a high toll, accounting for 13% of the total global burden

of disease in the year 2004. Depression alone accounts for 4.3% of the global burden of disease and is among the largest single causes of disability worldwide (11% of all years lived with disability globally), particularly for women. The economic consequences of these health losses are equally large: a recent study estimated that the cumulative global impact of mental disorders in terms of lost economic output will amount to US\$ 16.3 million million between 2011 and 2030.<sup>3</sup>

**13** Mental disorders frequently lead individuals and families into poverty.<sup>4</sup> Homelessness and inappropriate incarceration are far more common for people with mental disorders than for the general population, and exacerbate their marginalization and vulnerability. Because of stigmatization and discrimination, persons with mental disorders often have their human rights violated and many are denied economic, social and cultural rights, with restrictions on the rights to work and education, as well as reproductive rights and the right to the highest attainable standard of health. They may also be subject to unhygienic and inhuman living conditions, physical and sexual abuse, neglect, and harmful and degrading treatment practices in health facilities. They are often denied civil and political rights such as the right to marry and found a family, personal liberty, the right to vote and to participate effectively and fully in public life, and the right to exercise their legal capacity on other issues affecting them, including their treatment and care. As such, persons with mental disorders often live in vulnerable situations and may be excluded and marginalized from society, which constitutes a significant impediment to the achievement of national and international development goals. The Convention on the Rights of Persons with Disabilities, which is binding on States Parties that have ratified or acceded to it, protects and promotes the rights of all persons with disabilities, including persons with mental and intellectual impairments, and also promotes their full inclusion in international cooperation including international development programmes.

## Health system resources and responses

**14** Health systems have not yet adequately responded to the burden of mental disorders; as a consequence, the gap between the need for treatment and its provision is large all over the world. Between 76% and 85% of people with severe mental disorders receive no treatment for their disorder in low-income and middle-income countries; the corresponding range for high-income countries is also high: between 35% and 50%. A further compounding problem is the poor quality of care for those receiving treatment. WHO's Mental Health Atlas 2011 provides data that demonstrate the scarcity of resources within countries to meet mental health needs, and underlines the inequitable distribution and inefficient use of such resources. Globally, for instance, annual spending on mental health is less than US\$ 2 per person and less than US\$ 0.25 per person in low-income countries, with 67% of these financial resources allocated to stand-alone mental hospitals, despite their association with poor health outcomes and human rights violations. Redirecting this funding towards community-based services, including the integration of mental health into general health care settings, and through maternal, sexual, reproductive and child health, HIV/AIDS and chronic noncommunicable disease programmes, would allow access to better and more cost-effective interventions for many more people.

**15** The number of specialized and general health workers dealing with mental health in low-income and middle-income countries is grossly insufficient. Almost half the world's population lives in countries where, on average, there is one psychiatrist to serve 200 000 or more people; other mental health care providers who are trained in the use of psychosocial interventions are even scarcer. Similarly, a much higher proportion of high-income countries than low-income countries reports having a policy, plan and legislation on mental health; for instance, only 36% of people living in low income countries are covered by mental health legislation compared with 92% in high-income countries.

<sup>3</sup> *World Economic Forum, the Harvard School of Public Health. The global economic burden of non-communicable diseases. Geneva, World Economic Forum, 2011.*

<sup>4</sup> *Mental health and development. Targeting people with mental health conditions as a vulnerable group. Geneva, World Health Organization, 2010.*

**16** Civil society movements for mental health in low-income and middle-income countries are not well developed. Organizations of people with mental disorders and psychosocial disabilities are present in only 49% of low-income countries compared with 83% of high-income countries; for family associations the respective figures are 39% and 80%.

**17** Finally, the availability of basic medicines for mental disorders in primary health care is notably low (in comparison to medicines available for infectious diseases and even other noncommunicable diseases), and their use restricted because of the lack of qualified health workers with the appropriate authority to prescribe medications. In addition, the availability of non-pharmacological approaches and trained personnel to deliver these interventions is also lacking. Such factors act as important barriers to appropriate care for many persons with mental disorders.

**18** To improve the situation, and in addition to the data on mental health resources in countries (from WHO's Mental Health Atlas 2011, as well as the more detailed profiling obtained through use of WHO's assessment instrument for mental health systems),<sup>5</sup> information is available on cost-effective and feasible mental health interventions that can be expanded to a larger scale to strengthen mental health care systems in countries. WHO's Mental Health Gap Action Programme, launched in 2008, uses evidence-based technical guidance, tools and training packages to expand service provision in countries, especially in resource-poor settings. It focuses on a prioritized set of conditions and, importantly, directs its capacity building towards non-specialized health care providers in an integrated approach that promotes mental health at all levels of care.

**19** The Secretariat has elaborated other technical tools and guidance in support of countries in developing comprehensive mental health policies, plans and laws that promote improved quality and availability of mental health care (such as the WHO mental health policy and service guidance package),<sup>6</sup> in improving quality and respecting the rights of persons with mental disorders in health services (the WHO QualityRights toolkit),<sup>7</sup> and for disaster relief and post-disaster mental health system reconstruction (including the Inter-Agency Standing Committee Guidelines in mental health and psychosocial support in emergency settings).<sup>8</sup> Knowledge, information and technical tools are necessary but not sufficient; strong leadership, enhanced partnerships and the commitment of resources towards implementation are also required in order to move decisively from evidence to action and evaluation.

## STRUCTURE OF THE COMPREHENSIVE ACTION PLAN 2013–2020

**20** The vision of the action plan is a world in which mental health is valued, promoted and protected, mental disorders are prevented and persons affected by these disorders are able to exercise the full range of human rights and to access high quality, culturally-appropriate health and social care in a timely way to promote recovery, in order to attain the highest possible level of health and participate fully in society and at work, free from stigmatization and discrimination.

**21** Its overall **goal** is to promote mental well-being, prevent mental disorders, provide care, enhance recovery, promote human rights and reduce the mortality, morbidity and disability for persons with mental disorders.

<sup>5</sup> WHO-AIMS version 2.2: World Health Organization assessment instrument for mental health systems, Geneva, World Health Organization, 2005 (document WHO/MSD/MER/05.2).

<sup>6</sup> <http://www.who.int/mentalhealth/policy/package/> (accessed 24 May 2013)

<sup>7</sup> WHO QualityRights tool kit: assessing and improving quality and human rights in mental health and social care facilities. Geneva, World Health Organization, 2012

<sup>8</sup> Inter-Agency Standing Committee: IASC guidelines on mental health and psychosocial support in emergency settings. Geneva, Inter-Agency Standing Committee, 2007.

22 The action plan has the following **objectives**:

1. to strengthen effective leadership and governance for mental health;
2. to provide comprehensive, integrated and responsive mental health and social care services in community-based settings;
3. to implement strategies for promotion and prevention in mental health;
4. to strengthen information systems, evidence and research for mental health.

The global targets established for each objective provide the basis for measurable collective action and achievement by Member States towards global goals and should not negate the setting of more ambitious national targets, particularly for those countries that have already reached global ones. Indicators for measuring progress towards defined global targets are provided in Appendix 1.

23 The action plan relies on six **cross-cutting principles and approaches**:

1. **Universal health coverage:** Regardless of age, sex, socioeconomic status, race, ethnicity or sexual orientation, and following the principle of equity, persons with mental disorders should be able to access, without the risk of impoverishing themselves, essential health and social services that enable them to achieve recovery and the highest attainable standard of health.
2. **Human rights:** Mental health strategies, actions and interventions for treatment, prevention and promotion must be compliant with the Convention on the Rights of Persons with Disabilities and other international and regional human rights instruments.
3. **Evidence-based practice:** Mental health strategies and interventions for treatment, prevention and promotion need to be based on scientific evidence and/or best practice, taking cultural considerations into account.
4. **Life course approach:** Policies, plans and services for mental health need to take account of health and social needs at all stages of the life course, including infancy, childhood, adolescence, adulthood and older age.
5. **Multisectoral approach:** A comprehensive and coordinated response for mental health requires partnership with multiple public sectors such as health, education, employment, judicial, housing, social and other relevant sectors as well as the private sector, as appropriate to the country situation.
6. **Empowerment of persons with mental disorders and psychosocial disabilities:** Persons with mental disorders and psychosocial disabilities should be empowered and involved in mental health advocacy, policy, planning, legislation, service provision, monitoring, research and evaluation.

24 The framework provided in this action plan needs to be adapted at regional level in order to take into account region-specific situations. The actions proposed for Member States are to be considered and adapted, as appropriate, to national priorities and specific national circumstances in order to accomplish the objectives. There is no blueprint action plan that fits all countries, as countries are at different stages in developing and implementing a comprehensive response in the area of mental health.

## PROPOSED ACTIONS FOR MEMBER STATES AND INTERNATIONAL AND NATIONAL PARTNERS AND ACTIONS FOR THE SECRETARIAT

25 To achieve the plan's stated vision, goal and objectives, specific actions are proposed for Member States and for international and national partners. In addition, actions for the Secretariat have been identified. Although actions are specified separately for each objective, many of these will also contribute to the attainment of the other objectives of the action plan. Some possible options to implement these actions are proposed in Appendix 2.

26 Effective implementation of the global mental health action plan will require actions by international, regional and national partners. These partners include but are not limited to:

- development agencies including international multilateral agencies (for example, the World Bank and United Nations development agencies), regional agencies (for example, regional development banks), subregional intergovernmental agencies and bilateral development aid agencies;
- academic and research institutions including the network of WHO collaborating centres for mental health, human rights and social determinants of health and other related networks, within developing and developed countries;
- civil society, including organizations of persons with mental disorders and psychosocial disabilities, service-user and other similar associations and organizations, family member and carer associations, mental health and other related nongovernmental organizations, community-based organizations, human rights-based organizations, faith-based organizations, development and mental health networks and associations of health care professionals and service providers.

27 The roles of these three groups are often overlapping and can include multiple actions across the areas of governance, health and social care services, promotion and prevention in mental health, and information, evidence and research (see actions listed below). Country-based assessments of the needs and capacity of different partners will be essential to clarify the roles and actions of key stakeholder groups.

### ***Objective 1: To strengthen effective leadership and governance for mental health***

28 Planning, organizing and financing health systems is a complex undertaking involving multiple stakeholders and different administrative levels. As the ultimate guardian of a population's mental health, governments have the lead responsibility to put in place appropriate institutional, legal, financing and service arrangements to ensure that needs are met and the mental health of the whole population is promoted.

29 Governance is not just about government, but extends to its relationship with nongovernmental organizations and civil society. A strong civil society, particularly organizations of people with mental disorders and psychosocial disabilities and families and carers, can help to create more effective and accountable policies, laws and services for mental health in a manner consistent with international and regional human rights instruments.

30 Among the key factors for developing effective policies and plans addressing mental health are strong leadership and commitment by governments, involvement of relevant stakeholders, clear elaboration of areas for action, formulation of financially-informed and evidence-based actions, explicit attention to equity, respect for the inherent dignity and human rights of people with mental disorders and psychosocial disabilities, and the protection of vulnerable and marginalized groups.

**31** Responses will be stronger and more effective when mental health interventions are firmly integrated within the national health policy and plan. In addition, often it is necessary to develop a dedicated mental health policy and plan in order to provide more detailed direction.

**32** Mental health law, whether an independent legislative document or integrated into other health and capacity-related laws, should codify the key principles, values and objectives of policy for mental health, for example by establishing legal and oversight mechanisms to promote human rights and the development of accessible health and social services in the community.

**33** Policies, plans and laws for mental health should comply with obligations under the Convention on the Rights of Persons with Disabilities and other international and regional human rights conventions.

**34** The inclusion and mainstreaming of mental health issues more explicitly within other priority health programmes and partnerships (for instance, HIV/AIDS, women's and children's health, noncommunicable diseases and the global health workforce alliance), as well as within other relevant sectors' policies and laws, for example, those dealing with education, employment, disability, the judicial system, human rights protection, social protection, poverty reduction and development, are important means of meeting the multidimensional requirements of mental health systems and should remain central to leadership efforts of governments to improve treatment services, prevent mental disorders and promote mental health.

*Global target 1.1: 80% of countries will have developed or updated their policies/plans for mental health in line with international and regional human rights instruments [by the year 2020].*

*Global target 1.2: 50% of countries will have developed or updated their laws for mental health in line with international and regional human rights instruments [by the year 2020].*

## Proposed actions for Member States

**35 Policy and law:** Develop, strengthen, keep up to date and implement national policies, strategies, programmes, laws and regulations relating to mental health within all relevant sectors, including codes of practice and mechanisms to monitor protection of human rights and implementation of legislation, in line with evidence, best practice, the Convention on the Rights of Persons with Disabilities and other international and regional human rights instruments.

**36 Resource planning:** Plan according to measured need and allocate a budget across all relevant sectors that is commensurate with identified human and other resources required to implement agreed-upon evidence-based mental health plans and actions.

**37 Stakeholder collaboration:** Motivate and engage stakeholders from all relevant sectors, including persons with mental disorders, carers and family members, in the development and implementation of policies, laws and services relating to mental health, through a formalized structure and/or mechanism.

**38 Strengthening and empowerment of people with mental disorders and psychosocial disabilities and their organizations:** Ensure that people with mental disorders and psychosocial disabilities are given a formal role and authority to influence the process of designing, planning and implementing policies, laws and services.

## Actions for the Secretariat

**39 Policy and law:** Compile knowledge and best practices for – and build capacity in – the development, multisectoral implementation and evaluation of policies, plans and laws relevant to mental health, including codes of practice and mechanisms to monitor protection of human rights and implementation of legislation, in line with the Convention on the Rights of Persons with Disabilities and other international and regional human rights instruments.

**40 Resource planning:** Offer technical support to countries in multisectoral resource planning, budgeting and expenditure tracking for mental health.

**41 Stakeholder collaboration:** Provide best practices and tools to strengthen collaboration and interaction at international, regional and national levels between the stakeholders in the development, implementation and evaluation of policy, strategies, programmes and laws for mental health, including the health, judicial and social sectors, civil society groups, persons with mental disorders and psychosocial disabilities, carers and family members, and organizations in the United Nations system and human rights agencies.

**42 Strengthening and empowerment of people with mental disorders and psychosocial disabilities and their organizations:** Engage organizations of people with mental disorders and psychosocial disabilities in policy making at international, regional and national levels within WHO's own structures and provide support to organizations to design technical tools for capacity building, based on international and regional human rights instruments and WHO's own human rights and mental health tools.

## Proposed actions for international and national partners

**43** Mainstream mental health interventions into health, poverty reduction, development policies, strategies and interventions.

**44** Include people with mental disorders as a vulnerable and marginalized group requiring prioritized attention and engagement within development and poverty-reduction strategies, for example, in education, employment and livelihood programmes, and the human rights agenda.

**45** Explicitly include mental health within general and priority health policies, plans and research agenda, including noncommunicable diseases, HIV/AIDS, women's health, child and adolescent health, as well as through horizontal programmes and partnerships, such as the Global Health Workforce Alliance, and other international and regional partnerships.

**46** Support opportunities for exchange between countries on effective policy, legislative and intervention strategies for promoting mental health, preventing mental disorders and promoting recovery from disorders based on the international and regional human rights framework.

**47** Support the creation and strengthening of associations and organizations of people with mental disorders and psychosocial disabilities as well as families and carers, and their integration into existing disability organizations, and facilitate dialogue between these groups, health workers and government authorities in health, human rights, disability, education, employment, the judiciary and social sectors.

**Objective 2: To provide comprehensive, integrated and responsive mental health and social care services in community-based settings**

48 In the context of improving access to care and service quality, WHO recommends the development of comprehensive community-based mental health and social care services; the integration of mental health care and treatment into general hospitals and primary care; continuity of care between different providers and levels of the health system; effective collaboration between formal and informal care providers; and the promotion of self-care, for instance, through the use of electronic and mobile health technologies.

49 Developing mental health services of good quality requires the use of evidence-based protocols and practices, including early intervention, incorporation of human rights principles, respect for individual autonomy and the protection of people's dignity. Furthermore, health workers must not limit intervention to improving mental health but also attend to the physical health care needs of children, adolescents and adults with mental disorders, and vice versa, because of the high rates of co morbid physical and mental health problems and associated risk factors, for example, high rates of tobacco consumption, that go unaddressed.

50 Community-based service delivery for mental health needs to encompass a recovery-based approach that puts the emphasis on supporting individuals with mental disorders and psychosocial disabilities to achieve their own aspirations and goals. The core service requirements include: listening and responding to individuals' understanding of their condition and what helps them to recover; working with people as equal partners in their care; offering choice of treatment and therapies, and in terms of who provides care; and the use of peer workers and supports, who provide each other with encouragement and a sense of belonging, in addition to their expertise. In addition, a multisectoral approach is required whereby services support individuals, at different stages of the life course and, as appropriate, facilitate their access to human rights such as employment (including return-to-work programmes), housing and educational opportunities, and participation in community activities, programmes and meaningful activities.

51 More active involvement and support of service users in the reorganization, delivery and evaluation and monitoring of services is required so that care and treatment become more responsive to their needs. Greater collaboration with "informal" mental health care providers, including families, as well as religious leaders, faith healers, traditional healers, school teachers, police officers and local nongovernmental organizations, is also needed.

52 Another essential requirement is for services to be responsive to the needs of vulnerable and marginalized groups in society, including socioeconomically disadvantaged families, people living with HIV/AIDS, women and children living with domestic violence, survivors of violence, lesbian, gay, bisexual and transgendered people, indigenous peoples, immigrants, asylum seekers, persons deprived of liberty, and minority groups among others within the national context.

53 When planning for humanitarian emergency response and recovery, it is crucial to ensure that mental health services and community psychosocial supports are widely available.

54 Exposure to adverse life events or extreme stressors, such as natural disasters, isolated, repeated or continuing conflict and civil unrest or ongoing family and domestic violence, may have serious health and mental health consequences that require careful examination, particularly with regard to issues of diagnostic characterization (especially avoiding over-diagnosis and over-medicalization) and approaches to support, care and rehabilitation.

55 Having the right number and equitable distribution of competent, sensitive and appropriately skilled health professionals

and workers is central to the expansion of services for mental health and the achievement of better outcomes. Integrating mental health into general health, disease-specific and social care services and programmes (such as those on women's health and HIV/AIDS) provides an important opportunity to manage mental health problems better, promote mental health and prevent mental disorders. For example, health workers trained in mental health should be equipped not only to manage mental disorders in the persons they see, but also to provide general wellness information and screening for related health conditions, including noncommunicable diseases and substance use. Not only does service integration require the acquisition of new knowledge and skills to identify, manage and refer people with mental disorders as appropriate, but also the re-definition of health workers' roles and changes to the existing service culture and attitudes of general health workers, social workers, occupational therapists and other professional groups. Furthermore, in this context, the role of specialized mental health professionals needs to be expanded to encompass supervision and support of general health workers in providing mental health interventions.

*Global target 2: Service coverage for severe mental disorders will have increased by 20% [by the year 2020]*

## Proposed actions for Member States

**56 *Service reorganization and expanded coverage:*** Systematically shift the locus of care away from long-stay mental hospitals towards non-specialized health settings with increasing coverage of evidence-based interventions (including the use of stepped care principles, as appropriate) for priority conditions and using a network of linked community-based mental health services, including short-stay inpatient care, and outpatient care in general hospitals, primary care, comprehensive mental health centres, day care centres, support of people with mental disorders living with their families, and supported housing.

**57 *Integrated and responsive care:*** Integrate and coordinate holistic prevention, promotion, rehabilitation, care and support that aims at meeting both mental and physical health care needs and facilitates the recovery of persons of all ages with mental disorders within and across general health and social services (including the promotion of the right to employment, housing, and education) through service user-driven treatment and recovery plans and, where appropriate, with the inputs of families and carers.

**58 *Mental health in humanitarian emergencies (including isolated, repeated or continuing conflict, violence and disasters):*** Work with national emergency committees and mental health providers in order to include mental health and psychosocial support needs in emergency preparedness and enable access to safe and supportive services, including services that address psychological trauma and promote recovery and resilience, for persons with mental disorders (pre existing as well as emergency-induced) or psychosocial problems, including services for health and humanitarian workers, during and following emergencies, with due attention to the longer-term funding required to build or rebuild a community-based mental health system after the emergency.

**59 *Human resource development:*** Build the knowledge and skills of general and specialized health workers to deliver evidence-based, culturally appropriate and human rights-oriented mental health and social care services, for children and adolescents, inter alia, by introducing mental health into undergraduate and graduate curricula; and through training and mentoring health workers in the field, particularly in non-specialized settings, in order to identify people with mental disorders and offer appropriate treatment and support as well as to refer people, as appropriate, to other levels of care.

**60 *Address disparities:*** Proactively identify and provide appropriate support for groups at particular risk of mental illness who have poor access to services.

## Actions for the Secretariat

**61 Service reorganization and expanded coverage:** Provide guidance and evidence-based practices for deinstitutionalization and service reorganization, and provide technical support for expanding treatment and support, prevention and mental health promotion through recovery-oriented community-based mental health and social support services.

**62 Integrated and responsive care:** Collate and disseminate evidence and best practices for the integration and multisectoral coordination of holistic care, emphasizing recovery and support needs for persons with mental disorders, including alternatives to coercive practices and strategies to engage service users, families and carers in service planning and treatment decisions, and provide examples of financing mechanisms to facilitate multisectoral collaboration.

**63 Mental health in humanitarian emergencies (including isolated, repeated or continuing conflict, violence, and disasters):** Provide technical advice and guidance for policy and field activities related to mental health undertaken by governmental, nongovernmental and intergovernmental organizations, including the building or rebuilding after an emergency of a community-based mental health system that is sensitive to trauma-related issues.

**64 Human resource development:** Support countries in the formulation of a human resource strategy for mental health, including the identification of gaps, specification of needs, training requirements and core competencies for health workers in the field, as well as for undergraduate and graduate educational curricula.

**65 Address disparities:** Collect and disseminate evidence and best practices for reducing mental health and social service gaps for marginalized groups.

## Proposed actions for international and national partners

**66** Use funds received for direct service delivery to provide community-based mental health care rather than institutional care.

**67** Assist the training of health workers in skills to identify mental disorders and provide evidence-based and culturally-appropriate interventions to promote the recovery of people with mental disorders.

**68** Support coordinated efforts to implement mental health programmes during and after humanitarian emergency situations, including the training and capacity building of health and social service workers.

### **Objective 3: To implement strategies for promotion and prevention in mental health**

**69** In the context of national efforts to develop and implement health policies and programmes, it is vital to meet not only the needs of persons with defined mental disorders, but also to protect and promote the mental well-being of all citizens. Mental health evolves throughout the life-cycle. Therefore, governments have an important role in using information on risk and protective factors for mental health to put in place actions to prevent mental disorders and to protect and promote mental health at all stages of life. The early stages of life present a particularly important opportunity to promote mental health and prevent mental disorders, as up to 50% of mental disorders in adults begin before the age of 14 years. Children and adolescents with mental disorders should be provided with early intervention through evidence-based psychosocial and other non-pharmacological interventions based in the community, avoiding institutionalization and medicalization. Furthermore, interventions should respect the rights of children in line with the United Nations Convention on the Rights of the Child and other international and regional human rights instruments.

**70** Responsibility for promoting mental health and preventing mental disorders extends across all sectors and all government departments. This is because poor mental health is strongly influenced by a range of social and economic determinants including income level, employment status, education level, material standard of living, physical health status, family cohesion, discrimination, violations of human rights and exposure to adverse life events, including sexual violence, child abuse and neglect. Mental health needs of children and adolescents who are exposed to natural disasters or civil conflict and unrest, including those who have been associated with armed forces or armed groups, are very high and require special attention.

**71** Broad strategies for mental health promotion and the prevention of mental disorders across the life course may focus on: antidiscrimination laws and information campaigns that redress the stigmatization and human rights violations all too commonly associated with mental disorders; promotion of the rights, opportunities and care of individuals with mental disorders; the nurturing of core individual attributes in the formative stages of life (such as early childhood programmes, life skills and sexuality education, programmes to support the development of safe, stable and nurturing relationships between children, their parents and carers); early intervention through identification, prevention and treatment of emotional or behavioural problems, especially in childhood and adolescence; provision of healthy living and working conditions (including work organizational improvements and evidence-based stress management schemes in the public as well as the private sector); protection programmes or community protection networks that tackle child abuse as well as other violence at domestic and community levels and social protection for the poor.<sup>9</sup>

**72** Suicide prevention is an important priority. Many people who attempt suicide come from vulnerable and marginalized groups. Moreover, young people and the elderly are among the most susceptible age groups to suicidal ideation and self-harm. Suicide rates tend to be underreported owing to weak surveillance systems, a misattribution of suicide to accidental deaths, as well as its criminalization in some countries. Nevertheless, most countries are showing either a stable or an increasing trend in the rate of suicide, while several others are showing long-term decreasing trends. As there are many risk factors associated with suicide beyond mental disorder, such as chronic pain or acute emotional distress, actions to prevent suicide must not only come from the health sector, but also from other sectors simultaneously. Reducing access to means to cause self-harm or commit suicide (including firearms, pesticides and availability of toxic medicines that can be used in overdoses), responsible reporting by the media, protecting persons at high risk of suicide, and early identification and management of mental disorder and of suicidal behaviours can be effective.

*Global target 3.1: 80% of countries will have at least two functioning national, multisectoral promotion and prevention programmes in mental health (by the year 2020).*

*Global target 3.2: The rate of suicide in countries will be reduced by 10% (by the year 2020).*

## Proposed actions for Member States

**73 Mental health promotion and prevention:** Lead and coordinate a multisectoral strategy that combines universal and targeted interventions for: promoting mental health and preventing mental disorders; reducing stigmatization, discrimination and human rights violations; and which is responsive to specific vulnerable groups across the lifespan and integrated within the national mental health and health promotion strategies.

**74 Suicide prevention:** Develop and implement comprehensive national strategies for the prevention of suicide, with special attention to groups identified as at increased risk of suicide, including lesbian, gay, bisexual and transgender persons, youth and other vulnerable groups of all ages based on local context.

<sup>9</sup> See *Risks to mental health: an overview of vulnerabilities and risk factors. Background paper by WHO Secretariat for the development of a comprehensive mental health action plan.*

## Actions for the Secretariat

**75 *Mental health promotion and prevention:*** Provide technical support to countries on the selection, formulation and implementation of evidence-based and cost-effective best practices for promoting mental health, preventing mental disorders, reducing stigmatization and discrimination, and promoting human rights across the lifespan.

**76 *Suicide prevention:*** Provide technical support to countries in strengthening their suicide prevention programmes with special attention to groups identified as at increased risk of suicide.

## Proposed actions for international and national partners

**77** Engage all stakeholders in advocacy to raise awareness of the magnitude of burden of disease associated with mental disorders and the availability of effective intervention strategies for the promotion of mental health, prevention of mental disorders and treatment, care and recovery of persons with mental disorders.

**78** Advocate the rights of persons with mental disorders and psychosocial disabilities to receive government disability benefits, gain access to housing and livelihood programmes, and, more broadly, to participate in work and community life and civic affairs.

**79** Ensure that people with mental disorders and psychosocial disabilities are included in activities of the wider disability community, for example, when advocating for human rights and in processes for reporting on the implementation of the Convention on the Rights of Persons with Disabilities and other international and regional human rights conventions.

**80** Introduce actions to combat stigmatization, discrimination and other human rights violations towards people with mental disorders and psychosocial disabilities.

**81** Be partners in the development and implementation of all relevant programmes for mental health promotion and prevention of mental disorders.

## ***Objective 4: To strengthen information systems, evidence and research for mental health***

**82** Information, evidence and research are critical ingredients for appropriate mental health policy, planning and evaluation. The generation of new knowledge through research enables policies and actions to be based on evidence and best practice, and the availability of timely and relevant information or surveillance frameworks enables implemented actions to be monitored and improvements in service provision to be detected. Currently, the research imbalance whereby most research is conducted in and by high-income countries needs to be corrected in order to ensure that low-income and middle-income countries have culturally appropriate and cost-effective strategies to respond to mental health needs and priorities.

**83** Although summary mental health profiles are available through periodic assessments such as WHO's Project ATLAS, routine information systems for mental health in most low-income and middle-income countries are rudimentary or absent, making it difficult to understand the needs of local populations and to plan accordingly.

**84** Crucial information and indicators that are needed for the mental health system include: the extent of the problem (the prevalence of mental disorders and identification of major risk factors and protective factors for mental health and well-being); coverage of policies and legislation, interventions and services (including the gap between the number of people who have a mental disorder and those who receive treatment and a range of appropriate services, such as social services); health outcome

data (including suicide and premature mortality rates at the population level as well as individual- or group-level improvements related to clinical symptoms, levels of disability, overall functioning and quality of life) and social and economic outcome data (including relative levels of educational achievement, housing, employment and income among persons with mental disorders). These data need to be disaggregated by sex and age and reflect the diverse needs of subpopulations, including individuals from geographically diverse communities (for instance, urban versus rural), and vulnerable populations. Data will need to be collected through ad hoc periodic surveys in addition to the data collected through the routine health information system. Valuable opportunities also exist to draw on existing data, for example, gathering information from the reports submitted to treaty-monitoring bodies by governments and nongovernmental and other bodies as part of the periodic reporting mechanisms.

*Global target 4: 80% of countries will be routinely collecting and reporting at least a core set of mental health indicators every two years through their national health and social information systems (by the year 2020).*

### Proposed actions for Member States

**85 Information systems:** Integrate mental health into the routine health information system and identify, collate, routinely report and use core mental health data disaggregated by sex and age (including data on completed and attempted suicides) in order to improve mental health service delivery, promotion and prevention strategies and to provide data for the Global Mental Health Observatory (as a part of WHO's Global Health Observatory).

**86 Evidence and research:** Improve research capacity and academic collaboration on national priorities for research in mental health, particularly operational research with direct relevance to service development and implementation and the exercise of human rights by persons with mental disorders, including the establishment of centres of excellence with clear standards, with the inputs of all relevant stakeholders including persons with mental disorders and psychosocial disabilities.

### Actions for the Secretariat

**87 Information systems:** Develop a core set of mental health indicators and provide guidance, training and technical support on the development of surveillance/information systems to capture information for the core mental health indicators, facilitate the use of these data to monitor inequities and health outcomes, and augment the information collected by WHO's Global Mental Health Observatory (as a part of WHO's Global Health Observatory) by establishing baseline data to monitor the global mental health situation (including progress on reaching the targets laid out in this action plan).

**88 Evidence and research:** Engage relevant stakeholders, including people with mental disorders and psychosocial disabilities and their organizations, in the development and promotion of a global mental health research agenda, facilitate global networks for research collaboration, and carry out culturally validated research related to burden of disease, advances in mental health promotion, prevention, treatment, recovery, care, policy and service evaluation.

### Proposed actions for international and national partners

**89** Provide support to Member States to set up surveillance/information systems that: capture core indicators on mental health, health and social services for persons with mental disorders; enable an assessment of change over time; and provide an understanding of the social determinants of mental health problems.

**90** Support research aimed at filling the gaps in knowledge about mental health, including the delivery of health and social services for persons with mental disorders and psychosocial disabilities.

## INDICATORS FOR MEASURING PROGRESS TOWARDS DEFINED TARGETS OF THE COMPREHENSIVE MENTAL HEALTH ACTION PLAN 2013–2020

The indicators for assessing progress towards meeting the global targets of the comprehensive mental health action plan represent a subset of the information and reporting needs that Member States require to be able to monitor adequately their mental health policies and programmes. Given that targets are voluntary and global, each Member State is not necessarily expected to achieve all the specific targets but can contribute to a varying extent towards reaching them jointly. As indicated under Objective 4 of the plan, the Secretariat will provide guidance, training and technical support to Member States, upon request, on the development of national information systems for capturing data on indicators of mental health system inputs, activities and outcomes. The aim is to build on existing information systems rather than creating new or parallel systems. Baselines for each target will be established early during the implementation phase of the global action plan.

### ***Objective 1: To strengthen effective leadership and governance for mental health***

<b>Global target 1.1</b>	80% of countries will have developed or updated their policy/plan for mental health in line with international and regional human rights instruments (by the year 2020).
<b>Indicator</b>	Existence of a national policy and/or plan for mental health that is in line with international human rights instruments [yes/no].
<b>Means of verification</b>	Physical availability of the policy/plan and confirmation that it accords with international and regional human rights standards.
<b>Comments/assumptions</b>	Many policies and plans older than 10 years may not reflect recent developments in international human rights standards and evidence-based practice. For countries with a federated system, the indicator will refer to policies/plans of the majority of states/provinces within the country. Policies or plans for mental health may be stand-alone or integrated into other general health or disability policies or plans.
<b>Global target 1.2</b>	50% of countries will have developed or updated their law for mental health in line with international and regional human rights instruments (by the year 2020).
<b>Indicator</b>	Existence of a national law covering mental health that is in line with international human rights instruments [yes/no].
<b>Means of verification</b>	Physical availability of the law and confirmation that it accords with international and regional human rights standards.
<b>Comments/assumptions</b>	Laws older than 10 years may not reflect recent developments in international human rights standards and evidence-based practice. For countries with a federated system, the indicator will refer to the laws of the majority of states/provinces within the country. Laws for mental health may be stand-alone or integrated into other general health or disability laws.

**Objective 2: To provide comprehensive, integrated and responsive mental health and social care services in community-based settings**

<b>Global target 2</b>	Service coverage for severe mental disorders will have increased by 20% (by the year 2020).
<b>Indicator</b>	Proportion of persons with a severe mental disorder (psychosis; bipolar affective disorder; moderate-severe depression) who are using services [%].
<b>Means of verification</b>	Numerator: Cases of severe mental disorder in receipt of services, derived from routine information systems or, if unavailable, a baseline and follow-up survey of health facilities in one or more defined geographical areas of a country. Denominator: Total cases of severe mental disorder in the sampled population, derived from national surveys or, if unavailable, subregional global prevalence estimates.
<b>Comments/assumptions</b>	Estimates of service coverage are needed for all mental disorders, but are restricted here to severe mental disorders to limit measurement effort. Health facilities range from primary care centres to general and specialized hospitals, they may offer social care and support as well as psychosocial and/or pharmacological treatment on an outpatient or inpatient basis. To limit measurement effort, and where needed, countries may restrict the survey to hospital-based and overnight facilities only (with some loss of accuracy, due to omission of primary care and other service providers). The baseline survey will be undertaken in 2014, with follow-up at 2020 (and preferably also at mid-point in 2017), the survey questionnaire can be supplemented in order also to investigate service readiness and quality, as desired. The Secretariat can provide guidance and technical support to Member States regarding survey design and instrumentation.

**Objective 3: To implement strategies for promotion and prevention in mental health**

<b>Global target 3.1</b>	80% of countries will have at least two functioning national, multisectoral mental health promotion and prevention programmes (by the year 2020).
<b>Indicator</b>	Functioning programmes of multisectoral mental health promotion and prevention in existence [yes/no].
<b>Means of verification</b>	Inventory or project-by-project description of currently implemented programmes.
<b>Comments/assumptions</b>	Programmes may – and preferably should – cover both universal, population-level promotion or prevention strategies (e.g. mass media campaigns against discrimination) and those aimed at locally identified vulnerable groups (e.g. children exposed to adverse life events).

<b>Global target 3.2</b>	The rate of suicide in countries will be reduced by 10% (by the year 2020).
Indicator	Number of suicide deaths per year per 100 000 population.
Means of verification	Routine annual registration of deaths due to suicide (baseline year: 2012 or 2013).
Comments/assumptions	Effective action towards this target requires joint action from multiple sectors outside health/mental health sector. Obtaining accurate surveillance data is difficult and owing to more accurate reporting of suicides, population ageing and other possible factors, total recorded suicides may not decrease in some countries; however, the rate of suicide (as opposed to total suicides) best reflects improved prevention efforts.

**Objective 4: To strengthen information systems, evidence and research for mental health**

<b>Global target 4</b>	80% of countries will be routinely collecting and reporting at least a core set of mental health indicators every two years through their national health and social information systems (by the year 2020).
Indicator	Core set of identified and agreed mental health indicators routinely collected and reported every two years (yes/no).
Means of verification	Reporting and submission of core mental health indicator set to WHO every two years.
Comments/assumptions	Core mental health indicators include those relating to specified targets of this action plan, together with other essential indicators of health and social system actions (e.g. training and human resource levels, availability of psychotropic medicines, and admissions to hospital). The data need to be disaggregated by sex and age groups. Where needed, surveys can also be used to complement data from routine information systems. The Secretariat will advise countries on a set of core indicators to be collected in consultation with Member States. Data will be collected, analysed and reported by WHO on a global and regional basis (as part of WHO's Global Health Observatory).

## OPTIONS FOR THE IMPLEMENTATION OF THE COMPREHENSIVE MENTAL HEALTH ACTION PLAN 2013–2020

The actions proposed in this document for Member States convey what can be done to achieve the objectives of the action plan. This Appendix sets out some options for how these actions could be realized, recognizing the diversity of countries, particularly in terms of the level of development of mental health, health and social systems and resource availability. These options are neither comprehensive nor prescriptive, but provide illustrative or indicative mechanisms through which actions can be undertaken in countries.

### **Objective 1: To strengthen effective leadership and governance for mental health**

Actions	Options for implementation
<p><i>Policy and law:</i> Develop, strengthen, keep up to date and implement national policies, strategies, programmes, laws and regulations relating to mental health within all relevant sectors, including protective monitoring mechanisms and codes of practice, in line with evidence, best practice, the Convention on the Rights of Persons with Disabilities and other international and regional human rights instruments.</p>	<ul style="list-style-type: none"> <li>• Set up a functional mental health unit or coordination mechanism in the health ministry, with responsibility for strategic planning, needs assessment, multisectoral collaboration and service evaluation</li> <li>• Sensitize national policy-makers to mental health and human rights issues through the preparation of policy briefs and scientific publications and the provision of leadership courses in mental health.</li> <li>• Mainstream mental health and the rights of persons with mental disorders and psychosocial disabilities into all health and other sector policies and strategies including poverty reduction and development.</li> <li>• Improve accountability by setting up mechanisms, using existing independent bodies where possible, to monitor and prevent torture or cruel, inhuman and degrading treatment and other forms of ill treatment and abuse; and, involve appropriate stakeholder groups in these mechanisms, for example, lawyers and people with mental disorders and psychosocial disabilities, in a manner consistent with international and regional human rights instruments.</li> <li>• Repeal legislation that perpetuates stigmatization, discrimination and human rights violations against people with mental disorders and psychosocial disabilities.</li> <li>• Monitor and evaluate the implementation of policies and legislation to ensure compliance with the Convention on the Rights of Persons with Disabilities and feed this information into the reporting mechanism of that Convention.</li> </ul>
<p><i>Resource planning:</i> Plan according to measured or systematically estimated need and allocate a budget, across all relevant sectors, that is commensurate with identified human and other resources required to implement agreed-upon, evidence-based mental health plans and actions.</p>	<ul style="list-style-type: none"> <li>• Use – and if indicated, collect – data on epidemiological and resource needs in order to inform the development and implementation of mental health plans, budgets and programmes.</li> <li>• Set up mechanisms for tracking expenditure for mental health in health and other relevant sectors such as education, employment, criminal justice and social services.</li> <li>• Identify available funds at the planning stage for specific culturally-appropriate, cost-effective activities so that implementation can be assured.</li> <li>• Join with other stakeholders to effectively advocate increased resource allocation for mental health.</li> </ul>

Actions	Options for implementation
<p><b><i>Stakeholder collaboration:</i></b> Engage stakeholders from all relevant sectors, including persons with mental disorders, carers and family members, in the development and implementation of policies, laws and services relating to mental health, through a formalized structure and/or mechanism.</p>	<ul style="list-style-type: none"> <li>• Convene, engage with and solicit consensus from all relevant sectors and stakeholders when planning or developing policies, laws and services relating to health, including sharing knowledge about effective mechanisms to improve coordinated policy and care across formal and informal sectors.</li> <li>• Build local capacity and raise awareness among relevant stakeholder groups about mental health, law and human rights, including their responsibilities in relation to the implementation of policy, laws and regulations.</li> </ul>
<p><b><i>Strengthening and empowerment of people with mental disorders and psychosocial disabilities and their organizations:</i></b> Ensure that people with mental disorders and psychosocial disabilities are given a formal role and authority to influence the process of designing, planning and implementing policy, law and services.</p>	<ul style="list-style-type: none"> <li>• Provide logistic, technical and financial support to build the capacity of organizations representing people with mental disorders and psychosocial disabilities.</li> <li>• Encourage and support the formation of independent national and local organizations of people with mental disorders and psychosocial disabilities and their active involvement in the development and implementation of mental health policies, laws and services.</li> <li>• Involve people with mental disorders and psychosocial disabilities in the inspection and monitoring of mental health services.</li> <li>• Include people with mental disorders and psychosocial disabilities in the training of health workers delivering mental health care.</li> </ul>

**Objective 2: To provide comprehensive, integrated and responsive mental health and social care services in community-based settings**

Actions	Options for implementation
<p><i>Service reorganization and expanded coverage:</i> Systematically shift the locus of care away from long-stay mental hospitals towards non-specialized health settings with increasing coverage of evidence-based interventions (including the use of stepped care principles, as appropriate) for priority conditions and using a network of linked community-based mental health services, including short-stay inpatient, and outpatient care in general hospitals, primary care, comprehensive mental health centres, day care centres, support of people with mental disorders living with their families, and supported housing.</p>	<ul style="list-style-type: none"> <li>• Develop a phased and budgeted plan for closing long-stay psychiatric institutions and replacing them with support for discharged patients to live in the community with their families.</li> <li>• Provide outpatient mental health services and an inpatient mental health unit in all general hospitals.</li> <li>• Build up community-based mental health services, including outreach services, home care and support, emergency care, community-based rehabilitation and supported housing.</li> <li>• Establish interdisciplinary community mental health teams to support people with mental disorders and their families/carers in the community.</li> <li>• Integrate mental health into disease-specific programmes such as HIV/AIDS and maternal, sexual and reproductive health programmes.</li> <li>• Engage service users and family members/carers with practical experience as peer support workers.</li> <li>• Support the establishment of community mental health services run by nongovernmental organizations, faith-based organizations and other community groups, including self-help and family support groups.</li> <li>• Develop and implement tools or strategies for self-help and care for persons with mental disorders, including the use of electronic and mobile technologies.</li> <li>• Include mental health services and basic medicines for mental disorders in health insurance schemes and offer financial protection for socioeconomically disadvantaged groups.</li> </ul>

Actions	Options for implementation
<p><b><i>Integrated and responsive care:</i></b> Integrate and coordinate holistic prevention, promotion, rehabilitation, care and support that aims at meeting both mental and physical health care needs and facilitates the recovery of persons of all ages with mental disorders within and across general health and social services (including the promotion of the right to employment, housing and education) through service user-driven treatment and recovery plans, and where appropriate, with the inputs of families and carers.</p>	<ul style="list-style-type: none"> <li>• Encourage health workers to link people with services and resources available from other sectors as a routine part of care (for example, livelihood opportunities, education and employment)</li> <li>• Advocate with other sectors (for example, housing, education, employment, social welfare) for the inclusion of people with psychosocial disabilities in their services and programmes.</li> <li>• Cultivate recovery-oriented care and support through awareness-building opportunities and training for health and social service providers.</li> <li>• Provide information to people with mental disorders, their families and carers on causes and consequences of disorders, treatment and recovery options, as well as on healthy lifestyle behaviours in order to improve overall health and well-being.</li> <li>• Foster the empowerment and involvement of persons with mental disorders, their families and caregivers in mental health care.</li> <li>• Procure and ensure the availability of basic medicines for mental disorders included in the WHO List of Essential Medicines at all health system levels, ensure their rational use and enable non specialist health workers with adequate training to prescribe medicines.</li> <li>• Address the mental well-being of children when parents with severe illnesses (including those with mental disorders) are presenting for treatment at health services</li> <li>• Provide services and programmes to children and adults who have experienced adverse life events, including ongoing domestic violence and civil unrest or conflict, that address people's trauma, promote recovery and resilience, and avoid re-traumatizing those who seek support.</li> <li>• Implement interventions to manage family crises and provide care and support to families and carers in primary care and other service levels.</li> <li>• Implement the use of WHO QualityRights standards to assess and improve quality and human rights conditions in inpatient and outpatient mental health and social care facilities.</li> </ul>

Actions	Options for implementation
<p><b><i>Mental health in humanitarian emergencies (including isolated, repeated or continuing conflict, violence, and disasters):</i></b> Work with national emergency committees to include mental health and psychosocial support needs in emergency preparedness, and enable access to safe and supportive services, including services that address psychological trauma and promote recovery and resilience, for persons with (pre existing as well as emergency-induced) mental disorders or psychosocial problems, including for health and humanitarian workers, during and following emergencies, with due attention to the longer term funding required to build or rebuild a community-based mental health system after the emergency.</p>	<ul style="list-style-type: none"> <li>• Work with national emergency committees on emergency preparedness actions as outlined in the Sphere Project's minimum standard on mental health and the Inter-Agency Standing Committee Guidelines on Mental Health and Psychosocial Support in Emergency Settings.</li> <li>• Prepare for emergencies by orienting health and community workers on psychological first aid and providing them with essential mental health information.</li> <li>• During emergencies, ensure coordination with partners on the application of the Sphere Project's minimum standard on mental health and the guidelines mentioned above.</li> <li>• After acute emergencies, build or rebuild sustainable community-based mental health systems to address the long-term increase in mental disorders in emergency-affected populations.</li> </ul>
<p><b><i>Resource planning:</i></b> Build the knowledge and skills of general and specialized health workers to deliver evidence-based, culturally-appropriate and human rights-oriented mental health and social care services, for children and adolescents, inter alia, by introducing mental health into undergraduate and graduate curricula, and through training and mentoring health workers in the field, particularly in non-specialized settings, to identify and offer treatment and support to people with mental disorders as well as to refer people, as appropriate, to other levels of care.</p>	<ul style="list-style-type: none"> <li>• Develop and implement a strategy for building and retaining human resource capacity to deliver mental health and social care services in non-specialized health settings, such as primary health care and general hospitals.</li> <li>• Use WHO's mhGAP intervention guide for mental, neurological and substance use disorders in non-specialized settings (2010) and associated training and supervision materials to train health workers to identify disorders and provide evidence-based interventions for prioritized expanded care.</li> <li>• Collaborate with universities, colleges and other relevant educational entities to define and incorporate a mental health component in undergraduate and postgraduate curricula.</li> <li>• Ensure an enabling service context for training health workers including clear task definitions, referral structures, supervision and mentoring.</li> <li>• Improve the capacity of health and social care workers in all areas of their work (for example, covering clinical, human rights and public health domains), including eLearning methods where appropriate.</li> <li>• Improve working conditions, financial remuneration and career progression opportunities for mental health professionals and workers in order to attract and retain the mental health workforce.</li> </ul>

Actions	Options for implementation
<p><b>Address disparities:</b> Proactively identify and provide appropriate support for groups at particular risk of mental illness who have poor access to services.</p>	<ul style="list-style-type: none"> <li>• Identify and assess the needs of different socio-demographic groups in the community and also vulnerable groups not using services (such as homeless people, children, older people, prisoners, migrants and minority ethnic groups, and people caught up in emergency situations).</li> <li>• Assess the barriers that "at risk" and vulnerable groups face in accessing treatment, care and support.</li> <li>• Develop a proactive strategy for targeting these groups and provide services that meet their needs.</li> <li>• Provide information and training to health and social care staff to help them better understand the needs of "at risk" and vulnerable groups.</li> </ul>

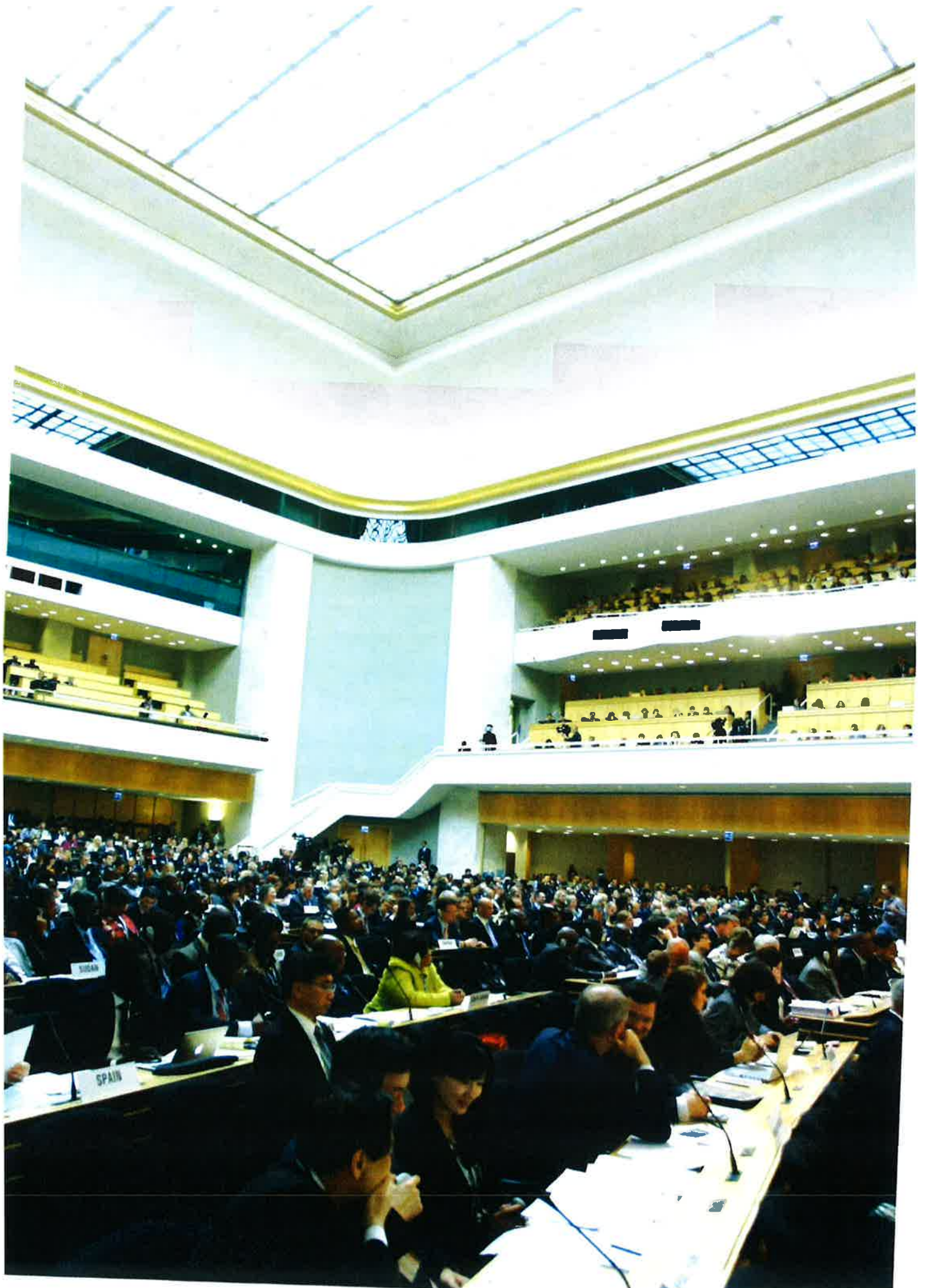
### **Objective 3: To implement strategies for promotion and prevention in mental health**

Actions	Options for implementation
<p><b>Mental health promotion and prevention:</b> Lead and coordinate a multisectoral strategy that combines universal and targeted interventions for: promoting mental health and preventing mental disorders, reducing stigmatization, discrimination and human rights violations, and which is responsive to specific vulnerable groups across the lifespan and integrated within the national mental health and health promotion strategies.</p>	<ul style="list-style-type: none"> <li>• Increase public knowledge and understanding about mental health, for instance, through media awareness and campaigns to reduce stigmatization and discrimination and to promote human rights.</li> <li>• Include emotional and mental health as part of home- and health facility-based antenatal and postnatal care for new mothers and babies, including parenting skills training.</li> <li>• Provide early childhood programmes that address the cognitive, sensory-motor and psychosocial development of children as well as promote healthy child-parent relationships.</li> <li>• Reduce exposure to the harmful use of alcohol (by implementation of measures included in the global strategy to reduce the harmful use of alcohol).</li> <li>• Introduce brief interventions for hazardous and harmful substance use.</li> <li>• Implement programmes to prevent and address domestic violence, including attention to violence related to alcohol use.</li> <li>• Provide services and programmes to children and adults who have experienced adverse life events that address their trauma, promote recovery and resilience, and avoid re-traumatizing those who seek support.</li> <li>• Protect children from abuse by introducing or strengthening community child protection networks and systems.</li> <li>• Address the needs of children with parents with chronic mental disorders within promotion and prevention programmes.</li> </ul>

Actions	Options for Implementation
	<ul style="list-style-type: none"> <li>• Develop school-based promotion and prevention, including: life/skills programmes; programmes to counter bullying and violence; awareness raising of the benefits of a healthy lifestyle and the risks of substance use; early detection and intervention for children and adolescents exhibiting emotional or behavioural problems.</li> <li>• Promote work participation and return-to-work programmes for those affected by mental and psychosocial disorders.</li> <li>• Promote safe and supportive working conditions, with attention to work organizational improvements, training on mental health for managers, the provision of stress management courses and workplace wellness programmes and tackling stigmatization and discrimination.</li> <li>• Enhance self-help groups, social support, community networks and community participation opportunities for people with mental disorders and psychosocial disabilities and other vulnerable groups.</li> <li>• Encourage the use of evidence-based traditional practices for promotion and prevention in mental health (such as yoga and meditation).</li> <li>• Enhance the use of social media in promotion and prevention strategies.</li> <li>• Implement preventive and control strategies for neglected tropical diseases (for instance, taeniasis and cysticercosis) in order to prevent epilepsy and other neurological and mental health problems.</li> <li>• Develop policies and measures for the protection of vulnerable populations during financial and economic crises.</li> </ul>
<p><b><i>Suicide prevention:</i></b> Develop and implement comprehensive national strategies for the prevention of suicide, with special attention to groups identified as at increased risk of suicide, including lesbian, gay, bisexual and transgender persons, youth and other vulnerable groups of all ages based on local context</p>	<ul style="list-style-type: none"> <li>• Increase public, political and media awareness of the magnitude of the problem, and the availability of effective prevention strategies.</li> <li>• Restrict access to the means of self-harm and suicide (for instance, firearms and pesticides).</li> <li>• Promote responsible media reporting in relation to cases of suicide</li> <li>• Promote workplace initiatives for suicide prevention.</li> <li>• Improve health system responses to self-harm and suicide.</li> <li>• Assess and manage self-harm/suicide and associated mental, neurological and substance use disorders (as outlined in the mhGAP Intervention Guide).</li> <li>• Optimize psychosocial support from available community resources both for those who have attempted suicide as well as for families of people who have committed suicide.</li> </ul>

**Objective 4: To strengthen information systems, evidence and research for mental health**

Actions	Options for implementation
<p><b>Information systems:</b> Integrate mental health into the routine health information system and identify, collate, routinely report and use core mental health data disaggregated by sex and age (including on completed and attempted suicides) to improve mental health service delivery, promotion and prevention strategies and to feed into the Global Mental Health Observatory (as a part of WHO's Global Health Observatory).</p>	<ul style="list-style-type: none"> <li>• Establish an active surveillance system for mental health and suicide monitoring, ensuring that records are disaggregated by facility, sex, age and other relevant variables.</li> <li>• Embed mental health information needs and indicators, including risk factors and disabilities, within national population-based surveys and health information systems.</li> <li>• Collect detailed data from secondary and tertiary services in addition to routine data collected through the national health information system.</li> <li>• Include mental health indicators within information systems of other sectors.</li> </ul>
<p><b>Evidence and research:</b> Improve research capacity and academic collaboration on national priorities for research in mental health, particularly operational research with direct relevance to service development and implementation and the exercise of human rights by persons with mental disorders, including the establishment of centres of excellence with clear standards, with the inputs of all relevant stakeholders including persons with mental disorders and psychosocial disabilities.</p>	<ul style="list-style-type: none"> <li>• Develop a prioritized national research agenda in the area of mental health, based on consultation with all stakeholders.</li> <li>• Improve research capacity to assess needs and to evaluate services and programmes.</li> <li>• Enable strengthened cooperation between universities, institutes and health services in the field of mental health research.</li> <li>• Conduct research, in different cultural contexts, on local understandings and expressions of mental distress, harmful (for instance, human rights violations and discrimination) or protective (for instance, social supports and traditional customs) practices, as well as the efficacy of interventions for treatment and recovery, prevention and promotion.</li> <li>• Develop methods for characterizing mental health disparities that occur among diverse subpopulations in countries including factors such as race/ethnicity, sex, socioeconomic status and geography (urban versus rural).</li> <li>• Strengthen collaboration between national, regional and international research centres for mutual interdisciplinary exchange of research and resources between countries.</li> <li>• Promote high ethical standards in mental health research, ensuring that: research is conducted only with the free and informed consent of the person concerned; researchers do not receive any privileges, compensation or remuneration in exchange for encouraging or recruiting people to participate in the research; research is not undertaken if it is potentially harmful or dangerous; and all research is approved by an independent ethics committee functioning according to national and international norms and standards.</li> </ul>



## Overview of the Mental Health Action Plan 2013 - 2020

### Vision

A world in which mental health is valued, promoted, and protected, mental disorders are prevented and persons affected by these disorders are able to exercise the full range of human rights and to access high-quality, culturally appropriate health and social care in a timely way to promote recovery, all in order to attain the highest possible level of health and participate fully in society and at work free from stigmatization and discrimination.

### Cross-cutting Principles

#### Universal health coverage

Regardless of age, sex, socioeconomic status, race, ethnicity or sexual orientation, and following the principle of equity, persons with mental disorders should be able to access, without the risk of impoverishing themselves, essential health and social services that enable them to achieve recovery and the highest attainable standard of health.

#### Human rights

Mental health strategies, actions and interventions for treatment, prevention and promotion must be compliant with the Convention on the Rights of Persons with Disabilities and other international and regional human rights instruments.

#### Evidence-based practice

Mental health strategies and interventions for treatment, prevention and promotion need to be based on scientific evidence and/or best practice, taking cultural considerations into account.

### Objectives and Targets

#### To strengthen effective leadership and governance for mental health

**Global target 1.1:** 80% of countries will have developed or updated their policy/plan for mental health in line with international and regional human rights instruments (by the year 2020)

**Global target 1.2:** 50% of countries will have developed or updated their law for mental health in line with international and regional human rights instruments (by the year 2020).

#### To provide comprehensive, integrated and responsive mental health and social care services in community based settings

**Global target 2:** Service coverage for severe mental disorders will have increased by 20% (by the year 2020).



## Goal

To promote mental well-being, prevent mental disorders, provide care, enhance recovery, promote human rights and reduce the mortality, morbidity and disability for persons with mental disorders

### Life course approach

Policies, plans, and services for mental health need to take account of health and social needs at all stages of the life course, including infancy, childhood, adolescence, adulthood and older age.

### Multisectoral approach

A comprehensive and coordinated response for mental health requires partnership with multiple public sectors such as health, education, employment, judicial, housing, social and other relevant sectors as well as the private sector, as appropriate to the country situation.

### Empowerment of persons with mental disorders and psychosocial disabilities

Persons with mental disorders and psychosocial disabilities should be empowered and involved in mental health advocacy, policy, planning, legislation, service provision, monitoring, research and evaluation.

### To implement strategies for promotion and prevention in mental health

**Global target 3.1:** 80% of countries will have at least two functioning national, multisectoral mental health promotion and prevention programmes (by the year 2020).

**Global target 3.2:** The rate of suicide in countries will be reduced by 10% (by the year 2020).

### To strengthen information systems, evidence and research for mental health

**Global target 4:** 80% of countries will be routinely collecting and reporting at least a core set of mental health indicators every two years through their national health and social information systems (by the year 2020).



#### RESOLUTION OF THE SIXTY-SIXTH WORLD HEALTH ASSEMBLY (MAY 2013)

##### ***WHA66.8 Comprehensive mental health action plan 2013–2020***

The Sixty-sixth World Health Assembly,

Having considered the report by the Secretariat on the draft comprehensive action plan 2013–2020, including the Annex<sup>1</sup>,

1. ADOPTS the comprehensive mental health action plan 2013–2020;
2. URGES Member States to implement the proposed actions for Member States in the comprehensive mental health action plan 2013–2020 as adapted to national priorities and specific national circumstances;
3. INVITES international, regional and national partners to take note of the comprehensive mental health action plan 2013–2020;
4. REQUESTS the Director-General to implement the actions for the Secretariat in the comprehensive mental health action plan 2013–2020 and to submit reports on the progress achieved in implementing the action plan, through the Executive Board, to the Sixty-eighth, Seventy-first and Seventy-fourth World Health Assemblies.

(Ninth plenary meeting, 27 May 2013  
Committee A, fourth report)

#### RESOLUTION OF THE SIXTY-FIFTH WORLD HEALTH ASSEMBLY (MAY 2012)

##### ***WHA65.4 The global burden of mental disorders and the need for a comprehensive, coordinated response from health and social sectors at the country level***

The Sixty-fifth World Health Assembly,

Having considered the report on the global burden of mental disorders and the need for a comprehensive, coordinated response from health and social sectors at the country level;<sup>2</sup>

Recalling resolution WHA55.10, which, inter alia, urged Member States to increase investments in mental health, both within countries and in bilateral and multilateral cooperation, as an integral component of the well-being of populations;

Recalling further United Nations General Assembly resolution 65/95, which recognized that mental health problems are of major importance to all societies and are significant contributors to the burden of disease and the loss of quality of life, and have huge economic and social costs, and which also welcomed the WHO report on mental health and development that highlighted the lack of appropriate attention to mental health and made the case for governments and development actors to reach out to people with mental disorders in the design of strategies and programmes that include those people in education, employment, health, social protection and poverty reduction policies;

Noting the High-level Meeting of the General Assembly on the Prevention and Control of Noncommunicable Diseases (New York, 19 and 20 September 2011), at which it was recognized that mental and neurological disorders, including Alzheimer's disease, are an important cause of morbidity and contribute to the global noncommunicable disease burden, necessitating provision of equitable access to effective programmes and health-care interventions;

Recognizing that mental disorders can lead to disabilities, as reflected in the United Nations Convention on the Rights of Persons with Disabilities, which also notes that disability results from the interaction between persons with impairments and attitudinal and environmental barriers that hinder their full and effective participation in society on an equal basis with others, and that the World Report on Disability 2011 charts the steps that are required to improve the participation and inclusion of people with disabilities, including those with mental disabilities;

<sup>1</sup> Document A66/10 Rev. 1

<sup>2</sup> Document A65/10

Recognizing also that mental disorders fall within a wider spectrum that includes neurological and substance-use disorders, which also cause substantial disability and require a coordinated response from health and social sectors;

Concerned that millions of people worldwide are affected by mental disorders, and that in 2004, mental disorders accounted for 13% of the global burden of disease, defined as premature death combined with years lived with disability, and also that, when taking into consideration only the disability component of the burden of disease calculation, mental disorders accounted for 25.3% and 33.5% of all years lived with a disability in low- and middle-income countries, respectively;

Concerned also that exposure to humanitarian emergencies is a potent risk factor for mental health problems and psychological trauma, and that social structures and ongoing formal and informal care of persons with severe, pre-existing, mental disorders are disrupted;

Recognizing further that the treatment gap for mental disorders is large all over the world, that between 76% and 85% of people with severe mental disorders in low- and middle-income countries receive no treatment for their mental health conditions, and that the corresponding figures for high income countries, although lower – between 35% and 50% - are also high;

Recognizing in addition that a number of mental disorders can be prevented and that mental health can be promoted in the health sector and in sectors outside health;

Concerned that persons with mental disorders are often stigmatized, and underlining the need for health authorities to work with relevant groups to change attitudes to mental disorders;

Noting also that there is increasing evidence on the effectiveness and cost-effectiveness of interventions to promote mental health and prevent mental disorders, particularly in children and adolescents;

Noting further that mental disorders are often associated with noncommunicable diseases and a range of other priority health issues, including HIV/AIDS, maternal and child health, and violence and injuries, and that mental disorders often coexist with other medical and social factors, such as poverty, substance abuse and the harmful use of alcohol, and, in the case of women and children, greater exposure to domestic violence and abuse;

Recognizing that certain populations live in a situation that makes them particularly vulnerable to developing mental disorders, and the consequences thereof;

Recognizing also that the social and economic impact of mental disorders, including mental disabilities, is diverse and far-reaching;

Taking into account the work already carried out by WHO on mental health, particularly through its Mental Health Gap Action Programme,

#### **1. URGES Member States:**

(1). according to national priorities and within their specific contexts, to develop and strengthen comprehensive policies and strategies that address the promotion of mental health, prevention of mental disorders, and early identification, care, support,

(2). to include in policy and strategy development the need to promote human rights, tackle stigmatization, empower service users, families and communities, address poverty and homelessness, tackle major modifiable risks, and as appropriate, promote public awareness, create opportunities for generating income, provide housing and education, provide health care services and community-based interventions, including de-institutionalized care;

(3). to develop, as appropriate, surveillance frameworks that include risk factors as well as social determinants of health to analyse and evaluate trends regarding mental disorders;

(4). to give appropriate priority to and to streamline mental health, including the promotion of mental health, the prevention of mental disorders, and the provision of care, support and treatment in programmes addressing health and development, and to allocate appropriate resources in this regard;

(5). to collaborate with the Secretariat in the development of a comprehensive mental health action plan;

## **2. REQUESTS the Director-General:**

(1). to strengthen advocacy, and develop a comprehensive mental health action plan with measurable outcomes, based on an assessment of vulnerabilities and risks, in consultation with and for consideration by Member States, covering services, policies, legislation, plans, strategies and programmes to provide treatment, facilitate recovery and prevent mental disorders, promote mental health and empower persons with mental disorders to live a full and productive life in the community;

(2). to include, in the comprehensive mental health action plan, provisions to address:

(a). assessment of vulnerabilities and risks as a basis for developing the mental health action plan;

(b). protection, promotion and respect for the rights of persons with mental disorders including the need to tackle stigmatization of persons with mental disorders;

(c). equitable access to affordable, quality and comprehensive health services that integrate mental health into all levels of the health care system;

(d). development of competent, sensitive, adequate human resources to provide mental health services equitably;

(e). promotion of equitable access to quality health care including psychosocial interventions and medication and addressing physical health care needs;

(f). enhancement of initiatives, including in policy, to promote mental health and prevent mental disorders;

(g). access to educational and social services, including health care, schooling, housing, secure employment and participation in income-generation programmes;

(h). involvement of civil society organizations, persons with mental disorders, families and caregivers in voicing their opinions and contributing to decision-making processes;

(i). design and provision of mental health and psychosocial support systems that will enable community resilience and will help people to cope during humanitarian emergencies;

(j). participation of people with mental disorders in family and community life and civic affairs;

- (k). design of mechanisms to involve the education, employment and other relevant sectors in Member States in the implementation of the mental health action plan;
- (l). building upon the work already done and avoidance of duplication of action;
- (3). to collaborate with Member States and, as appropriate, with international, regional and national nongovernmental organizations, international development partners and technical agency partners in the development of the mental health action plan;
- (4). to work with Member States and technical agencies to promote academic exchange, through which to contribute to policy-making in mental health;
- (5). to submit the comprehensive mental health action plan, through the Executive Board at its 132nd session, for consideration by the Sixty-sixth World Health Assembly.

(Ninth plenary meeting, 25 May 2012  
Committee A, first report)

## 1. GLOSSARY OF MAIN TERMS

### Mental health

Mental health is a state of well-being in which an individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and is able to make a contribution to his or her community.

Source: Promoting mental health: concepts, emerging evidence, practice. WHO, 2004  
[http://www.who.int/mental\\_health/evidence/en/promoting\\_mhh.pdf](http://www.who.int/mental_health/evidence/en/promoting_mhh.pdf)

### Mental disorders

Mental disorders comprise a broad range of problems, with different symptoms. However, they are generally characterized by some combination of abnormal thoughts, emotions, behaviour and relationships with others. These disorders are included and described in chapter V: Mental and behavioural disorders (F00-F99) of WHO's International Statistical Classification of Diseases and Related Health Problems 10th Revision (ICD-10). The area of disorders covered are as follows: F00-F09 Organic, including symptomatic, mental disorders; F10-F19 Mental and behavioural disorders due to psychoactive substance use; F20-F29 Schizophrenia, schizotypal and delusional disorders; F30-F39 Mood (affective) disorders; F40-F48 Neurotic, stress-related and somatoform disorders; F50-F59 Behavioural syndromes associated with physiological disturbances and physical factors; F60-F69 Disorders of adult personality and behaviour; F70-F79 Mental retardation; F80-F89 Disorders of psychological development; F90-F98 Behavioural and emotional disorders with onset usually occurring in childhood and adolescence; and F99 Unspecified mental disorder.

Source: International Statistical Classification of Diseases and Related Health Problems 10th Revision Version for 2010. WHO, 2010  
<http://apps.who.int/classifications/icd10/browse/2010/en#/V>

### Disability

Disability is an umbrella term for impairments, activity limitations and participation restrictions, denoting the negative aspects of the interaction between an individual (with a health condition) and that individual's contextual factors (environmental and personal factors).

Source: World report on disability 2011. WHO, 2011.  
[http://whqlibdoc.who.int/publications/2011/9789240685215\\_eng.pdf](http://whqlibdoc.who.int/publications/2011/9789240685215_eng.pdf)

### Mental health policy and mental health plan

A mental health policy is the official statement of a government which defines the vision and details an organized set of values, principles, objectives and areas for action to improve the mental health of a population. A mental health plan details the strategies, activities, timeframes and budgets that will be implemented to realize the vision and achieve the objectives of the policy as well as the expected outputs, targets and indicators that can be used to assess whether implementation has been successful.

Source: Mental health Atlas 2011. WHO, 2011.  
[http://whqlibdoc.who.int/publications/2011/9799241564359\\_eng.pdf](http://whqlibdoc.who.int/publications/2011/9799241564359_eng.pdf)  
Source: Mental Health policy, plans and programmes. WHO 2005  
[http://www.who.int/mental\\_health/policy/services/essentialpackage1v1/en/index.html](http://www.who.int/mental_health/policy/services/essentialpackage1v1/en/index.html)

### **Mental health legislation**

Mental health legislation, or mental health provisions integrated into other laws (e.g. anti-discrimination, general health, disability, employment, social welfare, education, housing, and other areas), may cover a broad array of issues including access to mental health care and other services, quality of mental health care, admission to mental health facilities, consent to treatment, freedom from cruel, inhuman and degrading treatment, freedom from discrimination, the enjoyment of a full range of civil, cultural, economic, political and social rights, and provisions for legal mechanisms to promote and protect human rights (e.g. review bodies to oversee admission and treatment to mental health facilities, monitoring bodies to inspect human rights conditions in facilities and complaint mechanisms).

Source: Mental health Atlas 2011. WHO, 2011.

[http://whqlibdoc.who.int/publications/2011/9799241564359\\_eng.pdf](http://whqlibdoc.who.int/publications/2011/9799241564359_eng.pdf)

Source: Drew, N., Funk, M., Tang, S. et al. Human rights violations of people with mental and psychosocial disabilities: an unresolved global crisis. *The Lancet*, 378 (9803), 1664 - 1675, 2011.

### **Mental health services**

Mental health services are the means by which effective interventions for mental health are delivered. The way these services are organized has an important bearing on their effectiveness. Typically, mental health services include outpatient facilities, mental health day treatment facilities, psychiatric wards in a general hospital, community mental health teams, supported housing in the community, and mental hospitals.

Source: Organization of services for mental health. WHO, 2003.

[http://www.who.int/mental\\_health/policy/services/essentialpackage1v2/en/index.html](http://www.who.int/mental_health/policy/services/essentialpackage1v2/en/index.html)

Mental Health Atlas 2011. WHO, 2011. [http://whqlibdoc.who.int/publications/2011/9799241564359\\_eng.pdf](http://whqlibdoc.who.int/publications/2011/9799241564359_eng.pdf)

### **Recovery**

From the perspective of the individual with mental illness, recovery means gaining and retaining hope, understanding of one's abilities and disabilities, engagement in an active life, personal autonomy, social identity, meaning and purpose in life and a positive sense of self. Recovery is not synonymous with cure. Recovery refers to both internal conditions experienced by persons who describe themselves as being in recovery – hope, healing, empowerment and connection – and external conditions that facilitate recovery – implementation of human rights, a positive culture of healing, and recovery-oriented services.

Source: WHO QualityRights tool kit: assessing and improving quality and human rights in mental health and social care facilities. WHO, 2012.

[http://whqlibdoc.who.int/publications/2012/9789241548410\\_eng.pdf](http://whqlibdoc.who.int/publications/2012/9789241548410_eng.pdf)

### **Psychosocial disabilities**

Refer to people who have received a mental health diagnosis, and who have experienced negative social factors including stigma, discrimination and exclusion. People living with psychosocial disabilities include ex-users, current users of the mental health care services, as well as persons that identify themselves as survivors of these services or with the psychosocial disability itself.

Source: Drew, N., Funk, M., Tang, S. et al. Human rights violations of people with mental and psychosocial disabilities: an unresolved global crisis. *The Lancet*, 378 (9803), 1664 - 1675, 2011.

<http://download.thelancet.com/pdfs/journals/lancet/PIIS014067361161458X.pdf?id=40bade4753939e7f2e5f8cf2:13a9c2030d0.54121351243806649>

### Vulnerable groups

Certain groups have an elevated risk of developing mental disorders. This vulnerability is brought about by societal factors and the environments in which they live. Vulnerable groups in society will differ across countries, but in general they share common challenges related to their social and economic status, social supports, and living conditions, including:

- Stigma and discrimination;
- Violence and abuse;
- Restrictions in exercising civil and political rights;
- Exclusion from participating fully in society;
- Reduced access to health and social services;
- Reduced access to emergency relief services;
- Lack of educational opportunities;
- Exclusion from income generation and employment opportunities;
- Increased disability and premature death.

Source: Mental Health and Development report. WHO, 2010.  
[http://whqlibdoc.who.int/publications/2010/9789241563949\\_eng.pdf](http://whqlibdoc.who.int/publications/2010/9789241563949_eng.pdf)

## 2. LINKS TO OTHER GLOBAL ACTION PLANS, STRATEGIES AND PROGRAMMES

The Global Mental Health Action Plan has close conceptual and strategic links to other global action plans which have been developed, including the following:

- [Global strategy to reduce the harmful use of alcohol \(2010\)](#) provides a portfolio of policy options and interventions that should be considered for implementation in each country and sets priority areas for global action that is intended to promote, support and complement relevant actions at local, national and regional levels. These directions and actions are reinforced in the Global Mental Health Action plan which is relevant for prevention, treatment and care for alcohol use disorders.

Full text available at [www.who.int/substance\\_abuse/msbalcstragegy.pdf](http://www.who.int/substance_abuse/msbalcstragegy.pdf)

- [Global Plan of Action on Social Determinants of Health \(2012\)](#) covers better governance for health and development, increased participation in policy making and implementation, reorientation of the health sector towards reducing health inequities, strengthening global governance and collaboration, monitoring progress and increasing accountability, and social determinants. Many of the risks and vulnerabilities for mental health problems are common to other health problems. Implementation of the Global Mental health Action Plan addresses the key areas covered in the Action Plan on the Social Determinants of Health and not only contributes to improved mental health, but also makes a positive contribution in tackling the social determinants of health more generally.

Full text of Rio Political Declaration on Social Determinants of Health (2011) available at:  
<http://www.who.int/sdhconference/declaration/en/index.html>

- [Action plan for the Global Strategy for the Prevention and Control of Noncommunicable Diseases \(2008-2013\)](#) outlines the proposed strategies and actions to tackle the growing public-health burden imposed by noncommunicable diseases with a focus on cardiovascular diseases, cancers, chronic respiratory diseases and diabetes. Given the considerable co-morbidity between mental health and physical problems, the Global Mental Health Action plan is expected to contribute to better health outcomes for people with the above four NCDs and vice versa. A new action plan for the period 2013-2020 is under development.

Full text available at [www.who.int/nmh/Actionplan-PC-NCD-2008.pdf](http://www.who.int/nmh/Actionplan-PC-NCD-2008.pdf)

- Workers' health: global plan of action (2008-2017) provides the principles and objectives necessary for maintaining physical and mental health in the workplace, including preventing exposures to occupational hazards, delivering essential public health interventions, and providing access to health services. The global plan of action includes implementation options aimed at ensuring the safety and productivity of workers in all Member States.

Full text available at: [http://www.who.int/entity/occupational\\_health/WHO\\_health\\_assembly\\_en\\_web.pdf](http://www.who.int/entity/occupational_health/WHO_health_assembly_en_web.pdf)

- Global campaign for violence prevention: plan of action for 2012-2020 presents a set of six goals for curbing the causes and ensuing repercussions of violence around the world. The first two goals aim to prioritize violence prevention within the global public health agenda; the next three aim to build strong foundations for on-going violence prevention efforts; and the last aims to focus support for violence prevention efforts on evidence-based prevention strategies (e.g. measures to improve parenting and parent-child relationships) with the potential to prevent multiple types of violence and other adverse childhood experiences, many of which may negatively affect the mental health status of individuals or communities.

Full text available at: [http://www.who.int/entity/violence\\_injury\\_prevention/violence/global\\_campaign/qcqv\\_plan\\_of\\_action.pdf](http://www.who.int/entity/violence_injury_prevention/violence/global_campaign/qcqv_plan_of_action.pdf)

The Global Mental Health Action plan will also build upon several WHO regional action plans and strategies for mental health and substance abuse that have been developed or are in the process of development. These include:

- Regional Strategy for Mental Health, Africa, 2000-2010,

Full text available at: <http://www.afro.who.int/en/clusters-a-programmes/dpc/mental-health-violence-and-injuries/mvi-publications.html>

- Regional NCD strategic Plan in the African Region, 2012-2016

Full text of Brazzaville Declaration on NCDs available at:

[http://www.afro.who.int/index.php?option=com\\_docman&task=doc\\_download&qid=6304](http://www.afro.who.int/index.php?option=com_docman&task=doc_download&qid=6304)

- Reduction of the Harmful Use of Alcohol: A Strategy for the WHO African Region (2010)

Full text available at: <http://www.afro.who.int/en/sixtieth-session.html>

- Strategy for mental health & substance abuse in the Eastern Mediterranean Region (2011)

Full text available at: [http://www.emro.who.int/docs/RC\\_technical\\_papers\\_2011\\_5\\_14223.pdf](http://www.emro.who.int/docs/RC_technical_papers_2011_5_14223.pdf)

- Pan American Health Organization Strategy and Plan of Action on mental health (2009)

Full text available at: [http://new.paho.org/hq/index.php?option=com\\_docman&task=doc\\_download&qid=3653&Itemid](http://new.paho.org/hq/index.php?option=com_docman&task=doc_download&qid=3653&Itemid)

- Pan American Health Organization Regional plan of action to reduce harmful use of alcohol (2011)

Full text available at: [http://new.paho.org/hq/index.php?option=com\\_content&task=view&id=5723&Itemid=4139&lang=en](http://new.paho.org/hq/index.php?option=com_content&task=view&id=5723&Itemid=4139&lang=en)

- Pan American Health Organization Regional plan of action on substance use and public health (2011)

Full text available at: [http://new.paho.org/hq/index.php?option=com\\_docman&task=doc\\_view&qid=14583&Itemid=2146&lang=en](http://new.paho.org/hq/index.php?option=com_docman&task=doc_view&qid=14583&Itemid=2146&lang=en)

- Regional Strategy for Mental Health, Western Pacific Region, 2002

Full text available at: [http://www.wpro.who.int/publications/pub\\_9290610077/en/index.html](http://www.wpro.who.int/publications/pub_9290610077/en/index.html)

- European action plan to reduce the harmful use of alcohol 2012-2020

Full text available at: [http://www.euro.who.int/\\_data/assets/pdf\\_file/0006/147732/RC61\\_wd13E\\_Alcohol\\_111372\\_ver2012.pdf](http://www.euro.who.int/_data/assets/pdf_file/0006/147732/RC61_wd13E_Alcohol_111372_ver2012.pdf)

- **Maternal, child, and adolescent mental health for the Eastern Mediterranean Region (2011)**

Full text available at <http://applications.emro.who.int/dsaf/dsa1214.pdf>

- **European Mental Health Strategy, - under development**

The global action plan has a number of synergies with programmes of other United Nations agencies, International Governmental Organizations (IGOs), and interagency groups with IGO membership as described below:

1. The Department of Economic and Social Affairs (DESA) of the United Nations promotes mainstreaming of the rights of persons with disabilities, including persons with mental and psychosocial disabilities into development responses. <http://www.un.org/disabilities/>

2. The Inter-Agency Standing Committee (IASC) has issued Guidelines on Mental Health and Psychosocial Support in Emergency Settings (2007). An IASC Reference Group on Mental Health and Psychosocial Support has been created to follow-up on the implementation of these guidelines. <http://www.humanitarianinfo.org/iasc/pageloader.aspx?page=content-subsidi-default&mainbodyid=2&publish=0>

3. The International Labour Organization (ILO) seeks to address psychosocial factors through health promotion in the workplace. [http://www.ilo.org/safework/events/courses/WCMS\\_126657/lang--en/index.htm](http://www.ilo.org/safework/events/courses/WCMS_126657/lang--en/index.htm)

4. The International Organization for Migration (IOM) works to strengthen the capacity of mental health and psychosocial services offered to migrants and crisis-affected populations in emergency and post-emergency situations. <http://www.iom.int/cms/en/sites/iom/home/what-we-do/migration-et-sante/mental-health-and-psychosocial-support.html>

5. The United Nations Population Fund (UNFPA) integrates mental health as part of the outputs of its strategic plan. UNFPA considers mental health an emerging issue. <http://www.unfpa.org/public/global/pid/910>

6. The Constitution of the United Nations Educational, Scientific and Cultural Organization (UNESCO) – as part of the Interagency Network of Education (INEE) in Emergencies - integrates concern for psychosocial well-being into emergency education programmes. [www.ineesite.org/](http://www.ineesite.org/)

7. UNICEF integrates a psychosocial perspective in its child protection and education activities. UNICEF, through the protection sector, has been the United Nations system's largest funder of community-based psychosocial support activities during and after emergencies. [http://www.unicef.org/protection/57929\\_57998.html](http://www.unicef.org/protection/57929_57998.html)

8. The United Nations Relief and Works Agency for Palestine refugees in the Near east (UNRWA) provides mental health and psychosocial support to Palestinian refugees in two of its five fields. In 2011, UNRWA and WHO signed a cooperation agreement for a Joint Programme on Community Mental Health Care for Palestine Refugees. <http://www.unrwa.org/etemplate.php?id=70#health>

9. The United Nations High Commissioner for Refugees (UNHCR) aims for full integration of mental health concerns within UNHCR's health services' operations for refugees. <http://www.unhcr.org/pages/49c3646cdd.html>  
<http://www.unhcr.org/4e26c9c69.html>

10. The United Nations Office on Drugs and Crime (UNODC) promotes the prevention, treatment and care of drug dependence and reintegration of people with drug abuse problems. In 2008, UNODC and WHO signed a cooperation agreement for a Joint Programme on Drug Dependence Treatment and Care.

<http://www.unodc.org/unodc/en/frontpage/unodc-and-who-launch-joint-drug-dependence-treatment-programme.html>

11. The United Nations University (UNU), a think-tank for the United Nations system, has an International Institute for Global Health, which plans to build a partnership for global mental health. <http://iigh.unu.edu/?q=node/152>

12. The United Nations Fund for Action Against Sexual Violence in Conflict (UN Action) funds United Nations agencies to collaborate to improve coordination and accountability, amplify advocacy, and support country efforts to prevent sexual violence and respond more effectively to the social, physical, and mental needs of survivors. <http://mptf.undp.org/factsheet/fund/UNA00>

13. The United Nations Development Programme (UNDP) is moving towards incorporation of non-communicable conditions, including mental disorders, in country-level United Nations Development Assistance Framework (UNDAF) programme planning. <http://www.undg.org/?P=232>

### 3. INTERNATIONAL AND REGIONAL HUMAN RIGHTS TREATIES

The constitution of the World Health Organization recognizes that the enjoyment of the highest attainable standard of health is a fundamental right of every human being. It defines health as a state of complete physical, mental and social well-being, and not merely as the absence of disease or infirmity. It thus recognizes mental health as an essential element of health.

The United Nations and regional human rights frameworks are an important means of promoting and protecting the rights of persons with mental disorders. By becoming parties to international treaties, States assume obligations and duties under international law to respect, to protect and to fulfill human rights. The obligation to respect means that States must refrain from interfering with or curtailing the enjoyment of human rights. The obligation to protect requires States to protect individuals and groups against human rights abuses. The obligation to fulfill means that States must take positive action to facilitate the enjoyment of basic human rights.

The UN Convention on the Rights of Persons with Disabilities (CRPD), which came into force in 2008 and has been widely ratified by Member States, is the first legally binding instrument with comprehensive rights and protections for persons with disabilities. The CRPD sets out a full range of civil, cultural, economic, political and social rights historically denied people with mental disorders, including the right to equal recognition before the law, to liberty and security of person, to be free from torture or cruel, inhuman or degrading treatment or punishment, to live independently and be included in the community as well as the right to education, health, employment and social protection and participation in political and public life.

## Key UN and regional human rights treaties

United Nations treaties	Regional treaties
<p><i>Convention on the Rights of Persons with Disabilities (CRPD)</i></p> <p><i>International Covenant on Economic, Social and Cultural Rights (ICESCR)</i></p> <p><i>International Covenant on Civil and Political Rights (ICCPR)</i></p> <p><i>Convention Against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (CAT)</i></p> <p><i>Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW)</i></p> <p><i>Convention on the Rights of the Child (CRC)</i></p>	<p>African Charter on Human and Peoples' Rights</p> <p>American Convention on Human Rights</p> <p>Additional protocol to the American Convention on Human Rights in the area of Economic, Social and Cultural Rights</p> <p>Inter-American Convention on all Forms of Discrimination Against Persons with Disabilities</p> <p>Inter-American Convention to Prevent and Punish Torture</p> <p>European Convention for the Protection of Human Rights and Fundamental Freedoms</p> <p>European Convention for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment</p>

#### 4. SELECTED WHO TECHNICAL MATERIALS AND RESOURCES ON MENTAL HEALTH

##### 1. mhGAP

[http://www.who.int/mental\\_health/mhgap/en/](http://www.who.int/mental_health/mhgap/en/)

- Mental Health Gap action Programme; Scaling up care for mental, neurological, and substance use disorders, WHO, 2008 (English, French, Spanish)
- Mental Health Gap action Programme - Intervention Guide (mhGAP-IG), WHO, 2010 (English, French, Spanish)

##### 2. Mental health and development

[http://www.who.int/mental\\_health/policy/mhtargeting/en/index.html](http://www.who.int/mental_health/policy/mhtargeting/en/index.html)

- Report on Mental health and development; WHO, 2010

##### 3. Policy, services and human rights

[http://www.who.int/mental\\_health/policy/en/](http://www.who.int/mental_health/policy/en/)

- All 14 WHO policy modules
- Improving health systems and services for mental health; WHO, 2009
- Integrating mental health into primary care: a global perspective; WHO and WONCA, 2009
- WHO QualityRights tool kit: assessing and improving quality and human rights in mental health and social care facilities; WHO, 2012 [http://www.who.int/mental\\_health/policy/quality\\_rights/en/index.html](http://www.who.int/mental_health/policy/quality_rights/en/index.html)

#### 4. Human rights and law

[http://www.who.int/mental\\_health/policy/resource\\_book\\_MHLeq.pdf](http://www.who.int/mental_health/policy/resource_book_MHLeq.pdf)

- WHO resource book on mental health, human rights and legislation. World Health Organization, 2005

#### 5. Information and surveillance

• Mental Health Atlas 2011 [www.who.int/mental\\_health/publications/mental\\_health\\_atlas\\_2011](http://www.who.int/mental_health/publications/mental_health_atlas_2011)

- WHO-AIMS [http://www.who.int/mental\\_health/evidence/WHO-AIMS/en/](http://www.who.int/mental_health/evidence/WHO-AIMS/en/)

#### 6. Emergency mental health

[http://www.who.int/mental\\_health/emergencies/en/](http://www.who.int/mental_health/emergencies/en/)

- WHO and IASC publications on emergency mental health: 9 in English and 8 in non- English

#### 7. Epilepsy

[http://www.who.int/mental\\_health/mhqap/evidence/epilepsy/en/](http://www.who.int/mental_health/mhqap/evidence/epilepsy/en/)

- Epilepsy Management at Primary Health Level in rural China, WHO, 2009
- A manual for Medical and Clinical Officers in Africa, WHO, 2002

#### 8. Dementia

[http://www.who.int/mental\\_health/publications/dementia\\_report\\_2012](http://www.who.int/mental_health/publications/dementia_report_2012)

- Dementia: a public health priority; WHO, 2012

#### 9. Alcohol and substance use disorders [http://www.who.int/substance\\_abuse/en/](http://www.who.int/substance_abuse/en/)

- Guidelines for the Psychosocially Assisted Pharmacological Treatment of Opioid Dependence, 2009
- Principles of Drug Dependence Treatment, 2008
- Basic Principles for Treatment and Psychosocial Support of Drug Dependent People Living with HIV/AIDS, 2006
- Substitution maintenance therapy in the management of opioid dependence and HIV/AIDS prevention; WHO/UNODC/UNAIDS position paper, 2004
- AUDIT - The Alcohol Use Disorders Identification Test: Guidelines for Use in Primary Care (second edition), 2001 (English and Spanish)
- ASSIST questionnaire version 3
- The ASSIST package (Alcohol, Smoking and Substance Involvement Screening Test), including a self-help guide

# The Search for Well-Being

Treating the whole person  
in the new health care era

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A Primer on Integrative Medicine

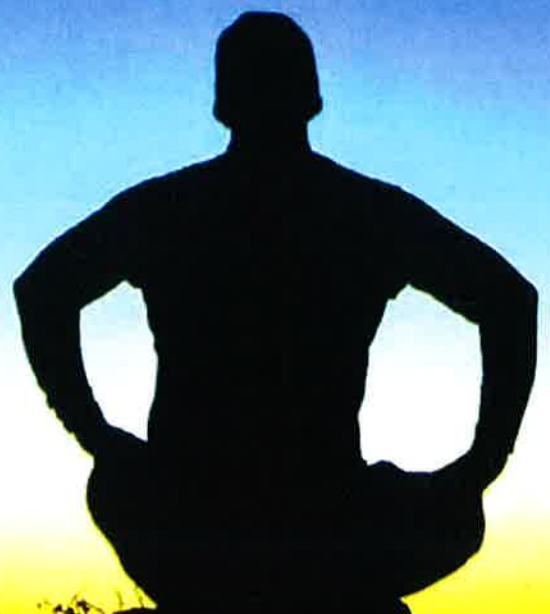
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From *Humankind* public radio

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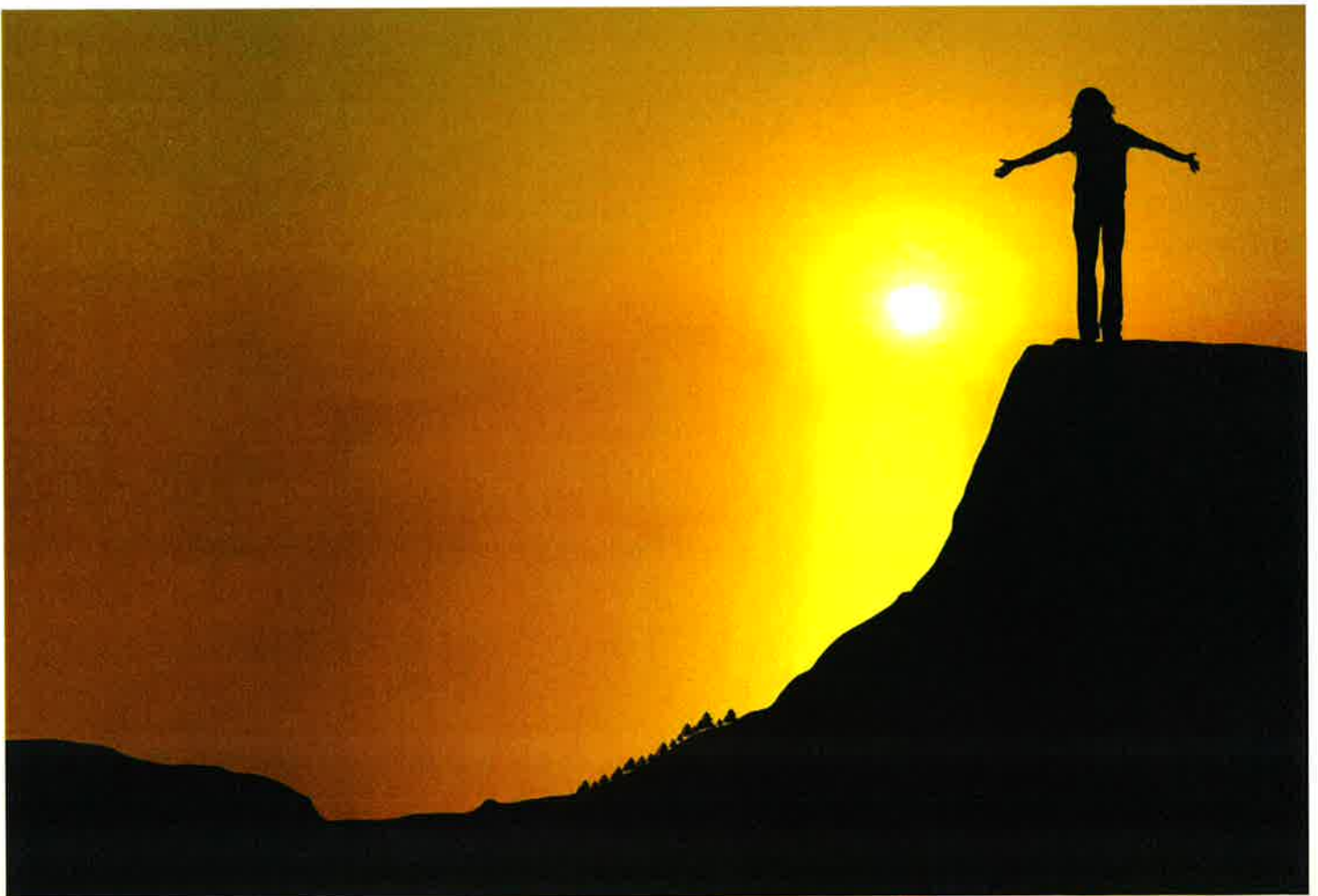


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## The Basics of Integrative Medicine

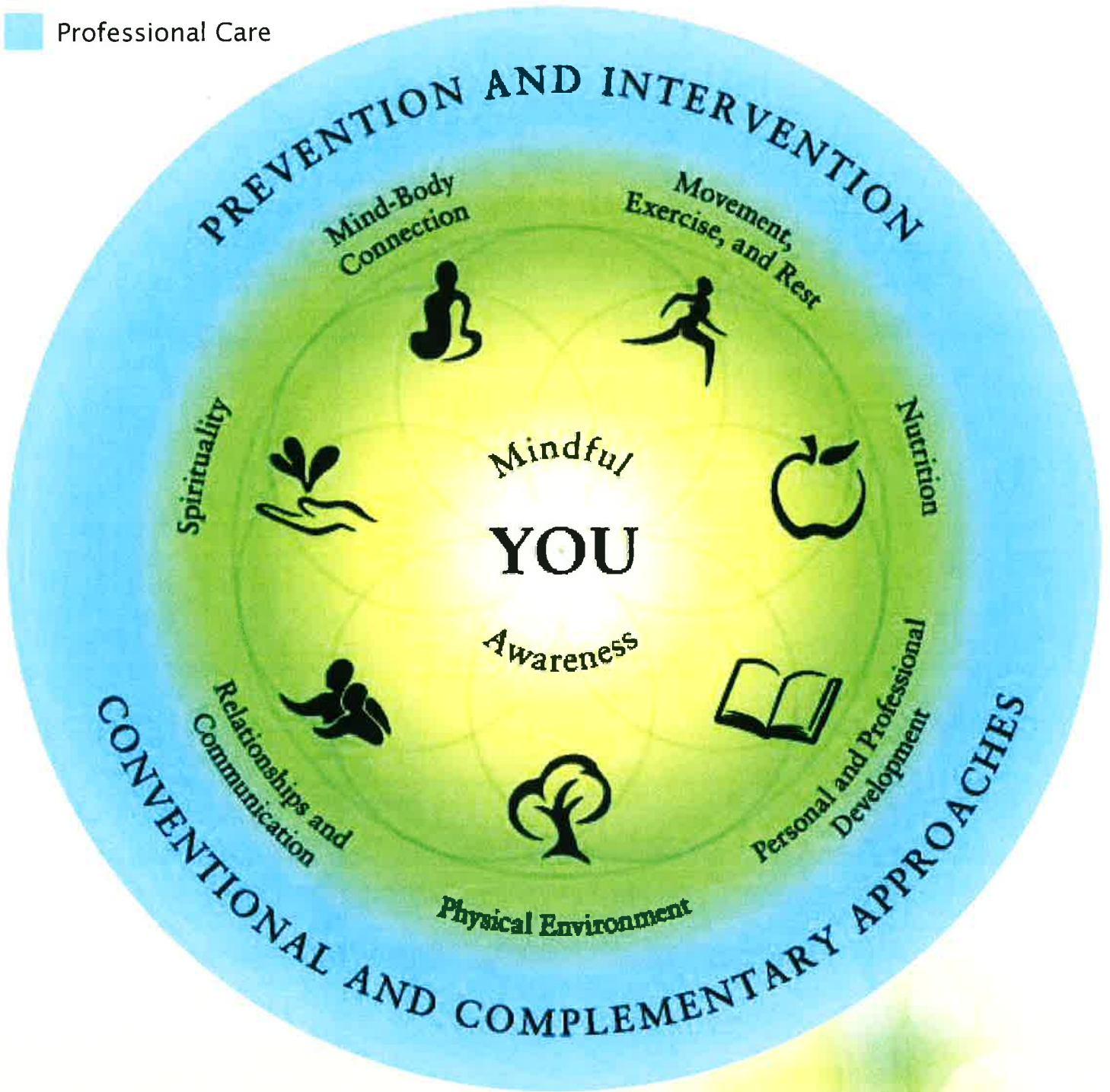
**W**HAT WOULD YOU THINK OF A HEALTHCARE system that focuses on helping people become and stay healthy—rather than one that focuses more narrowly on “managing” diseases? How about a system of care that is aimed first at optimizing conditions in which the body can use its remarkable powers of self-healing and regeneration, before it resorts to invasive interventions and powerful drugs that carry added cost and complications?

These are just a few of the themes that form the framework of an integrative approach to care - or simply, **integrative medicine**. Many leading hospitals now operate integrative health clinics.



# Integrative Health

- Self-Care
- Professional Care



“80% of how healthy people are has nothing to do with doctors, hospitals, drugs. It's their lifestyle. That is a huge mental shift... to really step back and say, I'm responsible.”

— Prof. Mary Jo Kreitzer  
Univ. of Minnesota  
School of Nursing

## What Is Integrative Medicine?

This approach to health care blends conventional medicine (including use of drugs and high-tech techniques, when appropriate) with evidence-based, natural, less invasive therapies (e.g. dietary change, meditation, acupuncture, yoga, herbal medicine and therapeutic massage).

It highlights a patient-practitioner relationship that offers personalized, participatory care. And it emphasizes healing of the whole person – mind, body, and spirit – in the context of our relationships and social environment.<sup>1</sup> In addition:

- Integrative care offers treatment for ailments, but is also very attentive to the broader concepts of health promotion (e.g. lifestyle counseling and dietary guidance) and the prevention of illness (i.e. eliminating ailment causes or increasing resistance to disease) is fundamental.
- Patients understand the importance of self-care techniques that may require lifestyle changes, rather than relying entirely on the health care system to “fix” the patient.

Over the course of a year, up to a third of the active duty military and about half of U.S. veterans use a complementary or alternative medicine product or practice.

(Samueli Institute)

## Is Integrative Medicine a Valid Approach to Health Care?

Integrative medicine combines the most scientifically validated and least harmful therapies from both high-tech and holistic medical practices.<sup>2</sup> Major hospitals across the country and the Veterans Administration (America's largest health care system) now include some integrative care. The majority of U.S. medical schools have now introduced some integrative content into the curriculum.

And much of this is driven by patient demand, even if their doctor is not involved. Some form of integrative health is now practiced by four in ten Americans, according to the latest study by the National Institutes of Health.



# How Does Conventional Medicine Compare with Integrative Medicine?

## What Conventional Medicine Does

Manages disease

Treats symptoms

Finds the problem and fixes it

Uses hi-tech, biomedical interventions

Reacts to existing health issues

## What Integrative Medicine Does

Optimizes health

Treats the whole person

Identifies the risk and minimizes it

Uses hi-touch, whole person approaches

Anticipates possible health issues and promotes prevention

## How Conventional Medicine Works

Intervenes as needed

Relies on the patient to achieve health goals

Directed by the physician

## How Integrative Medicine Works

Plans across the life span

Supports the patient to achieve health goals

Guided by a partnership among patient, physician and a team of clinical experts

## What Conditions Can Integrative Medicine Treat?

Integrative medicine can help patients relieve symptoms of a wide range of conditions. Specifically, a 2012 survey reported that integrative medicine centers were most successfully treating: chronic pain, gastrointestinal disorders, depression/anxiety, cancer, and stress. Beyond that, centers reported clinical success in treating: sleep disorders, fibromyalgia, headache, obesity, allergies, diabetes, immune disorders, heart disease, and more.<sup>3</sup>

## What Are Some Common Practices?

There are many valid techniques of integrative health. Here are some of the most effective:

### Mind-Body Connection



**Description:** Therapies that take advantage of the subtle interactions between a person's state of mind and basic physiological functions in their body. Mind-body medicine uses relaxation techniques and the power of thoughts and emotions to improve physical health.

**What form it takes:** Some of the most commonly used techniques include meditation, guided imagery, breathing exercises, and cognitive reframing to alter how we perceive life events.

**How it works:** These methods train the mind to focus without distraction. This can help a person reduce their levels of stress-related hormones. It can strengthen the immune system and can activate the body's remarkable capacities for self-healing.

**Benefits:** Mind-body medicine can have a profoundly positive impact on an individual's well-being because it encourages relaxation, reduces tension and pain, and lessens the need for drugs. These techniques can thus treat an array of conditions, including cancer, high blood pressure, asthma, insomnia, and mental health issues.<sup>4</sup>



## Dietary Choices

**Description:** Aligning what we eat not only with the body's need for fuel, but also with disease-preventing properties naturally found in certain foods. And avoiding foods that increase the risk of some diseases.

**What form it takes:** For most Americans, this means enjoying more fruits, vegetables, grains and beans, reducing or eliminating intake of animal products and generally eating less.

**How it works:** The human body is a biochemical environment, and everything put into it makes a difference—physically, mentally, and spiritually. Thus, eating habits play a major role in the development of certain chronic diseases. For example—lowering “bad” fat and cholesterol intake, and upping whole grain consumption can prevent plaque build up in the arteries; this reduces risk of heart disease.

**Benefits:** Eating properly can significantly reduce risk of chronic illnesses, including heart disease, obesity, diabetes and some cancers. This can result in an improved immune system, an increase in energy, a healthy weight, and a boosted natural healing capacity.<sup>5</sup>





## Activity

**Description:** Various forms of movement and exercise. Lifelong physical activity is key to optimum health and it keeps the whole person—body, mind, and spirit—strong, flexible, and balanced.

**What form it takes:** Two of the most popular forms of activity highlighted in integrative health are walking and yoga. But many other types of movement can be very beneficial, too—swimming, hiking, dancing, jumping, and so forth. Even activities like gardening and housework can be aerobic.

**Benefits:** The human body is built for movement. Moderate exercise optimizes health and healing capacities, and it discourages a sedentary lifestyle. Underuse of the body is a factor in many common illnesses.<sup>6</sup>

**What can it do:** Moderate-intensity physical activity has been shown to aid in weight control; reduce the risk of cardiovascular disease, diabetes, and some cancers; and improve mental health and mood, while the body releases stress.





## Spirituality

**Description:** A means of connection and/or self-reflection through which one finds comfort, purpose and inner peace.

**What form it takes:** Human spirituality is not necessarily religious. It is found both in organized traditions and on a uniquely personal basis. An essential component is connection, whether to others or a higher power, expressed through such qualities as compassion, humility, generosity and simplicity. Spirituality can be practiced in communal gatherings or through private meditation or prayer and can range from contemplative practices like journaling to acts of service.

**How it works:** Spiritual practices inherently improve coping skills, strengthen social support networks, promote healthy behaviors, and reduce feelings of stress, anxiety and loneliness.

**Benefits:** Spirituality can improve ability to cope with life problems and can provide a sense of deep meaning. The effects on health and well being can include benefits to immune, hormonal, cardiovascular, and nervous systems.<sup>7</sup>

**Half of American adults had prayed to cope with health concerns in the previous 12 months.**

(Centers for Disease Control and Prevention, 2007)



## Acupuncture

**Description:** An ancient practice from Traditional Chinese Medicine that involves the (generally painless) insertion of hair-thin needles into the skin at strategic points on the body to produce healing from a wide variety of medical conditions.

**What form it takes:** Treatment mainly involves needle insertion, needle manipulation, and needle removal. There is also acupressure, which applies similar principles as acupuncture but differs in that practitioners use body parts (fingers, palms, feet) to apply pressure.

**How it works:** Western medicine describes the mechanism of acupuncture as stimulating nerves, muscles, and connective tissue, which in turn release natural substances that alter the body's perception of pain (e.g. natural painkillers are stimulated and blood flow is increased). Chinese medicine posits that acupuncture manipulates and re-balances the body's energy flow ("Qi"), which ultimately activates one's natural healing capacities.

**Benefits:** Acupuncture can reduce symptoms of various diseases and conditions, including pain, nausea, vomiting, headaches, menstrual cramps, and osteoarthritis.<sup>8</sup>

Other popular integrative care modalities include: **herbal medicine** (the therapeutic use of plant products), **therapeutic massage**, **reiki** (a healing touch therapy), **reflexology** (the application of pressures to areas on the feet, hands, and ears), **aromatherapy** (the therapeutic use of essential oils extracted from plants), and **music therapy** (the therapeutic practice of using musical experiences and interventions).



## **Does Insurance Cover Integrative Medicine?**

Many leading hospitals now include an integrative clinic alongside more orthodox medical practices, and some of these integrative programs qualify for federal health care reimbursement (including Medicare). That said, a number of health insurance providers do not cover certain integrative medicine therapies, so patients should speak directly with their health insurer to verify coverage.

## **Does This Fit into the Affordable Care Act?**

Some integrative medicine services are newly covered under the Affordable Care Act. But some details are not yet confirmed and may vary by individual state. For details, see [this helpful FAQ](#), prepared by the Integrative Healthcare Policy Consortium.

## **Where Can I Learn More About Integrative Medicine?**

You can find topical links and reading lists over at our [Additional Resources](#).

## **Hear More of Our Public Radio Programs!**

At [\*\*humanmedia.org\*\*](http://humanmedia.org), you can hear about 300 of our public radio programs, including our award-winning Humankind series on a wide range of topics. These include personal health, spirituality and simplicity, environmental protection and history. Please visit: [\*\*humanmedia.org\*\*](http://humanmedia.org)

# The Search for Well-Being

Treating the whole person  
in the new health care era



## Credits

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## Footnotes:

<sup>1</sup> "Center for Integrative Health and Wellness." The Ohio State University Wexner Medical Center. <[http://www.medicalcenter.osu.edu/patientcare/healthcare\\_services/integrative\\_medicine/Pages/index.aspx](http://www.medicalcenter.osu.edu/patientcare/healthcare_services/integrative_medicine/Pages/index.aspx)>.

<sup>2</sup> Lemley, Brad. "What is Integrative Medicine?" DrWeil.com News. <<http://www.drweil.com/drw/u/ART02054/Andrew-Weil-Integrative-Medicine.html>>.

<sup>3</sup> Horrigan, Bonnie, Sheldon Lewis, Donald Abrams, and Constance Pechura. "Integrative Medicine in America: How Integrative Medicine Is Being Practiced in Clinical Centers Across the United States." Bravewell Collaborative. (Feb 2012). <<http://www.bravewell.org/content/Downloads/IMinAm.pdf>>.

<sup>4</sup> "Mind-Body Medicine." University of Maryland Medical Center. <<http://umm.edu/health/medical/altmed/treatment/mindbody-medicine>>.

<sup>5</sup> "Wheel of Health." Duke Integrative Medicine. <<http://www.dukeintegrativemedicine.org/about-us/wheel-of-health>>.

<sup>6</sup> Weil, Andrew. "Why Must We Exercise?." <<http://www.drweil.com/drw/u/ART02920/Why-Must-We-Exercise.html>>.

<sup>7</sup> "Spirituality." University of Maryland Medical Center. <<http://umm.edu/health/medical/altmed/treatment/spirituality>>.

<sup>8</sup> "Acupuncture." Mayo Clinic, 25 Jan 2012. <<http://www.mayoclinic.com/health/acupuncture/MY00946>>

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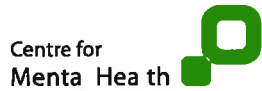
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# **Mental health promotion and mental illness prevention: The economic case**

**Martin Knapp, David McDaid and  
Michael Parsonage (editors)**

**Personal Social Services Research Unit,  
London School of Economics and Political Science**

**April 2011**

**Report published by the Department of Health, London**



## Mental health promotion and mental illness prevention: the economic case

This report is the result of collaboration between researchers in the Personal Social Services Research Unit (PSSRU), London School of Economics and Political Science; the Centre for Mental Health (CMH); and the Centre for the Economics of Mental Health (CEMH), Institute of Psychiatry at King's College London.

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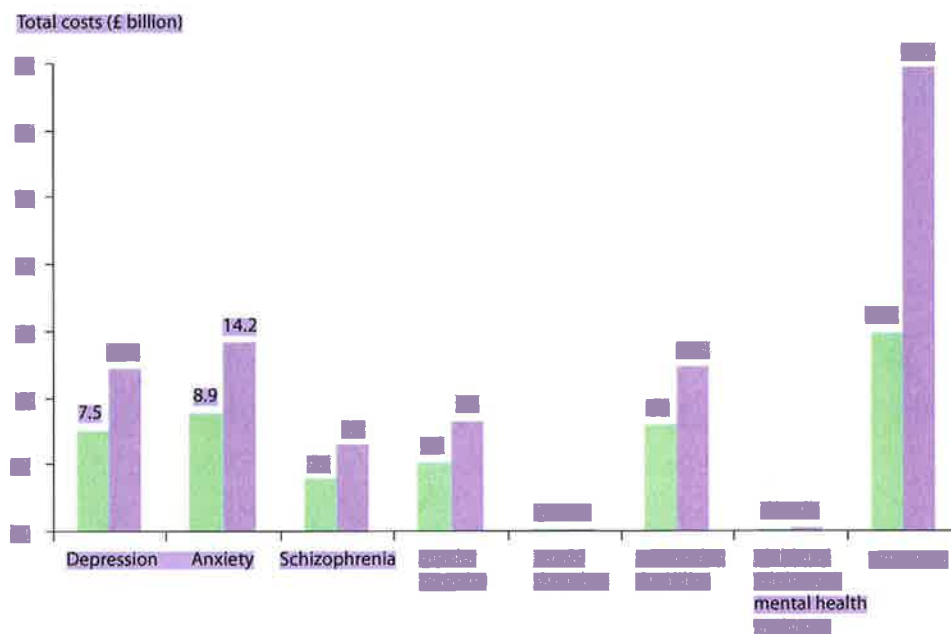
## 1. INTRODUCTION

### 1.1 Prevention, promotion and economics

Health systems aim to improve health and health-related well-being, but are always constrained by the resources available to them. They also need to be aware of the resources available in adjacent systems which can have such an impact on health, such as housing, employment and education. Careful choices therefore have to be made about how to utilise what is available. One immediate corollary is to ask whether investment in the prevention of mental health needs and the promotion of mental wellbeing might represent a good use of available resources. This is the question addressed in this report.

One reason to address such a question is clear from Figure 1. The figure is adapted from a report published three years ago that looked at how the costs of mental health problems might change over a 20-year period. For each of eight mental disorders (depression, anxiety, schizophrenia, bipolar disorder, eating disorders, personality disorders, child and adolescent mental health problems, and dementia), Figure 1 shows the costs of mental health problems in 2007 and the expected costs in 2026 if treatment and support arrangements remain unchanged, and if impacts on, for example, employment patterns also remain unchanged. The projections also assume that the proportion of mental health needs that are recognized and treated remains the same. The projections clearly show a substantial increase in the impact of mental health problems on the economy under current treatment and care arrangements. It is debatable whether such an increase would be widely seen as affordable.

Figure 1: Current and projected future costs by mental health disorder, England 2007, 2026



Source: McCrone, Dhanasiri, Patel, Knapp, Lawton-Smith. *Paying The Price*. London: King's Fund, 2008.

## 1.2 Objectives and approach

We were asked by the Department of Health to identify and analyse the costs and economic pay-offs of a range of interventions in the area of mental health promotion, prevention and early intervention, and to present this information in a way that would most helpfully support NHS and other commissioners in assessing the case for investment.

Key features of the approach taken in pursuit of these objectives were as follows. First, interventions were chosen for economic analysis only where there was strong evidence in the published research literature for their effectiveness in improving mental health or well-being. In identifying these evidence-based interventions, we used systematic reviews where available or carried out their own rapid reviews of the literature.

Second, for each of the interventions identified in this way, detailed estimates were made of costs and pay-offs using economic modelling and related techniques. As far as possible, a consistent approach was used in the coverage and measurement of economic impacts, in order to put the various interventions on a common footing and to allow comparisons between them. (Note that the cost calculations that fed into Figure 1 above are not identical to those used in the present report.)

Third, the economic analysis for each intervention was designed so as to produce a detailed breakdown of costs and pay-offs, year by year and by individual sector and budget type. Interventions can therefore be examined from two distinct perspectives: first, pay-offs to society as a whole, and second, budgetary impacts in the NHS and other public sector agencies. Both perspectives are important, the first in helping to understand the overall value for money of an intervention, and the second in providing information on its affordability at a time of severe constraints on public spending.

Finally, in order to ensure robust results, the approach and assumptions made were conservative across all areas investigated. Measures of net economic impacts should therefore be regarded as *minimum* estimates in all cases. In addition, no monetary value has been put on the health and quality of life gains for the direct beneficiaries of each intervention. Thus, the net economic impacts demonstrated by the models are *in addition* to the mental health and well-being improvements associated with the various programmes.

## 1.3 Challenges and limitations

The main problems facing this project were associated with data shortages. These imposed some limitations both on the range of interventions covered and on the comprehensiveness of the economic modelling.

Taking these in turn, some interventions initially identified as possible candidates for detailed economic analysis had to be dropped because of a lack of robust evidence on their effectiveness. This particularly applied to interventions which focus on the promotion of positive mental health and well-being rather than the prevention of mental ill health, and to those which operate at the community level rather than the individual level. It is important to emphasise that the fact that there was inadequate evidence to model some of these interventions does not necessarily mean that they are not cost-effective.

Among the interventions which were analysed in detail, limitations on the comprehensiveness of the modelling were particularly associated with shortages of data in the research literature on medium- and long-term impacts, and with the occasional difficulty in attaching reliable economic values to all evidence-based impacts. It is an important characteristic of mental ill health that it can affect many different areas of people's lives, sometimes over long periods of time. An inability to capture the full breadth and duration of these consequences in the modelling again implies that the estimated economic benefits of improved mental health are very much on the conservative side.

## 2. THE INTERVENTIONS MODELLED

Fifteen areas were modelled:

- Health visiting and reducing post-natal depression
- Parenting interventions for children with persistent conduct disorders
- School-based social and emotional learning programmes to prevent conduct problems in childhood
- School-based interventions to reduce bullying
- Early detection for psychosis
- Early intervention for psychosis
- Screening and brief intervention in primary care for alcohol misuse
- Workplace screening for depression and anxiety disorders
- Promoting well-being in the workplace
- Debt and mental health
- Population-level suicide awareness training and intervention
- Bridge safety measures for suicide prevention
- Collaborative care for depression in individuals with Type II diabetes
- Tackling medically unexplained symptoms
- Befriending of older adults

In this section we provide a summary for each, briefly setting out the context, the intervention(s) that were modelled and the key findings. In presenting results, there was a need for consistency across the different models. To this end, in all the tables given below, costs or expenditures associated with an intervention are shown with a plus sign, while savings or reductions in costs are shown with a minus sign. All costs and economic pay-offs are measured at 2009 prices, and economic impacts arising in future years are converted to present values using the public sector discount rate of 3.5% a year. Sensitivity analyses were conducted to examine the effects of different assumptions about parameter values, although generally we do not report the details here.

In this report we present only summary descriptions and findings. At the end of each subsection we have given the contact details for the lead researcher for each model, to whom inquiries should be directed for more information. Some of the more detailed analyses from which these summaries are drawn have been or will be submitted to peer-review journals. Some of the interventions are being examined in continuing work, for example in order to try to estimate impacts over a broader range of areas or for longer periods.

## 2.1 Health visiting and reducing post-natal depression

Annette Bauer, Martin Knapp, David McDaid

### Context

Moderate to severe post-natal depression affects around one in eight women in the early months following childbirth.<sup>i</sup> <sup>ii</sup> The condition has an adverse impact on the mother-infant relationship, a woman's quality of life, and the behavioural, emotional and intellectual development of children; it also increases the likelihood that fathers become depressed after birth.<sup>iii</sup> The National Institute for Health and Clinical Excellence (NICE) recommends the screening of post-natal depression as part of routine care, and the use of psychosocial interventions and psychological therapy for women depending on the severity of depressive symptoms.<sup>iv</sup> However, research suggests that in practice a significant proportion of women with post-natal depression are missed in primary care.<sup>v</sup> <sup>vi</sup>

The economic costs of post-natal depression are conservatively estimated at £45m for England and Wales.<sup>vii</sup> This includes additional health and social care costs, but does not include indirect costs to society, such as lost productivity due to a mother's reduced ability to return to work or to work at full capacity.

### Intervention

Health visitors are well placed to identify mothers suffering from postnatal depression and to provide preventative screening and early interventions. A range of UK trials with interventions provided by health visitors have been positive: women were more likely to recover fully after 3 months;<sup>viii</sup> targeted ante-natal intervention with high-risk groups was shown to reduce the average time mothers spent in a depressed state;<sup>i</sup> and a combination of screening and psychologically informed sessions with health visitors was clinically effective 6 and 12 months after childbirth.<sup>ix</sup>

The biggest direct costs of the interventions were associated with training (estimated at £1,400 per health visitor), plus the additional time spent by health visitors with mothers for screening and counselling.

### Impact

This study models a universal health visiting intervention compared with routine care after child birth. The intervention consists of post-natal screening during home visits using a standardised tool. It is assumed all women are screened and those with post-natal depression that does not resolve in the short-term receive psychologically informed sessions from their health visitors. If this intervention does not lead to improved mental health then the current routine treatment is provided.

An alternative strategy was also explored which targeted the intervention, for example via a pre-stratification process in hospital which identifies high-risk women based on common risk factors. The targeted individuals are then screened by health visitors, while other women receive current routine post-natal care. Findings, however, showed similar results to the universal strategy.

The model provides a conservative estimate of the cost impact of the health visitor intervention. On a one-year time horizon there are no cost savings when considering the impact on mothers (and not including the wider impact on fathers and infants), as lower treatment costs and a reduced productivity loss are outweighed by increased training and higher staff costs for providing the interventions. However, if it is assumed that depressive symptoms persist after one year, it is likely that cost savings could be achieved in the medium term as treatment costs and productivity loss would be further reduced. Longer-term, it would be important to include in any evaluation the economic costs of negative behavioural, emotional and cognitive consequences for the children of mothers who suffered from post-natal depression.

When quality of life benefits to women are incorporated, the health visiting intervention provides a positive net benefit with an incremental cost-effectiveness ratio (ICER) of around £4,500 per quality-adjusted life year (QALY).

### Key points

- Findings of a significant improvement in quality of life for mothers and of cost-effectiveness of the health visiting intervention mirror those of Morrell.<sup>ix</sup> Our model suggests wider application of this approach.
- On a one-year horizon, health visiting interventions to reduce post-natal depression do not reduce net costs, but do increase productivity for those who return to work.
- The intervention may produce cost savings in the medium- and long-term but this possibility remains to be evaluated.

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## 2.2 Parenting interventions for the prevention of persistent conduct disorders

*Eva-Maria Bonin, Madeleine Stevens, Jennifer Beecham, Sarah Byford, Michael Parsonage*

### Context

Conduct disorders are the most common childhood psychiatric disorders, with a UK prevalence of 4.9% for children aged 5–10 years.<sup>i</sup> The condition leads on to adulthood antisocial personality disorder in about 50% of cases, and is associated with a wide range of adverse long-term outcomes, particularly delinquency and criminality.<sup>ii</sup>

The costs to society are high, with average potential savings from early intervention previously estimated at £150,000 per case.<sup>iii</sup> Costs falling on the public sector are distributed across many agencies and are around ten times higher than for children with no conduct problems.<sup>iv</sup> The cost of conduct disorder-related crime in England may be as high as £22.5bn a year, and £1.1–1.9m over the lifetime of a single prolific offender.<sup>v</sup>

### Intervention

Parenting programmes can be targeted at parents of children with, or at risk of, developing conduct disorder, and are designed to improve parenting styles and parent-child relationships. Reviews have found parent training to have positive effects on children's behaviour, and that benefits remain one year later.<sup>vi,vii</sup> Longer-term studies show sustained effects but lack control groups; cost-effectiveness data are limited, but health and social services costs were found to reduce over time in one trial.<sup>viii</sup> Without intervention, conduct disorder will persist in about 50% of children.<sup>ii</sup>

The median cost of an 8–12 week group-based parenting programme is estimated at £952 per family, while that of individual interventions is £2,078.<sup>vii</sup> Assuming 80% of people receive group-based interventions and 20% individual interventions, in line with NICE guidance, the average cost of the intervention works out at £1,177 per family. An important ingredient of success in the design and implementation of these programmes is maximising the engagement of 'at-risk' families, as there is evidence that some services suffer from low rates of take-up and high rates of drop-out.

### Impact

The model looks at the costs/savings for 5-year-old children with conduct disorder whose parents attend a parenting programme, and estimates the impact to age 30 compared to no intervention. It is assumed that the intervention decreases the chance that early onset conduct disorder will persist into adulthood, thus avoiding high costs to society. Among those whose parents complete the programme, 33% of children improve to 'no problems', and 5% improve to moderate conduct problems; however, behaviour changes are not sustained beyond one year for 50% of children who initially improve.

Table 1 shows that total gross savings over 25 years amount to £9,288 per child and thus exceed the average cost of the intervention by a factor of around 8 to 1. Savings to the public sector come to £3,368 per child, including £1,278 accruing to the NHS. Under the assumptions made, the intervention will provide a positive return to the public sector in year 8, and to the NHS in year 14, after the intervention. No benefits are assumed from a range of other potential wider impacts such as improved employment prospects, reduced adult mental health issues, and improved outcomes for the child's family and peers; these are likely to be substantial, making the intervention an even better investment.

**Table 1: Gross pay-offs from parenting interventions at age 5, per child with conduct disorder (2008/09 prices)**

	Age 6 (£)	Age 7–16 (£)	Age 17+ (£)	Total (£)
NHS	-168	-912	-197	-1,278
Social services	-24	-29	-14	-67
Education	-132	-304	0	-437
Criminal justice system	0	-1,247	-340	-1,588
<b>Public sector total</b>	<b>-324</b>	<b>-2,493</b>	<b>-551</b>	<b>-3,368</b>
Voluntary sector	-3	-6	-5	-15
Victim costs (crime)	0	-3,361	-810	-4,171
Lost output (crime)	0	-995	-232	-1,227
Other crime costs	0	-377	-129	-506
<b>Other sectors/individuals total</b>	<b>-3</b>	<b>-4,740</b>	<b>-1,176</b>	<b>-5,919</b>
<b>Total</b>	<b>-328</b>	<b>-7,233</b>	<b>-1,727</b>	<b>-9,288</b>

### Key points

- Parenting programmes are cost-saving to the public sector, and to the NHS alone, over the long term, with the main benefits accruing to the NHS and criminal justice system.
- When the wider costs of crime are included, total gross savings over 25 years exceed the average cost of the intervention by a factor of around 8 to 1.

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## 2.3 School-based social and emotional learning programmes to prevent conduct problems in childhood

*Jennifer Beecham, Eva Bonin, Sarah Byford, David McDaid, Gerald Mullally, Michael Parsonage*

### Context

Conduct problems in childhood cover a range of oppositional or anti-social forms of behaviour such as disobedience, lying, fighting and stealing. Such problems are very common: 6% of children aged 5–10 years have severe conduct problems (SCP) and 19% have mild conduct problems (MCP), rising to 9% and 29% respectively in adolescence.<sup>i</sup> Conduct problems are associated with a range of poor outcomes including increased risk of criminal activity, fewer school qualifications, parenthood at a young age, unemployment, divorce or separation, substance abuse, and psychiatric disorders – many of which lead to increased costs across several agencies.

Potential savings (including intangibles) from each case prevented through early intervention have been estimated at £150,000 for SCP and £75,000 for MCP.<sup>ii</sup> Crime accounts for about two-thirds of these long-term costs, with the other main contributors being the costs of mental illness in adulthood and lower lifetime earnings. The annual cost of crime in England attributable to people who had early conduct problems (either severe or mild) may be as high as £60bn.<sup>iii</sup>

### Intervention

School-based Social and Emotional Learning (SEL) programmes help children and young people to recognise and manage emotions, set and achieve positive goals, appreciate the perspectives of others, establish and maintain positive relationships, make responsible decisions and handle interpersonal situations constructively.<sup>iv</sup> International evidence shows that SEL participants demonstrate significantly improved social and emotional skills, attitudes, behaviour, and academic performance.

The costs of a representative intervention, including teacher training, programme co-ordinator and materials were estimated as £132 per child per year (2009 prices).<sup>v</sup> There are no empirical cost-effectiveness studies evaluating the impact of whole school SEL programmes on conduct problems.<sup>vi</sup> There is a need for evaluation of specific schemes in a UK context.

### Impact

The model looks at the cost savings from school-based SEL programmes through their impact on conduct problems. It is assumed that the intervention occurs at age 10 years and that a child starts in one of three different conduct 'health states': no conduct problems, mild conduct problems or severe conduct problems. International data is used to approximate the probability of transition between these three states between childhood, adolescence and adult hood. For each health state, the model incorporates estimates of the related costs incurred by various public sector agencies, the voluntary sector, and from the wider impact of crime (including the psychological impact on victims). Costs/savings for other outcomes, such as improved academic performance, have not been included; nor have those relating to parents, siblings or other peers.

Without SEL, approximately 46% of children have few conduct problems throughout their life course; 24% have conduct problems in childhood that do not persist; 20% develop conduct problems in adolescence; and approximately 11% have life-course persistent conduct problems.<sup>vii</sup> Based on the evidence, the model conservatively assumes that school-based SEL programmes achieve a 9% reduction in transition between conduct 'health states'.

**Table 2: Cumulative pay-offs per child through social and emotional learning programmes (2009 prices)**

	Year 1 (£)	Year 5 (£)	Year 10 (£)
NHS	-39	-751	-1,148
Social Services	-4	-13	-23
Education	-26	-135	-186
Criminal Justice	-14	-1,139	-1,849
<b>Public sector total</b>	<b>-83</b>	<b>-2,038</b>	<b>-3,206</b>
Voluntary Sector	0	-4	-8
Victim costs (crime)	-30	-3,164	-4,912
Other crime costs	-12	-1,295	-2,038
<b>Other sector/individuals total</b>	<b>-42</b>	<b>-4,463</b>	<b>-6,958</b>
Total pay-offs	-125	-6,501	-10,164
Cost of intervention	132	132	132
<b>Net costs/pay-offs</b>	<b>7</b>	<b>-6,369</b>	<b>-10,032</b>

The results show that the SEL intervention is cost-saving overall after the first year, while education recoups its costs in five years. A key driver of net savings is the crime-related impacts of conduct problems that can be avoided (Table 2). Reducing the assumption about the impact of SEL to 3% (down from 9%) produces cost savings to the NHS after four years; assuming an impact of just 1% across the 'health states', the model is cost saving to the public sector after five years.

### Key points

- There is a strong case that school-based SEL programmes are cost-saving for the public sector.
- The key drivers of net savings are the crime and NHS-related impacts of the intervention.
- Education services are likely to recoup the cost of the intervention in five years.
- There are substantial wider benefits stemming from this intervention.

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## 2.4 School-based interventions to reduce bullying

*Jennifer Beecham, Sarah Byford, Canny Kwok, Michael Parsonage*

### Context

Bullying in schools is a common problem with potentially long-lasting consequences for victims. According to a recent Ofsted survey, 39% of children report being bullied in the previous 12 months,<sup>i</sup> although estimates of prevalence vary widely between studies, mainly because of differences in definition.

Being bullied at school has adverse effects on both psychological well-being and educational attainment. There is evidence from longitudinal data that this has a negative long-term impact on employability and earnings; on average, lifetime earnings of a victim of bullying are reduced by around £50,000.<sup>ii</sup>

### Intervention

Anti-bullying programmes in schools show mixed results, depending on the design of the intervention and its implementation. That said, there is a consensus in the literature that whole-school programmes with a range of components operating at different levels within the school are more effective in reducing the prevalence of bullying than curriculum-based programmes. One high-quality evaluation of a school-based anti-bullying intervention found a 21–22% reduction in the proportion of children victimised.<sup>iii</sup> Benefits include improvements in the emotional, physical and social health of victims, school attendance and educational attainment, all of which are associated with better long-term employment and earnings outcomes. However, the available evidence about anti-bullying interventions uses relatively short follow-up periods, and little is known about the longer-term impact on prevalence.

Information is limited on the cost of anti-bullying programmes, but one study estimates this at £15.50 per pupil, per year.<sup>ii</sup>

### Impact

This study makes use of a model developed for the National Institute for Health and Clinical Excellence (NICE)<sup>ii</sup> which explores the link between being bullied at school and subsequent earnings. The NICE model incorporates recent analysis<sup>iv</sup> of data from the longitudinal National Child Development Survey (NCDS), covering a large sample of children born in 1958, and takes into account variables such as family background, health problems and educational aptitude. Based on NCDS data, the prevalence of bullying in the NICE model is put at 24%. The school-based programme includes peer mediators and a classroom intervention, and it is assumed that the anti-bullying intervention achieves a sustained reduction in bullying of 15%.

The results estimate that, averaged across all children whether bullied or not, the benefit of intervention is £1,080 per school pupil. Given that the cost of the intervention is just £15.50 per pupil per year, it offers good value for money even if repeated annually. The economic case is even stronger if allowance is made for other benefits of reduced bullying, such as improved psychological well-being, which are not included in the NICE model. The quantified benefits are long-term in nature and accrue mainly to individuals in the form of higher incomes. However, there will also be benefits to the Exchequer, from increased tax revenues and savings in social security expenditure.

**Key points**

- On the limited evidence available, inexpensive anti-bullying interventions appear to offer good value for money on a long-term perspective, based on improved future earnings.
- Further evidence is needed about which interventions are most effective, and whether their impact is sustained over the longer-term.

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## 2.5 Early detection for psychosis

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### Context

The first symptoms of psychosis typically present in the late teenage and early adult years. It is estimated that each year in England 15,763 people exhibit early (prodromal) symptoms before the onset of full psychosis.<sup>i</sup> However, early detection services are not routinely provided and provision is currently very limited.

Progression of the disease is associated with higher costs to public services (including health, social care, and criminal justice), lost employment, and greatly diminished quality of life for the patient and their family. A 2008 analysis<sup>i</sup> estimated the average annual direct costs per average patient with schizophrenia at £10,605, and total costs (including lost employment) at £19,078. The corresponding costs for bipolar disorder and related conditions were £1,424 and £4,568. Total costs for these conditions combined were estimated at £3.9bn for services and £9.2bn for services and lost employment.

### Intervention

Early detection services aim to identify the early symptoms of psychosis, reduce the risk of transition to full psychosis and shorten the duration of untreated psychosis for those who do develop it. Such services include the provision of sessions of cognitive behavioural therapy, psychotropic medication, and contact with psychiatrists; this contrasts with treatment as usual which typically consists of GP and counsellor contacts. There is some evidence that such services can reduce the rate of transition to full psychosis.<sup>ii</sup>

One year of early detection intervention has been estimated to cost £2,948 (2008/9 prices) per patient, compared with £743 for standard care.<sup>ii</sup> The costs of community mental health care and inpatient admissions (formal and informal) were included.

### Impact

The model looks at whether investments in specialist early detection services can be cost-saving in terms of health care services, criminal justice services, suicide, homicide and lost employment for a one-year cohort of patients. It is based on one specific implementation of early detection services that is provided by Outreach and Support in South London (OASIS). The target group is young people aged 15 to 35 years old in the general population with prodromal symptoms of psychosis.

The model assumes that transition from prodromal symptoms to full psychosis occurs for 20% of patients compared to 35% under standard care.<sup>ii</sup> Table 3 shows the impact on annual costs/savings of full coverage by early detection services, compared to standard care. Savings from year 3 onwards are assumed to be due to 2,364 avoided cases of psychosis estimated from the model; it is also assumed that patients with avoided psychosis would otherwise have been treated either by an early intervention team (67%) or a standard care team (33%). The impact on costs from reductions in the suicide and homicide rates is assumed to appear from year 4 onwards.

The savings associated with ED are, in the model, entirely driven by reduced numbers of people making a transition to psychosis. The assumed 'success rate' in the model is 15 percentage points (20% compared to 35%). If the difference was only 5 percentage points, the annual saving in years 2–5 would fall to around £16m, but would increase to around £79m if the success rate were 25 percentage points. Using these two extreme scenarios, the annual savings over years 6–10 are approximately £14m and £68m, respectively. The assumed difference of 15 percentage points<sup>ii</sup> is in fact similar to the impact reported elsewhere.<sup>iii iv v</sup>

**Table 3: Impact of early detection services on annual costs/pay-offs, based on 15,763 people with prodromal symptoms of psychosis (2008/9 prices)**

	Year 1	Years 2–5	Year 6–10
<b>Per person</b>	<b>(£)</b>	<b>(£)</b>	<b>(£)</b>
Services	2,228	-1,149	-1,053
Productivity losses		-1,835	-1,476
Intangibles (negative impact on quality of life)		-39	-£75
<b>Total</b>	<b>2,228</b>	<b>-3,022</b>	<b>-2,604</b>
<b>By sector</b>	<b>(£m)</b>	<b>(£m)</b>	<b>(£m)</b>
NHS	35.1	-15.2	-13.2
Other public sector	0	-2.9	-3.6
Productivity losses	0	-28.9	-23.3
Intangible	0	-0.6	-1.2
<b>Total</b>	<b>35.1</b>	<b>-47.6</b>	<b>-41.0</b>

**Key points**

- Early detection services for patients with prodromal symptoms of schizophrenia are cost-saving overall, and also cost-saving from the perspective of the NHS from year 2.
- Further evidence is needed on the impact of different models of early detection services.

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## 2.6 Early intervention for psychosis

*Paul McCrone, A-La Park, Martin Knapp*

### Context

The number of young people each year aged 15–35 who experience a first episode of psychosis is estimated at 6,900 in England. Psychosis related to schizophrenia is associated with higher costs to public services (including health, social care, and criminal justice), lost employment, and greatly diminished quality of life for the individual with the illness and their family. Estimates of the costs of schizophrenia and bipolar disorder are given in the report on early detection for psychosis (see previous model).

### Intervention

Early intervention teams aim to reduce relapse and readmission rates for patients who have suffered a first episode of psychosis, and to improve their chances of returning to employment, education or training, and more generally their future quality of life. Such intervention involves a multidisciplinary team that could include a range of professionals (psychiatrists, psychologists, occupational therapists, community support workers, social workers, vocational workers). The emphasis is on an assertive approach to maintaining contact with the patient and on encouraging a return to normal vocational pursuits. In the UK evidence has shown that early intervention can reduce relapse and readmission to hospital and to improve quality of life.<sup>i ii</sup>

The annual direct cost per patient of this type of service in terms of input from an early intervention team plus other community psychiatric services and inpatient care has been estimated at £10,927 at 2008/09 prices, considerably less than that of standard care at £16,704.<sup>iii</sup> The reduction in overall service costs is primarily due to the lower demand for inpatient care when specialist early intervention is provided; the first year of the actual early intervention team's input (including contacts with psychiatrists, social workers and community mental health nurses) is estimated to cost £2,282 per patient, which is higher than the £1,284 for standard care.

### Impact

The model looks at whether investments in specialist early intervention services can be cost-saving in terms of use of health care services, criminal justice services, suicide, homicide and lost employment. The target group is young people aged 15 to 35 years old in the general population experiencing a first episode of psychosis.

Table 4 shows the impact on annual costs/savings of full coverage by early intervention services of a one-year cohort of patients, compared to standard care. Savings are reduced after three years (when discharge to standard care is assumed to occur) because it is conservatively assumed that, from then on, the inpatient admission rates for early intervention services are the same as for standard care.

### Key points

- The expansion of the coverage of early intervention services to all patients experiencing a first episode of psychosis is cost-saving overall, and also cost-saving from the perspective of the NHS alone, from year 1.
- Savings are estimated to decrease over time because there is no current evidence to suggest that reductions in inpatient stays are maintained when patients are discharged from the early intervention team.

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**Table 4: Impact of early intervention services on annual costs/pay-offs, based on a one-year cohort of patients (2008/09 prices)**

	Year 1	Years 2–5	Year 6–10
<b>Per person</b>	<b>(£)</b>	<b>(£)</b>	<b>(£)</b>
Services	-5,777	-2,408	-60
Productivity losses		-2,052	-1,912
Intangibles (negative impact on quality of life)		-314	-628
<b>Total</b>	<b>-5,777</b>	<b>-4,774</b>	<b>-2,600</b>
<b>By sector</b>	<b>(£m)</b>	<b>(£m)</b>	<b>(£m)</b>
NHS	-39.1	-16.0	0
Other public sector	-0.8	-0.6	-0.4
Productivity losses	0	-14.2	-13.2
Intangible	0	-2.2	-4.3
<b>Total</b>	<b>-39.9</b>	<b>-32.9</b>	<b>-17.9</b>

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## 2.7 Screening and brief intervention in primary care for alcohol misuse

*Rabee'h Aslam, Martin Knapp, Michael Parsonage, Jamie Vela*

### Context

It is estimated that 6.6 million adults in England currently consume alcohol at hazardous levels and 2.3 million at harmful levels.<sup>i</sup> Hazardous drinking is defined as weekly alcohol consumption of 21–50 and 14–35 units for men and women, respectively, and harmful drinking as above 50 and 35 units.

The total costs of alcohol misuse in England, based on inflation-adjusted Department of Health data,<sup>ii</sup> can be estimated in 2009/10 prices at around £23.1bn, comprising: £3.0bn in NHS costs, £7.2bn in output losses and £12.9bn from the costs of crime. In practice, these figures understate the costs falling on the NHS as more than £1bn allocated to crime covers medical treatment for injuries suffered by the victims of alcohol-related violence. Harmful alcohol misuse is disproportionately costly: analysis for this study estimates that the overall average annual costs of a harmful drinker are around 3.4 times that of a hazardous drinker.

### Intervention

Effective strategies to reduce alcohol-related harm require a combination of measures, covering both population-level approaches (such as price increases and advertising controls) and interventions aimed at individuals.<sup>iii</sup> In the latter category, evidence indicates that brief interventions in primary care settings achieve an average 12.3% reduction in alcohol consumption per individual.<sup>iv</sup> However, this is a short-term effect and evidence about its duration is less clear cut.

An inexpensive intervention in primary care combines universal screening by GPs of all patients, followed by a 5-minute advice session for those who screen positive. The total cost of the intervention averaged over all those screened is £17.41 per head in 2009/10 prices.<sup>v</sup>

### Impact

The model analyses the costs and benefits of GPs using the Alcohol Use Disorders Identification Test (AUDIT) to screen a representative sample of 1,000 adults attending their next GP consultation, followed by 5 minutes of advice for those identified as hazardous or harmful drinkers. Based on national prevalence data, the numbers per 1,000 in these two categories are estimated at 224 and 78 respectively, but it is assumed that around 20% of relevant individuals are missed in the screening. In line with other studies,<sup>v</sup> the effectiveness of the intervention is assumed to decline linearly to zero in seven years. To avoid any exaggeration of benefits, no allowance is made in the analysis for any savings associated with alcohol-related premature mortality.

Given the £17.41 cost of the intervention, the results demonstrate that savings after seven years exceed costs by a factor of nearly 12 to 1 (Table 5). Purely in terms of public expenditure, the intervention offers good value for money over the same period as combined savings in the NHS and criminal justice system exceed the costs of the intervention by a factor of more than 3 to 1. Estimated savings in the NHS alone exceed costs by more than 2 to 1.

**Table 5: Costs/pay-offs per head for screening and brief advice based on a representative sample of 1,000 adults attending their next GP consultation (2009/10 prices)**

	Year 1 (£)	Years 2–5 (£)	Years 6–7 (£)	Total (£)
NHS	-10.55	-24.61	-3.91	-39.07
Crime	-28.49	-66.02	-10.49	-105.00
Productivity losses	-16.20	-38.24	-6.05	-60.48
Total	-55.23	-128.87	-20.45	-204.55

### Key points

- There is a robust economic case: low-cost interventions in primary care offer good value for money in reducing alcohol-related harm.
- The main constraint on national implementation is one of scale; options to consider include targeted approaches (e.g. focusing on young males), screening people only when they change GP rather than at next consultation, or using practice nurses rather than GPs to provide the screening and/or follow-up advice.

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## 2.8 Workplace screening for depression and anxiety disorders

David McDaid, Derek King, Michael Parsonage

### Context

Substantial potential economic costs arise for employers from productivity losses due to depression and anxiety in the workforce. The main costs occur due to staff absenteeism and presenteeism (lost productivity while at work). From the perspective of the public purse, failure to intervene also risks higher future health and social care costs.

Labour Force Survey data suggest that 11.4 million working days were lost in Britain in 2008/09 due to work-related stress, depression or anxiety. This equates to 27.3 days lost per affected worker. It is estimated that the average annual cost of lost employment in England attributable to an employee with depression is £7,230, and £6,850 for anxiety (2005/06 prices).<sup>i</sup> If these conditions are not treated, additional costs are also likely to arise from related physical health problems. In the longer term, wider costs may also be incurred, such as from acute care, the impact on family members and premature death. There may also be additional recruitment and training costs for employers if their employees permanently withdraw from the workforce.

### Intervention

Workplace-based enhanced depression care consists of completion by employees of a screening questionnaire, followed by care management for those found to be suffering from, or at risk of developing, depression and/or anxiety disorders. Those identified as being at risk of depression or anxiety disorders are offered a course of cognitive behavioural therapy (CBT) delivered in six sessions over 12 weeks. This intervention has been shown in a number of studies to be effective in tackling depression and reducing productivity losses in various workplaces. In a similar approach in Australia, productivity improvements outweighed the costs of the intervention.<sup>ii</sup>

It is estimated that £30.90 (at 2009 prices) covers the cost of facilitating the completion of the screening questionnaire, follow-up assessment to confirm depression, and care management costs.<sup>iii</sup> For those identified as being at risk, the cost of six sessions of face-to-face CBT is £240. Computerised CBT courses are cheaper, and may be less stigmatising to individual workers, but less is known about their longer-term effectiveness.

### Impact

The model assesses the cost-effectiveness of a workplace-based intervention for depression and anxiety disorders, and whether it reduces sickness, absenteeism and presenteeism, compared with no intervention. The target population is a hypothetical cohort of working age individuals in a white collar enterprise with 500 full time equivalent employees, all of whom are screened. The cost/savings impact is addressed from the perspective of the health system (including personal social services) and business, with the enterprise bearing the total costs of the intervention. It assumes that only two-thirds of employees offered CBT as a result of screening will make use of this treatment. It is estimated that the reduction in presenteeism as a result of successful intervention is equivalent to an extra 2.6 hours of work per week.<sup>iv</sup> In year 1 it is assumed that this benefit is seen only in the 36 weeks after the completion of the CBT course. If depression and anxiety disorders are averted, then 27.3 days of absenteeism per annum associated with these disorders will be avoided. Conservatively, the model assumes that health and personal social services costs relating to depression and anxiety only occur in year 2.

The results show that from a business perspective the intervention appears cost-saving, despite the cost of screening all employees (Table 6). Benefits are gained through both a reduction in the level of absenteeism

**Table 6: Total net costs/pay-offs from business and societal perspectives for a company with 500 employees (2009 prices)**

	Year 1 (£)	Year 2 (£)
Intervention cost	20,676	0
Health (including social care)	0	-10,522
Absenteeism (productivity losses)	-17,508	-23,006
Presenteeism (productivity losses)	-22,868	-30,050
Total	-19,700	-63,578

and improved levels of workplace productivity through a reduction in presenteeism. However, the impact may differ across industries; the case may be less strong where staff turnover is high and skill requirements low. From a health and personal social services perspective the model is cost-saving, assuming the costs of the programme are indeed borne by the enterprise.

### Key points

- The intervention is cost-saving from the perspectives of both business and the health system, on the assumption that all costs are borne by business.
- The costs of the intervention are more than outweighed by gains to business due to a reduction in both presenteeism and levels of absenteeism.
- Public sector employers also have the potential to benefit from investing in universal workplace depression and anxiety screening interventions.

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## 2.9 Promoting well-being in the workplace

*David McDaid, Derek King, A-La Park, Michael Parsonage*

### Context

The workplace provides a convenient location for addressing the physical and mental health of a large proportion of the adult population. Problems inside and beyond work can be identified and tackled, and there is also scope for general health promotion. Aside from the potential benefits to public health, this type of well-being intervention can improve an organisation's productivity, image and workplace safety. It may also reduce the vulnerability of employees to work-related mental health problems.

Deteriorating well-being in the workplace is potentially costly for businesses as it may increase absenteeism and presenteeism (lost productivity while at work), and in the longer term potentially leads to premature withdrawal from the labour market. Estimates of the costs of depression and anxiety in the labour force are given in the report on workplace screening for depression and anxiety disorders (see previous model). From a health system perspective, improved well-being potentially will help avoid the use of services for some mental and physical health problems.

### Intervention

There are a wide range of approaches to mental health promotion in the workplace. These include flexible working arrangements; career progression opportunities; ergonomics and environment; stress audits; and improved recognition of risk factors for poor mental health by line managers. Other measures targeted at general well-being can include access to gyms, exercise and sports opportunities and changes to the canteen food. One study found that Scottish health care workers who were helped to adopt more active commuting habits showed significantly improved mental health.<sup>i</sup>

A multi-component health promotion intervention of the sort modelled in the current study consists of personalised health and well-being information and advice; a health risk appraisal questionnaire; access to a tailored health improvement web portal; wellness literature; and seminars and workshops focused on identified wellness issues. A quasi-experimental evaluation of this type of programme has reported significantly reduced stress levels, reduced absenteeism and reduced presenteeism, compared with a control group.<sup>ii</sup> Promotion of long-term mental well-being may be associated with reduced longer term risk of poor mental health, although the evidence for this remains weak.<sup>iii iv</sup>

The cost of a multi-component intervention is estimated at £80 per employee per year.<sup>ii</sup>

### Impact

The model assesses the impact of a workplace-based health promotion and well-being programme in a white collar enterprise with 500 employees, all of whom are covered by the intervention. The costs/savings are addressed from the perspective of the business, which is assumed to bear costs of the intervention. Estimates of the effectiveness, uptake of the intervention (43% of all employees) and impact on absenteeism and presenteeism (lost productivity while at work) are taken from a study undertaken in the UK offices of a large multi-national company.<sup>ii</sup>

From a business perspective the model appears cost saving compared to taking no action (Table 7). In year 1, the initial costs of £40,000 for the programme are outweighed by gains arising from reduced presenteeism and absenteeism of £387,722. This represents a substantial annual return on investment of more than 9 to 1. In addition there are likely to be benefits to the health system from reduced physical and mental health problems as a result of the intervention, but these are not quantified here.

**Table 7: Total net costs/pay-offs from a business perspective for a company with 500 employees (2009 prices)**

	Year 1 (£)
Intervention cost	40,000
Absenteeism (productivity losses)	-110,527
Presenteeism (productivity losses)	-277,195
Total	-347,722

### Key points

- A strong case can be made to businesses that workplace well-being interventions can be significantly cost-saving in the short term, but some smaller companies may need public support to implement such schemes.
- The public sector, including the NHS, can also benefit as an employer from improved investment in workplace well-being programmes.

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## 2.10 Debt and mental health

*Martin Knapp, David McDaid, Sara Evans-Lacko, Chris Fitch, Derek King*

### Context

Even before the current global financial crisis, it was estimated that 8% of the population had serious financial problems and another 9% showed signs of financial stress.<sup>i</sup> These problems have wide-ranging implications. In particular, research has demonstrated a link between debt and mental health; individuals who initially have no mental health problems but find themselves having unmanageable debts within a 12-month period have a 33% higher risk of developing depression and anxiety-related problems compared to the general population who do not experience financial problems.<sup>ii</sup>

The vast majority of these mental health problems take the form of depression and anxiety-related disorders. These conditions are associated with significant costs arising from health service use, legal fees, debt recovery and lost productivity. On average, the lost employment costs of each case of poor mental health are £11,432 per annum, while the annual costs of health and social service use are £1,508.<sup>iii</sup>

Only about half of all people with debt problems seek advice,<sup>iv</sup> and without intervention almost two-thirds of people with unmanageable debt problems will still face such problems 12 months later.

### Intervention

The current evidence suggests that there is potential for debt advice interventions to alleviate financial debt, and hence reduce mental health problems resulting from debt. For the general population, contact with face-to-face advice services is associated with a 56% likelihood of debt becoming manageable,<sup>v</sup> while telephone services achieve 47%.<sup>vi</sup> In comparison, around one-third of problem debt may be resolved without any intervention.

The costs of this type of intervention vary significantly, depending on whether it is through face-to-face, telephone or internet-based services. The Department for Business, Innovation and Skills suggests expenditure of £250 per client for face-to-face debt advice; telephone and internet-based services are cheaper. Funding for debt advice comes from a range of sources including government, NHS, charities and creditors.

### Impact

The model explores the cost-effectiveness of different types of debt advice services targeted at working age adults without mental health problems. It follows a hypothetical cohort of people at risk of unmanageable debt over a 24-month period, and looks at the impact of subsequent debt-related mental health problems (depression and anxiety) on costs to the health, social care and legal systems, and from lost productivity due to reduced employment. Legal and debt advice costs are assumed to fall in year 1, while other costs fall mostly in year 2.

A range of scenarios was explored in models. Even under conservative assumptions, investment in debt advice services can both lower expected costs and reduce the risk of developing mental health problems. The intervention appears to be cost-effective from most societal and public expenditure perspectives. However, face-to-face services will only be the most cost-effective option if a high proportion of the costs of providing the service is recovered from creditors. This is feasible: one major not-for-profit debt advice service covers more than 90% of its costs in this way. In other scenarios, where cost recovery is lower, either telephone or web-delivered services will be most cost-effective. Table 8 shows the impact on costs/savings of face-to-face intervention for a hypothetical population of 100,000, compared with no intervention, assuming that one-third of the cost of the debt advice is borne by the NHS, with the rest paid for by creditors.

**Table 8: Impact on costs/pay-offs of face-to-face debt intervention (with NHS paying one-third of the costs of the debt advice services) (2009 prices)**

	Year 1 (£)	Year 2 (£)	Year 3 (£)	Year 4 (£)	Year 5 (£)
Health and social care	151,512	-13,209	-13,017	-12,829	-12,643
Legal	-87,908	-	-	-	-
Productivity losses	-7,827	-100,128	-98,677	-97,426	-95,837
Net costs/pay-offs	55,777	-113,336	-111,694	-110,075	-108,480

In practice, this type of intervention could be targeted at specific groups who may be particularly vulnerable to financial debt and mental health problems, for example low-income communities.

#### Key points

- In nearly all modelled scenarios, at least one type of debt management intervention has better outcomes and lower costs over a two-year period compared to no action.
- For greatest cost-effectiveness, careful consideration needs to be given to models of financing and to the mix between face-to-face, telephone and web-based provision.

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## 2.11 Population-level suicide awareness training and intervention

David McDaid, A-La Park, Eva-Maria Bonin

### Context

The economic impacts of suicide are profound, although comparatively few studies have sought to quantify these costs. Updating work undertaken previously by one of the authors,<sup>i</sup> it is estimated that the average cost per completed suicide for those of working age only in England is £1.67m (at 2009 prices). This includes intangible costs (loss of life to the individual and the pain and suffering of relatives), as well as lost output (both waged and unwaged), police time and funerals.

There are also costs to the public purse from recurrent non-fatal suicide events; these are more difficult to estimate, and will vary by means of suicide attempt. One recent English study indicates that only 14% of costs are associated with A&E attendance and medical or surgical care; more than 70% of costs are incurred through follow up psychiatric inpatient and outpatient care.<sup>ii</sup> This is in part because a proportion of individuals who survive suicide attempts are likely to make further attempts, in some cases fatal. There are nevertheless economic benefits from delaying completed suicide as the number of lost years of productive activity will be reduced; overall it is estimated that costs are averted of £66,797 per year per person of working age where suicide is delayed.

### Intervention

Around 81% of working age adults in England come into contact with a GP at least once a year,<sup>iii</sup> and there is evidence that suicide prevention education for GPs can have an impact as a population-level intervention to prevent suicide. This has the potential to be cost-effective if it leads to adequate subsequent treatment.<sup>iv</sup> With greater identification of those at risk, individuals can receive cognitive behavioural therapy (CBT), followed by ongoing pharmaceutical and psychological support to help manage underlying depressive disorders. Evidence from the US suggests that CBT can help reduce the risk of future suicidal events by up to 50%.<sup>v</sup>

The cost of this type of intervention has several components. A course of ten sessions of CBT in the first year is around £400 per person. Further ongoing pharmaceutical and psychological therapy is estimated to cost £1,182 a year (2009 prices). The cost of suicide prevention training for GPs, based on the Applied Suicide Intervention Skills Training (ASIST) course, is £200 which would mean a total cost of around £8m if delivered to all GPs in England.

### Impact

The model looks at the economic case over 10 years for investing in GP suicide prevention education aimed at reducing suicide among the cohort of working age adults. It is assumed that, without any action, 20% of individuals experiencing suicidal thoughts are at risk of completing suicide within a one year period. The risk of serious non-fatal events in the year following a non-fatal suicide attempt falls from 41.6% to 24.1% as a result of the intervention.<sup>v</sup> The model does not assume any decrease in the risk of suicide in the 10 years after the first self-harm event other than that initially achieved, and that individuals identified as being at risk will continue to receive a combination of therapies to help maintain reduced risk. Based on an earlier study, GPs who go on the suicide prevention training course will have a 20% greater chance of identifying those at risk of suicidal behaviour in the year following training.<sup>vi</sup> The model indicates that 603, 706 or 669 suicides would be avoided over the 1-, 5- and 10-year time horizons, respectively.

The analysis of costs/savings includes expenditure on health care, police/coroner activities, funerals, productivity and intangible costs. The additional treatment and support costs for individuals who do not complete suicide are to some extent offset by a reduction in the costs to the health care system of completed

**Table 9: Net costs/pay-offs for suicide prevention following suicide awareness training, compared with no intervention in England (2009 prices)**

	After 1 year (£m)	After 5 years (£m)	After 10 years (£m)
Health			
– Suicide awareness training	8.1	8.1	8.1
– Suicide prevention measures	1.8	7.2	12.5
– Emergency Treatment	-0.4	-0.9	-1.0
Police/coroner costs	-0.3	-0.5	-0.6
<b>Total public services</b>	<b>9.2</b>	<b>14.0</b>	<b>19.0</b>
Funerals	-0.5	-0.9	-1.2
Productivity losses	-186.2	-340.2	-416.8
Intangible costs	-390.3	-713.0	-873.6
<b>Total</b>	<b>-567.8</b>	<b>-1,040.1</b>	<b>-1,272.6</b>

suicides and serious self harm events, but the intervention has significant net costs to the health care system of up to £19m over 10 years. However, if the reductions in productivity losses are also included then the intervention is cost-saving by a very large margin (Table 9), and remains so even if the estimated impact on productivity is reduced to just 5% of the baseline case. Overall, net savings of £1.27bn arise over 10 years if intangible costs are also included. All results are sensitive to assumptions about the future risk of suicide.

From a cost-effectiveness perspective, for the health system the cost per life saved would be £15,726, £20,438 and £29,235 over 1, 5 and 10 years respectively. Using conservative assumptions about the gain in life and quality of life, this yields a highly effective cost to the NHS per QALY saved of £1,573, £2,044, and £2,924, respectively.

### Key points

- Investment in GP suicide prevention training is cost-saving overall from year 1 even if only very modest reductions in productivity losses are factored in.
- The intervention appears highly cost-effective from a health system perspective alone.

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## 2.12 Bridge safety measures for suicide prevention

*Eva-Maria Bonin, David McDaid*

### Context

In England alone, there were 12,479 suicides and an estimated 121,634 non-fatal suicide attempts in the three years from 2006 to 2008. The costs of suicide to society are high, in both human and financial terms; on average, for the whole population, these are estimated at £1.45m (at 2009 prices), including intangible costs (loss of life to the individual and the pain and suffering of relatives) as well as lost output (both waged and unwaged) and police time.<sup>i</sup>

Jumping from a height accounts for around 3% of completed suicides. Given high fatality rates of over 50%, the lifetime costs of completed and attempted suicides by jumping account for more than £176m per year.

### Intervention

Bridges provide obvious jumping sites, and the construction of safety barriers has been shown successfully to reduce suicides on particular bridges.<sup>ii iii iv</sup> It appears that these averted suicides are not simply displaced to other, unsecured jumping sites, but whether suicide occurs by another method is difficult to analyse.

The Clifton Suspension Bridge in Bristol is one such suicide 'hot spot'. Following the installation of a safety barrier in 1998, at a cost of £300,000 (in 2009 prices), the number of suicides reduced from an average of 8.2 per annum in the five years before the barrier, to 4 per annum in the five years after it was installed.<sup>v</sup>

### Impact

Using the Clifton Suspension Bridge as a case study, the model estimates the savings (both tangible and intangible) to society of installing a safety barrier. It assumes that the barrier prevents around half of suicide attempts, but also considers the impact if these individuals instead attempt suicide using other methods. This displacement can still lead to a lower number of suicides, as the mortality of those who jump from this bridge is 95%, compared with around 9% for other suicide methods combined. The model includes the probability of subsequent attempted and fatal suicides.

The cost savings are calculated first for a 1-year cohort of those attempting suicide from the bridge in a single year, and follows this group over a 10-year period. It then looks at aggregated savings from ten consecutive cohorts, assuming that the pattern of suicides would have recurred every year. The savings do not include the costs of bereavement support, or the impact on children losing a parent. It is assumed that barrier construction costs are incurred in the first year.

The results show that investment to prevent individuals from attempting suicide using high-fatality methods are likely to be cost saving, even if all the averted attempts are diverted to other suicide methods (Table 10).

### Key points

- Investment in a barrier to prevent suicide jumping from a particular bridge can generate substantial financial benefits, even if suicides are displaced to other, less lethal, methods.
- Such savings would potentially also apply to other suicide "hot spots", including alternative jumping sites, and other high fatality suicide methods.

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**Table 10: Pay-offs following installation of the Clifton Suspension Bridge safety barrier (2009 prices)**

	After 1 year (£m)	After 5 years (£m)	After 10 years (£m)
1-year cohort			
– No displacement	-3.0	-2.7	-2.6
– Displacement to other methods	-2.5	-2.2	-2.1
10 consecutive cohorts			
– No displacement	-3.0	-22.4	-44.0
– Displacement to other methods	-2.5	-20.0	-40.0

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### 2.13 Collaborative care for depression in individuals with Type II diabetes

*Derek King, Iris Molosankwe, David McDaid*

#### Context

Depression is commonly associated with chronic physical health problems. NICE has estimated that 20% of individuals with a chronic physical problem are likely to have depression,<sup>i</sup> while US data indicate that 13% of all new cases of Type II diabetes will also have clinical depression.<sup>ii</sup>

These patterns are important as evidence shows that co-morbid depression exacerbates the complications and adverse consequences of diabetes,<sup>iii</sup> in part because patients may more poorly manage their diabetes. Not only does this increase the risk of disability and premature mortality, it also has substantial economic consequences. Health care costs are higher, and productivity is lower due to reduced work performance, increased absenteeism and withdrawal from the labour force. In the UK, compared to people with diabetes alone, individuals with co-morbid depression and diabetes are four times more likely to have difficulties in self-managing their health and seven times more likely to have days off work.<sup>iv</sup> In the US, health care costs for those with severe depression and diabetes are almost double those with diabetes alone.<sup>v</sup>

#### Intervention

'Collaborative care' can be delivered in a primary care setting to individuals with co-morbid diabetes and depression. Like 'usual care', collaborative care includes GP advice and care, the use of antidepressants and cognitive behavioural therapy (CBT) for some patients. The difference is that for collaborative care a GP practice nurse acts as a case manager for patients receiving care; GPs also incur additional time costs liaising with practice nurses.

Using a NICE analysis, it is estimated that the total cost of six months of collaborative care is £682, compared with £346 for usual care. A two-year evaluation in the US found that, on average, collaborative care achieved an additional 115 depression-free days per individual; total medical costs were higher in year 1, but there were cost savings in year 2.<sup>vi</sup>

#### Impact

The model assessed the economic case for investing in six months of collaborative care in England for patients with newly diagnosed cases of Type II diabetes who screen positive for depression, compared with care as usual. The costs associated with screening are not included in the baseline model; we were given expert advice that in GP care all individuals with diabetes would already be screened for depression. The analysis assumed that 20% of patients under collaborative care would receive CBT, compared with 15% of the usual care group. Existing data on the cost-effectiveness of CBT were used to estimate the impact on health care and productivity losses.

Table 11 shows the estimated costs/savings for 119,150 new cases of Type II diabetes in England in 2009, assuming 20% screen positive for co-morbid depression. Completing and successfully responding to collaborative care leads to an additional 117,850 depression-free days in year 1 and 111,860 depression-free days in year 2. According to the model, the intervention results in substantial additional net costs in year 1 due to the costs of the treatment. In year 2, however, there are net savings for the health and social care system due to lower costs associated with depression in the intervention group, plus further benefits from reduced productivity losses. Using a lower 13% rate of co-morbid diabetes and depression, total net costs in year 1 would be more than £4.5m, while net savings in year 2 would be more than £450,000.

The study also estimated the incremental cost per Quality-Adjusted Life Year (QALY) gained, which over two years was £3,614. This is highly cost-effective in an English context.

**Table 11: Costs/pay-offs of collaborative care for new cases of Type II diabetes screened positive for depression in England (2009 prices)**

	Year 1 (£)	Year 2 (£)
Health and social care	7,298,860	-385,240
Productivity losses	-331,170	-314,330
Net cost/pay-off	6,967,690	-699,570

These estimates of the potential benefits are, however, very conservative. The model does not factor in productivity losses due to premature mortality, nor further quality of life gains associated with avoidance of the complications of diabetes, such as amputations, heart disease and renal failure. Nor does the analysis include long-term cost savings from reduced complications. These are potentially substantial: research in 2003 showed that for diabetes-related cases the average initial health care costs of an amputation were £8,500 and for a non-fatal myocardial infarction £4,000.<sup>vii</sup> If, on average, costs of just £150 per year could be avoided for the intervention group then investment in collaborative care would overall be cost-saving from a health and social care perspective after just two years.

### Key points

- The intervention is cost-effective in an English context after two years, but has high net additional costs in the short term due to implementation costs.
- A wider-ranging analysis is merited to demonstrate the potential longer-term savings in health and social care costs due to reduced complications of diabetes.

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## 2.14 Tackling medically unexplained symptoms

David McDaid, Michael Parsonage, A-La Park

### Context

Somatoform conditions present physical symptoms for which there is no identifiable physical cause. These medically unexplained symptoms are thought to be triggered or exacerbated by mental and emotional factors, such as psychosocial stress, depression or anxiety. Somatoform conditions are commonly encountered in primary care and elsewhere in the NHS; it is estimated that in England 1.2% of working age adults consulting their GPs have full somatoform disorders, and a further 23.4% have sub-threshold levels.<sup>i</sup> Overall, for working age adults, it is estimated that somatoform conditions account for 22% of all primary care consultations, 7% of all prescriptions, 25% outpatient care, 8% of inpatient bed days and 5% of A&E attendances.

The financial costs to public services and society are considerable. NHS expenditure arising from working age patients with somatoform conditions has been estimated at £2.892bn for 2008/2009, equivalent to 11% of total expenditure on health care services for this population. In addition, sickness absence from work associated with somatoform conditions accounted for a further £5.235bn.<sup>i</sup>

### Intervention

Cognitive behavioural therapy (CBT) has been found to be an effective intervention for tackling somatoform conditions and their underlying psychological causes.<sup>ii</sup> Studies report a positive impact on symptoms and lower health care resource utilisation due to reduced primary care consultations and the avoidance of unnecessary diagnostic tests and invasive procedures.<sup>iii</sup> <sup>iv</sup> The limited data indicates that 40% of individuals receiving CBT continue to report much improved, or very much improved, somatisation (physical symptoms caused by mental or emotional factors) 15 months after treatment, compared with just 5% of those who receive treatment as usual.<sup>iii</sup>

A course of CBT may last for 10 sessions at £40 per session. Costs associated with the need to raise the awareness of GPs to the potential role of CBT treatment for somatoform conditions, either through e-learning or (much more expensively) face-to-face training are also included. These include costs associated with encouraging GPs to attend regional workshops prior to e-learning, and the costs of ICUMS while GPs are attending face-to-face courses.

### Impact

The model looks at the impact on costs in England, over three years, of the CBT intervention for working age individuals in England who present to GPs with somatoform conditions. Based on existing studies, it is assumed that 50% of those offered CBT (after six months observation) take up the treatment, and that patients who improve will avoid the additional utilisation of health care resources commonly associated with somatoform conditions. While no data are available on clinical effectiveness beyond 21 months, the model assumes that the benefits are maintained until the end of year 3. The economic analysis looks at the costs to the health care system and the impact on productivity as a result of somatoform-related sickness absence from work.

The results show the impact on net costs and the cost per QALY gained. When all patients with somatoform conditions (sub-threshold and full disorders) receive CBT, and e-learning is used to increase GP awareness, the model shows an overall saving of £639m over three years, nearly all because of reduced sickness absence (Table 12). The impact on the NHS is broadly cost-neutral. If the more costly option of face-to-face GP training is used, net NHS costs increase by £143m, but the cost per QALY gained is only £3,402 which would be considered highly cost-effective. Also taking into account reduced sickness absence, the model shows that

**Table 12: Annual costs/pay-offs impact of investment in CBT for sub-threshold and full somatoform disorders (with e-learning for GPs) (2009 prices)**

	Year 1 (£m)	Year 2 (£m)	Year 3 (£m)	Total (£m)
CBT awareness training for GPs	0.6	0	0	0.6
CBT cost	847.6	0	0	847.6
GP consultations	-45.8	-45.1	-44.5	-135.3
Prescriptions	-13.3	-13.1	-12.9	-39.2
Outpatient consultations	-5.8	-19.7	-19.5	-45.0
Inpatient stays	-82.2	-181.7	-179.0	-442.9
A&E attendances	-64.3	-63.3	-62.4	-190.0
<b>Net NHS costs</b>	<b>636.9</b>	<b>-322.9</b>	<b>-318.2</b>	<b>-4.2</b>
Productivity losses	-214.7	-211.6	-208.5	-634.8
Net NHS and productivity costs	422.2	-534.5	-526.7	-639.1

CBT for all somatoform conditions with face-to-face GP learning would start to be cost-saving in year 3. A variety of sensitivity analyses were conducted. For instance, if we assume that all individuals treated for medically unexplained symptoms received 15 sessions of therapy at £50 per session then total costs of the CBT treatment would rise to £1.59bn, with net costs to the NHS of £737m at a cost per QALY gained of £17,527.

The analysis also demonstrates the higher returns available when the intervention is targeted solely on patients with full somatoform disorders. In this scenario, the model shows that the net impact of the intervention is cost-saving to the NHS after two years if face-to-face GP training is used, and after just one year (saving around £60m in year 1) if e-learning is used. In both cases, net cost savings are improved when the analysis includes reduced sickness absence of around £40m a year.

### Key points

- While the economic case for CBT is most compelling if resources are targeted at those with full somatoform disorders, the case for also tackling sub-threshold conditions is strong. All models are likely to be cost saving in the long term.
- The model relies on evidence of effectiveness from US studies, which may not be easily generalisable to an English context. However, sensitivity and threshold analyses indicate that – even assuming very limited improvements in health outcomes – investing in actions to tackle somatoform disorders remains cost-effective from a societal perspective under most scenarios.
- More information is required on the relative effectiveness of e-learning compared to face to face learning as a way of raising GP awareness as costs are substantially lower.

*Further details: David McDaid (d.mcdaid@lse.ac.uk)*

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## 2.15 Befriending of older adults 2.15

Annette Bauer, Martin Knapp, Margaret Perkins

### Context

Befriending initiatives, often delivered by volunteers, provide an 'upstream' intervention that is potentially of value both to the person being befriended and the 'befriender'. For those receiving the intervention, particularly older people, it promotes social inclusion and reduces loneliness;<sup>i</sup> for the befriender, there is the personal satisfaction of contributing to the local community by offering support and skills. Specific potential benefits include the improved mental well-being of the person receiving the intervention, a reduced risk of depression, and associated savings in health care costs.

### Intervention

In a typical befriending intervention, a befriender visits a person in their home, usually on a one-to-one basis, where that individual has requested and agreed to such a contact. The intervention is not usually structured and nor does it have formally-defined goals. Instead an informal, natural relationship develops between the participants, who will usually have been matched for interests and preferences. This relationship facilitates improved mental health, reduced loneliness and greater social inclusion. A recent research review confirmed that, compared with usual care and support (which may mean no intervention at all), befriending has a modest but significant effect on depressive symptoms, at least in the short term.<sup>ii</sup> Another evaluation showed decreased depression and anxiety in 5% of people receiving socio-emotional interventions, including befriending.<sup>iii</sup>

The contact is generally for an hour per week or fortnight. The cost to public services of 12 hours of befriending contact is estimated at £85, based on the lower end of the cost range for befriending interventions.<sup>iv</sup>

### Impact

The model looked at the cost-effectiveness of befriending interventions in terms of the reduction in depressive symptoms and the consequent decline in the use of health services by the recipient of the intervention. The intervention is assumed to be targeted at lonely and isolated individuals aged over 50. The analysis included costs/savings associated with the use of mental health services, primary care, hospital services and medication; home helps, but no other social care services, were included. The model did not factor in any benefits to the befriender.

Using existing estimates of savings associated with reduced treatment of depression,<sup>v</sup> the model found total gross cost savings to the NHS were around £40 (at 2008/9 prices) in year 1 for every £85 invested in the intervention. Thus, befriending schemes do not appear to be cost-saving from a public expenditure perspective.

If the analysis includes the quality of life benefits associated with reduced depressive symptoms, then befriending schemes have the potential to create further improvements worth £270 per person and are likely to be cost-effective with an incremental cost effectiveness ratio (ICER) of around £2,900.

### Key points

- Befriending interventions are unlikely to achieve cost savings to the public purse, but they do improve an individual's quality of life at a low cost.
- The targeting of at-risk groups (e.g. older people discharged from hospital or mothers at risk of post-natal depression) would potentially offer better returns on an investment in befriending, and this could be explored through further research.

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### 3. SUMMARY IMPACTS

The estimated economic pay-offs per £ of expenditure from each of these fifteen models can be pulled together in summary tables, distinguishing pay-offs for the NHS, other public sector bodies, and non-public sector impacts, and also separating impacts in the short term (in the first year), medium term (in years 2 to 5) and long term (year 6 and beyond). It should be reiterated that for some interventions it was not possible to estimate the potential pay-offs across the full span of sectors or for many years, even though it might be expected that there would be such impacts.

In Tables 13–16, the symbol ‘–’ indicates that the economic pay-off could not be estimated, whereas ‘0’ indicates a genuine zero. Comparisons between interventions should therefore be made only with caution.

**Table 13: Total returns on investment (all years): economic pay-offs per £1 expenditure <sup>a</sup>**

	NHS	Other public sector	Non-public sector	Total
<b>Early identification and intervention as soon as mental disorder arises</b>				
Early intervention for conduct disorder	1.08	1.78	5.03	7.89
Health visitor interventions to reduce postnatal depression	0.40	–	0.40	0.80
Early intervention for depression in diabetes	0.19	0	0.14	0.33
Early intervention for medically unexplained symptoms <sup>b</sup>	1.01	0	0.74	1.75
Early diagnosis and treatment of depression at work	0.51	–	4.52	5.03
Early detection of psychosis	2.62	0.79	6.85	10.27
Early intervention in psychosis	9.68	0.27	8.02	17.97
Screening for alcohol misuse	2.24	0.93	8.57	11.75
Suicide training courses provided to all GPs	0.08	0.05	43.86	43.99
Suicide prevention through bridge safety barriers	1.75	1.31	51.39	54.45
<b>Promotion of mental health and prevention of mental disorder</b>				
Prevention of conduct disorder through social and emotional learning programmes	9.42	17.02	57.29	83.73
School-based interventions to reduce bullying	0	0	14.35	14.35
Workplace health promotion programmes	–	–	9.69	9.69
<b>Addressing social determinants and consequences of mental disorder</b>				
Debt advice services	0.34	0.58	2.63	3.55
Befriending for older adults	0.44	–	–	0.44

*Notes:*

- a Returns on investment calculated as gross economic pay-offs divided by expenditure on the intervention. Depending on the availability of data, these returns may be calculated over different time periods for different interventions; see Section 2 and Tables 14–16 for details. Returns and expenditures discounted back to present values, expressed in 2009/10 prices.
- b For e-learning of GPs, plus CBT for all people with somatoform conditions (including sub-threshold cases as well as those with full somatoform disorders).

**Table 14: Short-term returns on investment (year 1): economic pay-offs per £1 expenditure <sup>a</sup>**

	NHS	Other public sector	Non-public sector	Total
<b>Early identification and intervention as soon as mental disorder arises</b>				
Early intervention for conduct disorder	0.14	0.13	0	0.28
Health visitor interventions to reduce postnatal depression	–	–	–	–
Early intervention for depression in diabetes	0.06	0	0.05	0.11
Early intervention for medically unexplained symptoms <sup>b</sup>	0.25	0	0.25	0.50
Early diagnosis and treatment of depression at work	0	–	1.96	1.96
Early detection of psychosis	-1.00	0	0	-1.00
Early intervention in psychosis	5.70	0.12	0	5.82
Screening for alcohol misuse	0.61	0.25	2.31	3.17
Suicide training courses provided to all GPs	0.04	0.03	18.97	19.04
Suicide prevention through bridge safety barriers	0.02	0.06	2.32	2.40
<b>Promotion of mental health and prevention of mental disorder</b>				
Prevention of conduct disorder through social and emotional learning programmes	0.29	0.33	0.32	0.95
School-based interventions to reduce bullying	0	0	0	0
Workplace health promotion programmes	–	–	9.69	9.69
<b>Addressing social determinants and consequences of mental disorder</b>				
Debt advice services	0	0.58	0.05	0.63
Befriending for older adults	0.44	–	–	0.44

*Notes:*

- a Returns on investment calculated as gross economic pay-offs divided by expenditure on the intervention. Depending on the availability of data, these returns may be calculated over different time periods for different interventions; see Section 2 and Tables 14–16 for details. Returns and expenditures discounted back to present values, expressed in 2009/10 prices.
- b For e-learning of GPs, plus CBT for all people with somatoform conditions (including sub-threshold cases as well as those with full somatoform disorders).

**Table 15: Medium-term returns on investment (years 2–5): economic pay-offs per £1 expenditure<sup>ab</sup>**

	NHS	Other public sector	Non-public sector	Total
<b>Early identification and intervention as soon as mental disorder arises</b>				
Early intervention for conduct disorder	0.13	0.13	0.05	0.30
Health visitor interventions to reduce postnatal depression	–	–	–	–
Early intervention for depression in diabetes <sup>c</sup>	0.13	0	0.09	0.22
Early intervention for medically unexplained symptoms <sup>d</sup>	0.75	0	0.49	1.25
Early diagnosis and treatment of depression at work	0.51	–	2.56	3.07
Early detection of psychosis	1.74	0.32	3.37	5.43
Early intervention in psychosis	3.98	0.10	3.60	7.69
Screening for alcohol misuse	1.41	0.59	5.40	7.40
Suicide training courses provided to all GPs	0.03	0.01	21.15	21.19
Suicide prevention through bridge safety barriers	0.64	0.42	16.66	17.73
<b>Promotion of mental health and prevention of mental disorder</b>				
Prevention of conduct disorder through social and emotional learning programmes	5.39	9.42	33.49	48.30
School-based interventions to reduce bullying	0	0	0	0
Workplace health promotion programmes	–	–	–	–
<b>Addressing social determinants and consequences of mental disorder</b>				
Debt advice services	0.34	0	2.58	2.92
Befriending for older adults	–	–	–	–

**Notes:**

- a Returns on investment calculated as gross economic pay-offs divided by expenditure on the intervention. Depending on the availability of data, these returns may be calculated over different time periods for different interventions; see Section 2 and Tables 14–16 for details. Returns and expenditures discounted back to present values, expressed in 2009/10 prices.
- b Estimated returns for some interventions are not available for all years; see Section 2 for these details.
- c Estimates for this model only cover year 2; estimates for further years are not available.
- d For e-learning of GPs, plus CBT for all people with somatoform conditions (including sub-threshold cases as well as those with full somatoform disorders).

**Table 16: Long-term returns on investment (year 6 onwards): economic pay-offs per £1 expenditure<sup>ab</sup>**

	NHS	Other public sector	Non-public sector	Total
<b>Early identification and intervention as soon as mental disorder arises</b>				
Early intervention for conduct disorder	0.81	1.52	4.98	7.31
Health visitor interventions to reduce postnatal depression	-	-	-	-
Early intervention for depression in diabetes	-	-	-	-
Early intervention for medically unexplained symptoms <sup>c</sup>	0	0	0	0
Early diagnosis and treatment of depression at work	-	-	-	-
Early detection of psychosis	1.88	0.47	3.48	5.84
Early intervention in psychosis	0	0.05	4.42	4.47
Screening for alcohol misuse	0.22	0.09	0.86	1.18
Suicide training courses provided to all GPs	0.01	0.01	3.74	3.76
Suicide prevention through bridge safety barriers	1.09	0.83	32.31	34.23
<b>Promotion of mental health and prevention of mental disorder</b>				
Prevention of conduct disorder through social and emotional learning programmes	3.75	7.25	23.48	34.48
School-based interventions to reduce bullying	0	0	14.35	14.35
Workplace health promotion programmes	-	-	-	-
<b>Addressing social determinants and consequences of mental disorder</b>				
Debt advice services	-	-	-	-
Befriending for older adults	-	-	-	-

**Notes:**

- a Returns on investment calculated as gross economic pay-offs divided by expenditure on the intervention. Depending on the availability of data, these returns may be calculated over different time periods for different interventions; see Section 2 and Tables 14–16 for details. Returns and expenditures discounted back to present values, expressed in 2009/10 prices.
- b Estimated returns for some interventions are not available for all years; see Section 2 for these details.
- c For e-learning of GPs, plus CBT for all people with somatoform conditions (including sub-threshold cases as well as those with full somatoform disorders).

## 4. CONCLUSIONS

We stress again that the interventions examined and modelled here are not necessarily the only ones for which there may be an economic case: they are the interventions for which we were able to find sufficient evidence to build economic models. We would also emphasise that we have reported our findings for every intervention we modelled: nothing has been dropped because the economic case was weak or for other reasons.

The results of these models suggest some general conclusions:

**Value for money** Even though the economic modelling is based on conservative assumptions, many interventions are seen to be outstandingly good value for money.

**Self-financing** A number of interventions are self-financing over time, even from the narrow perspective of the NHS alone. However, the scope for 'quick wins', in the sense of very short payback periods for the NHS, is relatively limited.

**Range of impacts** Many interventions have a broad range of pay-offs, both within the public sector and more widely (such as through better educational performance, improved employment/earnings and reduced crime).

**Timescales** In some cases the pay-offs are spread over many years. Most obviously this is the case for programmes dealing with childhood mental health problems, which in the absence of intervention have a strong tendency to persist throughout childhood and adolescence into adult life. However, the overall scale of economic pay-offs from these interventions is generally such that their costs are fully recovered within a relatively short period of time.

**Low cost** Many interventions are very low cost. A small shift in the balance of expenditure from treatment to prevention/promotion should generate efficiency gains.

**Range of interventions** The interventions included in the analysis cover a wide range, from the prevention of childhood conduct disorder to early intervention for psychosis, practical measures to reduce the number of suicides and well-being programmes provided in the workplace. Many of these interventions are an NHS responsibility, but the analysis also highlights opportunities for the NHS to work closely in partnerships with other organisations and in jointly funded programmes.

**Programme design and implementation** In many cases the modelling of economic impacts reveals the importance of key elements of programme design and implementation such as targeting, take-up and drop-out, although we have not reported details here. One consequence is that for some interventions the most cost-effective action when refining a programme may be to increase take-up among high-risk groups or to improve completion rates, rather than to broaden coverage of the intervention.

**Evidence-based** Finally, it should be emphasised once again that each of the modelled interventions is evidence-based, in the sense of having been shown to be effective in improving mental health. The economic analyses summarised in this report show that, *over and above these gains in health and quality of life*, the interventions also generate very significant economic benefits including savings in public expenditure.