The Economist

Mental health

Out of the shadows

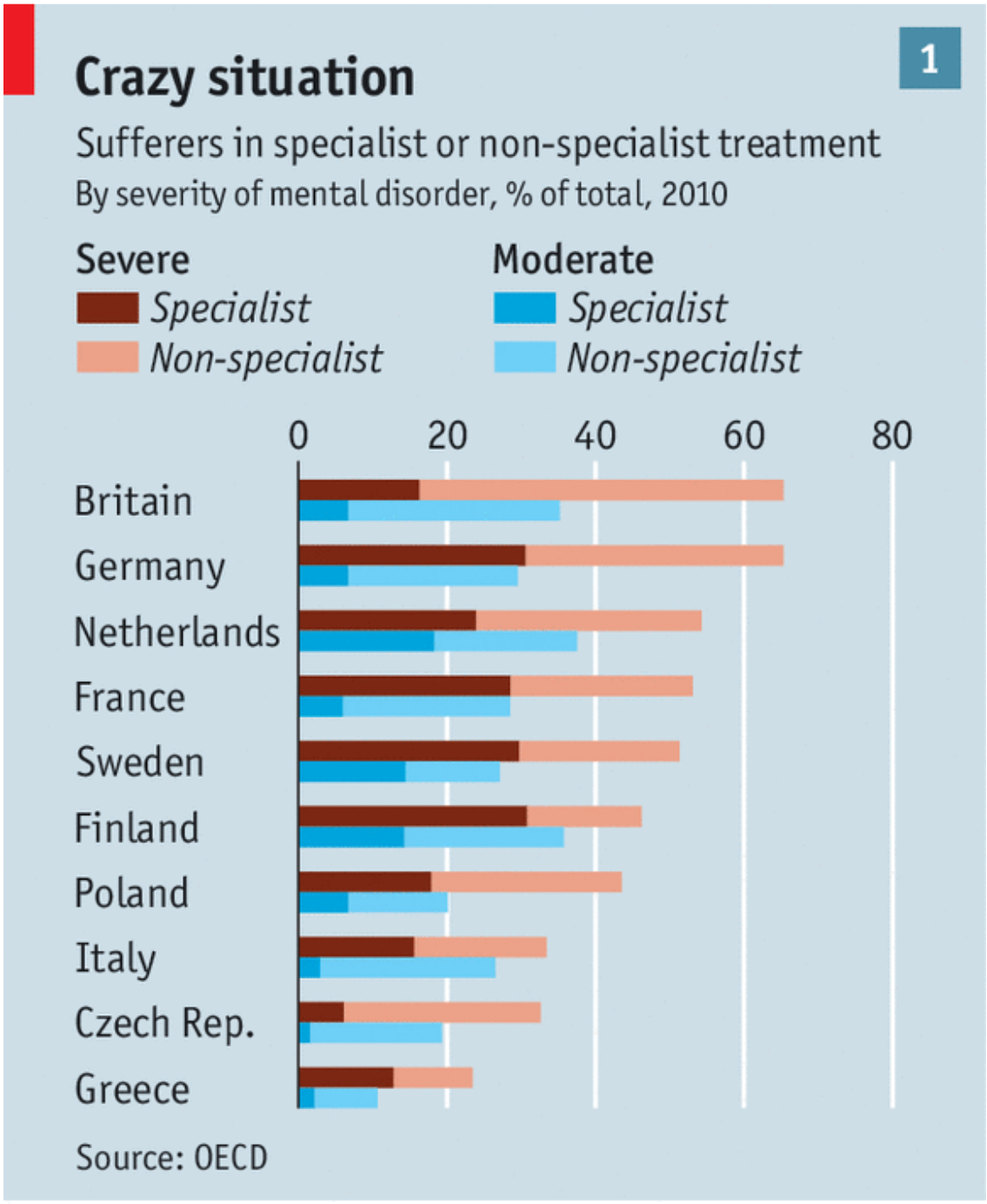
The stigma of mental illness is fading. But it will take time for sufferers to get the treatment they need

Apr 25th 2015 | From the print edition

FOR John Mooney, it was a career highlight. In March the Irish cricketer took a crucial catch that gave his team the victory in a World Cup match and eliminated the higher-ranked Zimbabwe. But afterwards the *Zimbabwe Herald*, a daily paper with links to Zanu-PF, the thuggish ruling party, claimed that Mr Mooney had lied when he said that his foot had not been touching the boundary, meaning the catch should have been disallowed. The article cited previous interviews in which the sportsman had spoken frankly about his long battles with drink, depression and suicidal thoughts. Under pressure, it claimed, a “man of such a character” could not be trusted to have “the honesty, let alone the decency” to tell the truth.

The prospect of such prejudice leads many with mental ailments to conceal their conditions and avoid seeking help. Even if they know better than to believe that mental illnesses are untreatable, or that all sufferers are delusional, they may fear being shunned by friends or employers. Many people think the mentally ill cannot work, but in reality few jobs are off-limits, and only for the most severe cases. (Someone suicidal should not be flying a plane.) What bothered Mr Mooney most about the *Zimbabwe Herald* article, he says, was that other sufferers might read it and decide never to risk letting anyone know. So he kept talking about his condition. The reaction was heartening. Messages of support and thanks are still coming in.

More people from all walks of life are opening up about mental illness, says Sophie Corlett of MIND, a British mental-health advocacy group. Campaigns by many governments and charities to get rid of the stigma are part of a virtuous circle in which each person who speaks out lessens ignorance and makes it easier for other sufferers to do so too. Only 13% of Britons surveyed in 2013 agreed that a history of mental illness should bar someone from public office, down from 21% five years earlier. The number who said that they would be willing to have a mentally ill co-worker or neighbour went up.

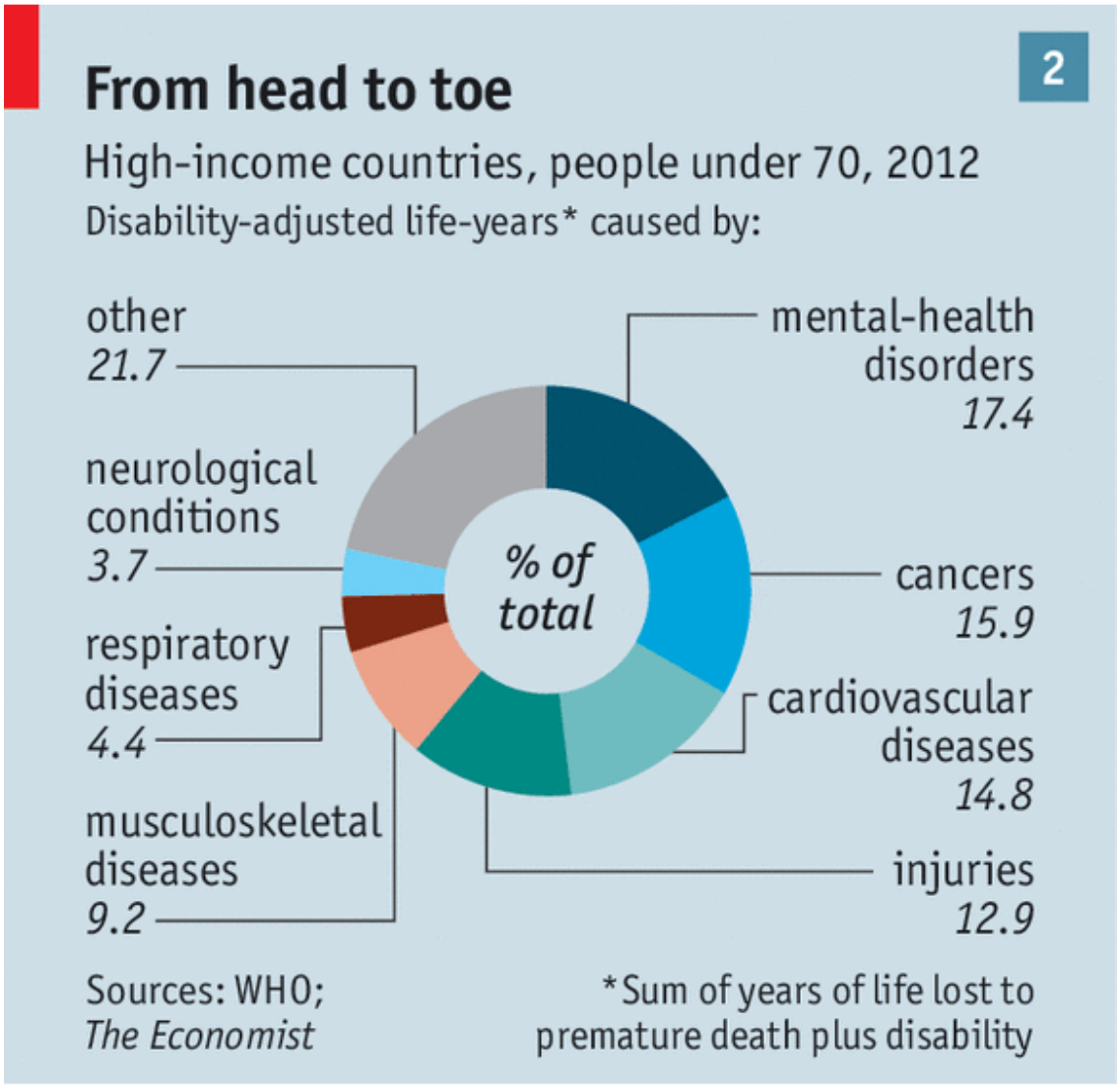


Economist.com

With greater openness comes more understanding of just how common mental illness is. One in five working-age people in rich countries suffer from a mental condition each year. About a quarter of those suffer from severe illnesses, such as schizophrenia or bipolar disorder, and the rest from less debilitating ones, such as mild depression or anxiety. But mental ailments are far less likely to receive treatment than physical ones.

Over three-quarters of those suffering severe conditions, and over 90% of those with moderate ones, are treated by non-specialists or not at all (see chart 1). Lack of training means primary-care doctors miss some cases. Others go untreated because their conditions make it hard to push for referrals or deal with the insurance paperwork.

The resulting misery is huge. Put together, mental illnesses account for more suffering and premature death in rich countries than heart disease and strokes, or than cancer (see chart 2). One study estimates that depression is 50% more disabling than angina, asthma or arthritis, as measured by a health score that combines factors such as reduced mobility and pain. Men with mental-health problems die 20 years earlier than those without, according to the British Medical Association, mostly from causes other than suicide. That is partly because mental illnesses make physical ones tougher to treat, and because sufferers often live less healthily. Research has linked even moderate levels of stress to lower life-expectancy. Nearly half of Finns who seek help for addictions, for instance, have a mental illness. Most of the long-term homeless in rich countries are seriously mentally ill, addicted or both.



Economist.com

Estimates from several rich countries put the economic cost of mental illness at 3-4% of GDP. Around a third of that is the cost of treatment; the rest is from lost productivity and the payment of disability benefits. Worklessness and mental illness feed off each other. Between a third and a half of claims for disability benefit are for mental conditions. A study in the Netherlands estimated that €1 ($1.07) spent on treatment saves €4.24 in increased productivity and reduced costs of care.

All this is propelling mental-health care up governments' agendas. In 2013 nearly 200 countries approved the WHO's Mental Health Action Plan, which calls for more and better treatment by 2020. Since 2012 Britain's National Health Service is supposed to grant "parity of esteem" to mental and physical care. Though funding is still very unequal, the principle has improved the attitude of bureaucrats and patients' access to care, says Ms Corlett. Since last year health insurers in America have had to cover

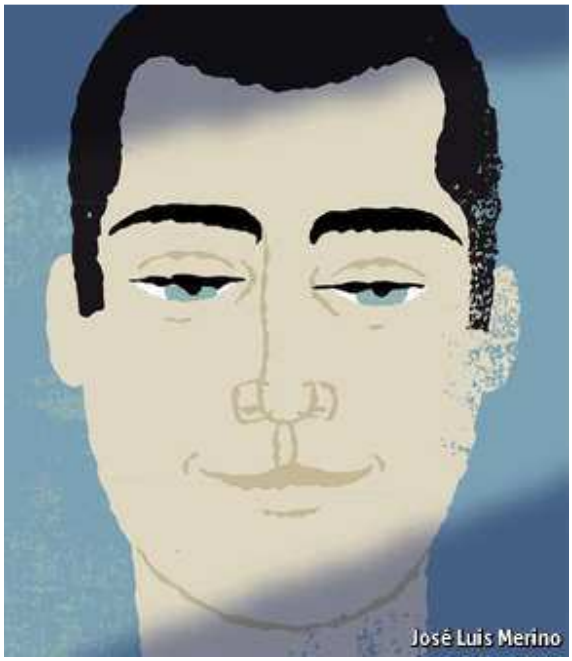
mental-health services. But demand far outstrips supply, says Paul Appelbaum of Columbia University, because not enough medics specialised in mental-health care during the many years when insurance paid little or nothing for it.

Over the past few decades some rich countries have moved away from housing patients with severe psychiatric conditions in asylums and started opening community centres and care homes, and hiring more social workers and mental-health nurses. Australia, Britain, Italy and the Nordics have largely completed the transition. Japan, Korea and most countries in eastern Europe have barely started.

Though the idea was sound, in some countries community-based care was not ready before institutions closed. America is perhaps the starkest example, and the consequences are visible in its criminal-justice system. In 44 states the biggest mental-health institution is a prison, and police spend much of their time dealing with the effects of untreated mental illness (see article). But it is not the only one. British police spend as much as two-fifths of their time dealing with cases that involve mental illness, though few have the necessary training. Across Europe, 40-70% of prison inmates are mentally ill.

Mental-health courts, introduced in Florida in the 1990s and now opening in other American states, aim to divert the mentally ill from prison to community care. In Britain mental-health nurses join police officers on patrol. Their contribution can be as simple as using health records to find the address of someone who is acting oddly or causing a disturbance, or to assess the threat he poses. In a pilot scheme, the approach led to police detaining 26% fewer mentally ill people and sending more who needed acute care to psychiatric assessment rather than a jail cell.

The stigma of mental illness has fallen particularly fast in Australia, says Patrick McGory, a psychiatrist whom the government named “Australian of the year” in 2010. Last year the country’s biggest television station raised A$1.5m ($1.2m) for mental-health research during a weeklong campaign, which included programmes about mental illness. Most treatment, even for severe conditions, is at home, with backup from crisis-resolution teams that combine social and medical care. The country’s family doctors are being trained to identify and treat mental-health problems, and paid to hire mental-health nurses. An early-intervention model for psychosis, which aims to diagnose patients and provide intensive care quickly after the onset of symptoms, has been shown to improve patient outcomes and is now being copied elsewhere.



Britain has expanded access to cognitive behavioural therapy for anxiety and depression, and is now doing so for severe mental illness and those with physically unexplained symptoms. This consists of a series of counselling sessions in which sufferers are taught to watch out for situations that trigger their affliction, and how to avoid thoughts and actions that are likely to lead to a relapse. Half of patients with anxiety conditions (such as social phobia, health anxiety or panic disorders) recover after an average of ten sessions, in most cases for life. Around the same share of those with depression recover within four months, and they are less likely to have a relapse. Such therapy alleviates the severity of physical illness, too, whether psychosomatic or physical in origin. It is particularly helpful for those with pain for which no cause can be found. Greater awareness is boosting demand for treatment, though waiting lists are long.

Cheaper options that can reach more people quickly also show promise. According to a study published on April 21st in the *Lancet*, a British medical journal, group cognitive behavioural therapy could be as effective as antidepressants for recurrent depression. The MoodGYM, an online programme that works along the same lines, is now in use in Australia, China, Finland, the Netherlands and Norway.

Employers have woken up to the toll of mental illness too. Nearly a third of companies surveyed by the World Economic Forum in 2010 had established some sort of stress-reduction programme. Last year a group of big European businesses launched a charter to target the impact of depression at work. Canada's voluntary psychological safety standard for business, published in 2013, mirrors initiatives to improve physical safety. It includes a guide on how to cut stress at work, for example by cracking down on bosses who harangue their underlings or set unachievable deadlines, and suggests

training some managers to spot the signs of common problems such as anxiety and depression.

Girls and boys, interrupted

The biggest gains will come from improving mental-health services for young people. Half of adults with long-term mental conditions suffered their first symptoms before turning 14. Left untreated, even moderate conditions such as anxiety hurt school results and the prospects for employment. For serious conditions such as psychosis, prompt treatment greatly improves outcomes.

But teenagers are image-conscious creatures for whom the fear of being labelled “crazy” or thought weak looms even larger than for adults. That means tact is needed, and targeted programmes. Australia’s “Headspace” centres, which combine a range of health and employment services for 12- to 25-year-olds, make it easier for the embarrassed or ashamed to seek help. Finland, Norway and Sweden have schemes in schools to tackle the stigma of mental illness. Better to sort out problems early, says Mr Mooney. He dates the start of his problems to losing his father when he was 11, bottling up his grief and turning to drink to cope. Back then, he says, no one even talked about depression. Now they do.

From the print edition: International