

Making the economic case for brief psychological interventions

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Scalable psychological interventions: Quo vadis?"

University of Zurich, January 18 2024;

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Overview

- The importance of making an economic case
- What do we know about the economic case?
- How can this be strengthened further?

The importance of making an economic case

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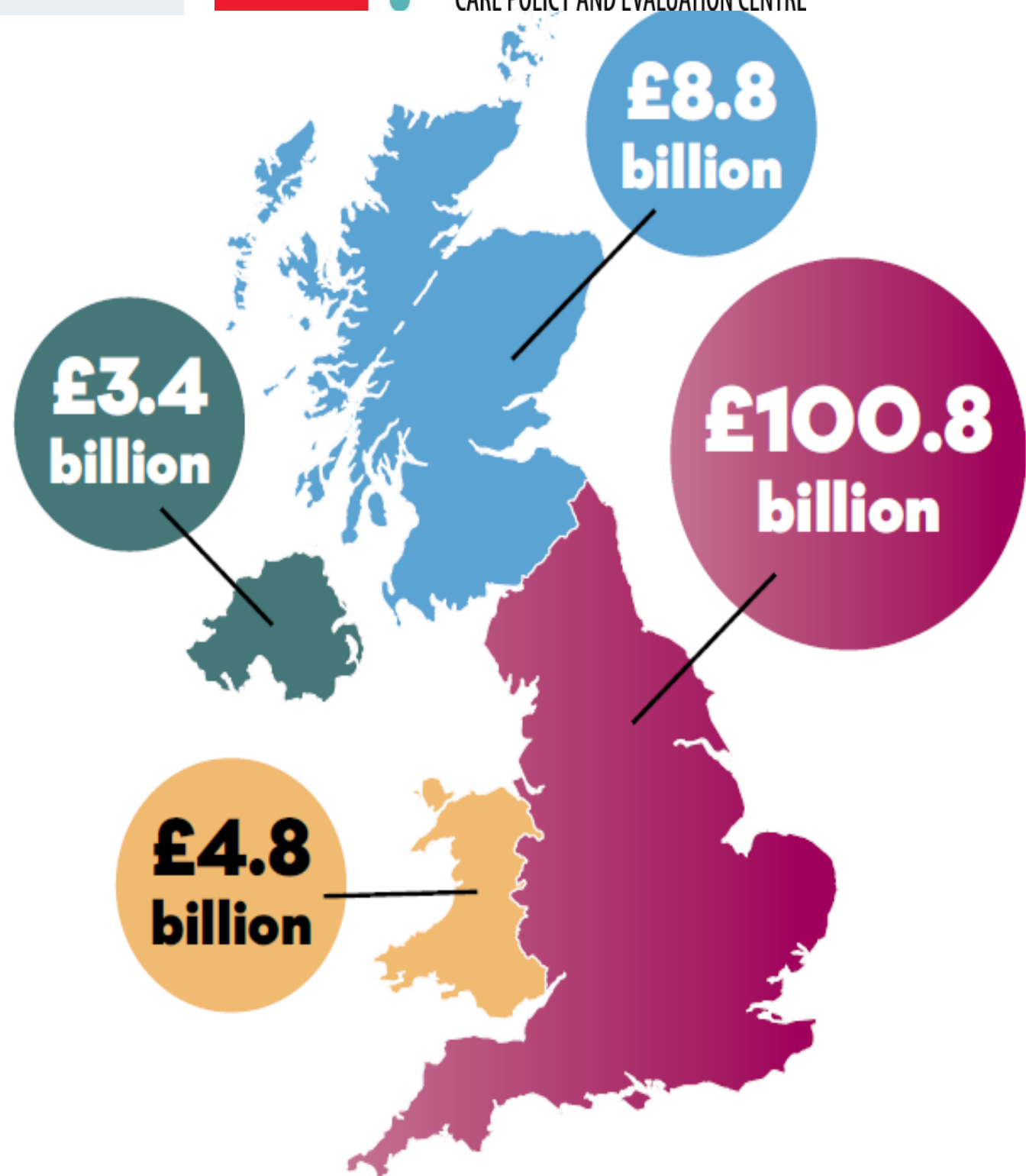
CARE POLICY AND EVALUATION CENTRE

What happens when mental health needs are unrecognised and untreated?

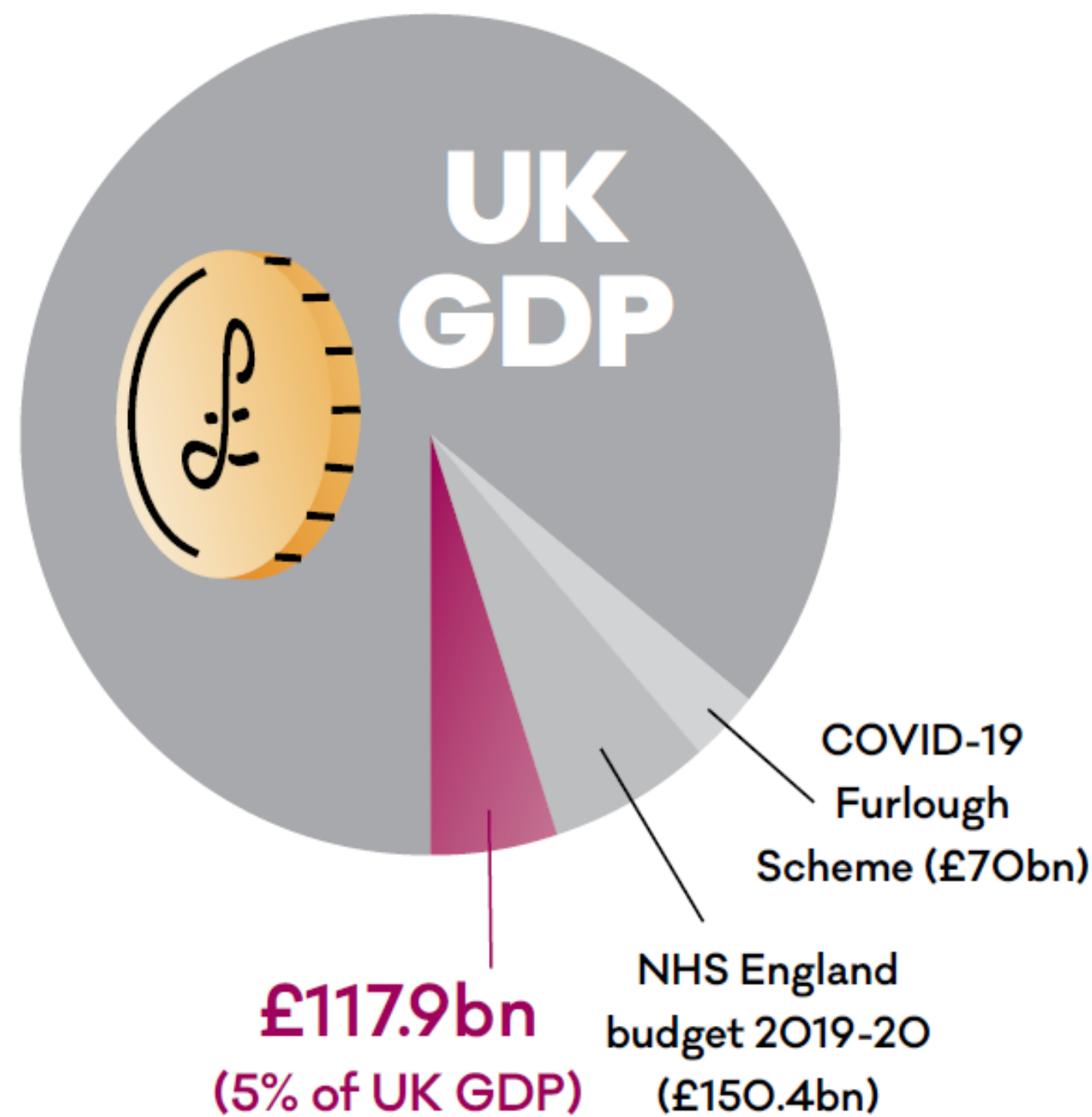
If the mental health needs of people are missed the consequences could include:

- Poor **educational outcomes**
- Low **employment** rates → income losses
- Poor **health behaviours** (smoking, poor diet etc.) → higher long-term health risks
- **Substance misuse** → crime, health damage etc.
- **Antisocial behaviour & crime** → social costs
- Damage to quality of life / **wellbeing**
- **Suicide & self-harm**

STR



Cost of mental health problems



- Productivity Loss Including Informal Care 61%**
- Net Lost Quality of Life 22%**
- Specialist Mental Health Services 11%**
- Education 2.3%**
- Primary & Social Care 3%**

What happens when mental health needs in migrants /refugees are unrecognised and untreated?

- Systematic reviews indicate **long term high risks** of depression and PTSD
- Electronic health records analyses, e.g. in Switzerland indicate **significantly higher health care costs** than for refugees without mental health conditions over 20 months (Tzogiou et al 2022)
- Hospital costs in Germany for refugees with diagnosed mental health conditions but **no insurance** were **1.3 times greater** than a matched cohort of insured people/
- **Long term physical health consequences** of poor mental health in Vietnamese refugees in the US (Wagner 2013)

Long term impacts following war in the former Yugoslavia

OPEN ACCESS Freely available online



Long-Term Impact of War on Healthcare Costs: An Eight-Country Study

Ramon Sabes-Figuera^{1*}, Paul McCrone¹, Marija Bogic², Dean Ajdukovic³, Tanja Franciskovic⁴, Niccolò Colombini⁵, Abdulah Kucukalic⁶, Dusica Lecic-Tosevski⁷, Nexhmedin Morina⁸, Mihajlo Popovski⁹, Matthias Schützwohl¹⁰, Stefan Priebe²

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Abstract

Objective: Exposure to war can negatively affect health and may impact on healthcare costs. Estimating these costs and identifying their predictors is important for appropriate service planning. We aimed to measure use of health services in an adult population who had experienced war in the former-Yugoslavia on average 8 years previously, and to identify characteristics associated with the use and costs of healthcare.

Method: War-affected community samples in Bosnia-Herzegovina, Croatia, Kosovo, FYR Macedonia, and Serbia were recruited through a random walk technique. Refugees in Germany, Italy and the UK were contacted through registers, organisations and networking. Current service use was measured for the previous three months and combined with unit costs for each country for the year 2006/7. A two-part approach was used, to identify predictors of service use with a multiple logistic regression model and predictors of cost with a generalised linear regression model.

Results: 3,313 participants were interviewed in Balkan countries and 854 refugees in Western European countries. In the Balkan countries, traumatic events and mental health status were related to greater service use while in Western countries these associations were not found. Participants in Balkan countries with post traumatic stress disorder (PTSD) had costs that were 63% higher ($p=0.005$) than those without PTSD. Distress experienced during the most traumatic war event was associated with higher costs ($p=0.013$). In Western European countries costs were 76% higher if non-PTSD anxiety disorders were present ($p=0.027$) and 63% higher for mood disorders ($p=0.006$).

Conclusions: War experiences and their effects on mental health are associated with increased health care costs even many years later, especially for those who stayed in the area of conflict. Focussing on the mental health impact of war is important for many reasons including those of an economic nature.

- Survey of health service use in 8 European countries on average 8 years after war exposure.
- PTSD and Depressive Disorders associated with significantly higher use of services and costs in all 5 Balkan countries: BiH, Croatia, Kosovo, North Macedonia & Serbia
- Anxiety and Depression associated with higher health care costs in Germany, Italy and UK.

How to make an economic case

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CARE POLICY AND EVALUATION CENTRE


What is economic evaluation?

The effectiveness question:

Does this intervention work?

The economic question:

Is it worth it?



Four key economic questions to inform policy on use of brief psychological interventions

- **The costs of inaction:** What are the economic consequences of not taking action to addressing risks of mental health conditions such as depression, anxiety, trauma
- **The costs of action:** What would it cost to intervene by prevention, treatment, ongoing support?
- **The economic case for action:** What is the balance between costs of effective intervention and the likelihood of reduce risk of poor mental health, (self-harm and suicide) plus wider benefits better mental health, improved societal participation, less physical health problems etc?
- **The budgetary impacts of scaling up access to psychological interventions?** What resources are require to sustain implementation, how can this be achieved, and where will the resource come from?

What do we know about the economic case for action?

Widening evidence base on the economic case

- Brief psychological interventions have been shown to be cost effective in many different settings for different target population groups.
- Context is very important, not all interventions have been shown cost effective; most of the empirical evidence covers studies of 6 months or less duration
- Evidence base is rapidly growing; sometimes combinations of psychological therapy and other interventions, not just therapy in isolation
- Growing evidence base on digital delivery of these interventions
- Some evidence of cost effective of preventive actions as well

An overview of research on the value for money of community mental health services: a review of reviews and bibliometric analysis

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Background and Aims

The World Health Organization's World Health Report 2001 called for a continued shift away from the use of psychiatric hospitals and long-stay institutions to the provision of community-based mental health care, arguing that such care produces better outcomes, such as quality of life, that it better respects human rights and that it is more cost-effective than institutional treatment. The report recognised that community care implies providing a comprehensive range of services and points of contact, with contributions from different professionals and sufficient links to other sectors such as housing and employment.

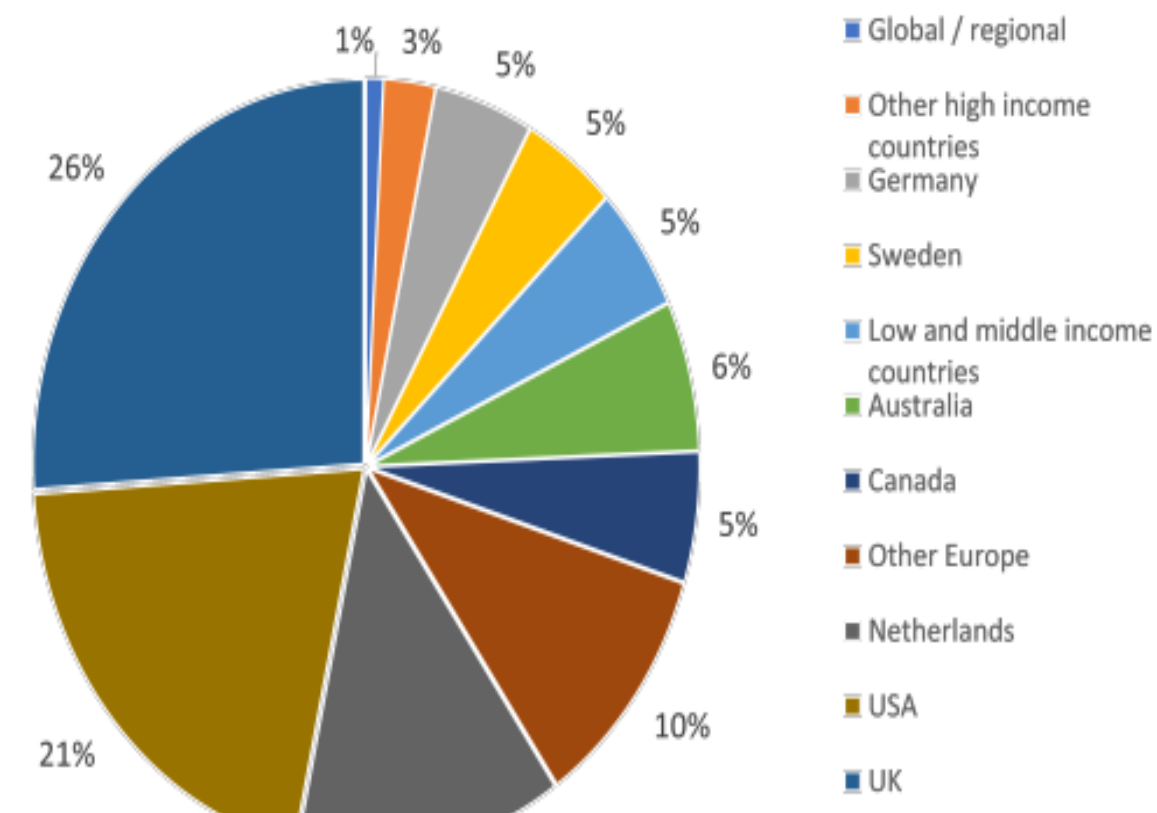
A review more than a decade ago looked at economic evidence on the consequences of deinstitutionalisation in Germany, Italy and the UK, countries that had already substantially rebalanced their mental health care systems away from 'asylums' towards more community-based models of care (Knapp, Beecham, McDaid, Matosevic, & Smith, 2011). The economic case for deinstitutionalisation was strong because of the improved quality of life that can be associated with community-based care. Moreover, individuals with lived experience of mental health conditions preferred living in the community.

We examined how this evidence base on the value for money for investing in community mental health services has developed further over the last decade.

Methods

60% of included studies were from 3 countries: UK 124 (26%), United States 98 (21%) and Netherlands 62 (13%). Very few studies were found in central and eastern Europe where in some countries there is still a reliance on traditional hospital-based models of health care. A small number of studies were found in low and middle income countries.

Countries where value for money assessed



Intervention	Total Studies	Positive		Inconclusive		Negative	
		Count	Percentage	Count	Percentage	Count	Percentage
Occupational Therapy	2	2	100%	0	0%	0	0%
Screening	2	1	50%	0	0%	1	50%
Midwife Delivered Care	3	0	0%	2	67%	1	33%
Peer support	5	2	40%	1	20%	2	40%
Personal budgets	5	4	80%	1	20%	0	0%
Shared Decision Making	5	2	40%	2	40%	1	20%
Home Treatment Teams	6	6	100%	0	0%	0	0%
Integrated Care	6	3	50%	3	50%	0	0%
Task Shifting	6	5	83%	1	17%	0	0%
Case Management	17	11	65%	5	29%	1	6%
Early Intervention Psychosis	22	20	91%	2	9%	0	0%
Supported Housing / Alternative Accommodation	25	17	68%	8	32%	0	0%
Various	29	17	59%	8	28%	4	14%
Community Mental Health Teams	32	22	69%	8	25%	2	6%
Collaborative Care	38	25	66%	10	26%	3	8%
Supported Employment	39	26	67%	10	26%	3	8%
Digital Psychotherapies	87	49	56%	25	29%	13	15%
Psychotherapies	200	123	62%	59	30%	18	9%

Intervention	Total Studies	Positive	Inconclusive	Negative			
Occupational Therapy	2	2	100%	0	0%		
Screening	2	1	50%	0	0%	1	50%
Midwife Delivered Care	3	0	0%	2	67%	1	33%
Peer support	5	2	40%	2	20%	2	40%
Personal budgets	5	0	0%	5	100%	0	0%
Shared Decision Making	5	1	20%	3	60%	1	20%
Home Treatment Teams	5	0	0%	5	100%	0	0%
Integrated Care	5	0	0%	5	100%	0	0%
Task Shifting	5	0	0%	5	100%	0	0%
Case Management	5	1	20%	3	60%	1	20%
Early Intervention Psychosis	5	0	0%	5	100%	0	0%
Supported Housing / Alternative Accommodation	5	1	20%	3	60%	1	20%
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Psychotherapies	200	123	62%	59	30%	18	9%

Only 15% of studies on remote/digital psychotherapies negative and only 9% of face-to-face delivery of psychotherapy in review had negative economic findings

RESEARCH ARTICLE

Sustained effectiveness and cost-effectiveness of the Healthy Activity Programme, a brief psychological treatment for depression delivered by lay counsellors in primary care: 12-month follow-up of a randomised controlled trial

Benedict Weobong^{1,6}, Helen A. Weiss², David McDaid³, Daisy R. Singla⁴, Steven D. Hollon⁵, Abhijit Nadkarni^{1,6}, A-La Park³, Bhargav Bhat⁶, Basavraj Katti⁶, Arpita Anand⁶, Sona Dimidjian⁷, Ricardo Araya^{1,8}, Michael King⁹, Lakshmi Vijayakumar¹⁰, G. Terence Wilson¹¹, Richard Velleman^{6,12}, Betty R. Kirkwood¹, Christopher G. Fairburn¹³, Vikram Patel^{1,6,14*}

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OPEN ACCESS

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Abstract

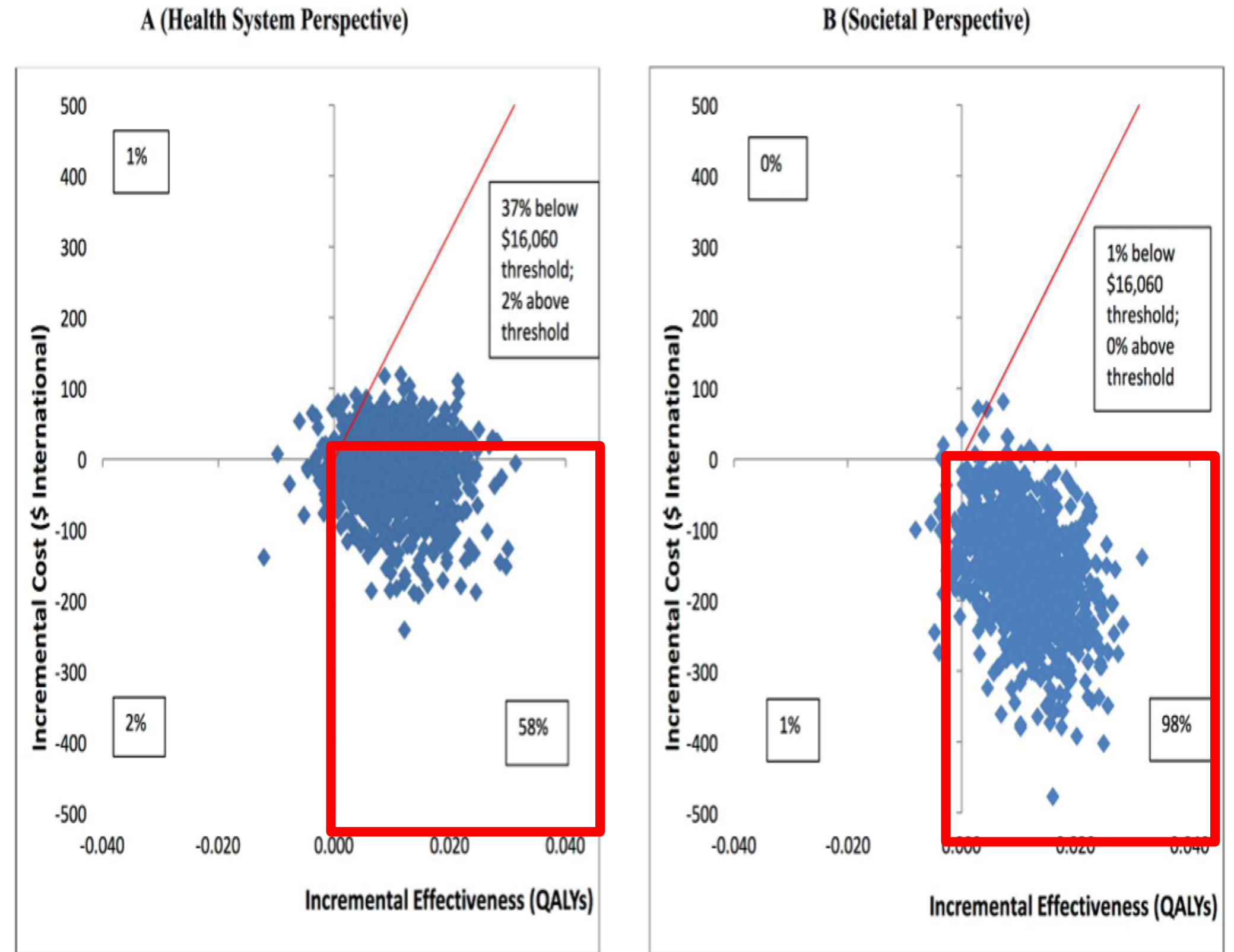


Fig 5. Cost-effectiveness planes: HAP plus EUC compared to EUC. (A) Health system perspective; (B) societal perspective. EUC, enhanced usual care; HAP, Healthy Activity Programme; QALY, quality-adjusted life year.

<https://doi.org/10.1371/journal.pmed.1002385.g005>

Brief psychological interventions to address psychological distress in health care workers

Open access

Original research

BMJ
Mental
Health

PSYCHOTHERAPIES

Effectiveness of a mental health stepped-care programme for healthcare workers with psychological distress in crisis settings: a multicentre randomised controlled trial

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► Additional supplemental material is published online only. To view, please visit the journal online (<http://dx.doi.org/10.1136/bmjment-2023-300697>).

For numbered affiliations see end of article.

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JMH and JLA-M are joint senior authors.

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ABSTRACT

Background Evidence-based mental health interventions to support healthcare workers (HCWs) in crisis settings are scarce.

Objective To evaluate the capacity of a mental health intervention in reducing anxiety and depression symptoms in HCWs, relative to enhanced care as usual (eCAU), amidst the COVID-19 pandemic.

Methods We conducted an analyst-blind, parallel, multicentre, randomised controlled trial. We recruited HCWs with psychological distress from Madrid and Catalonia (Spain). The intervention arm received a stepped-care programme consisting of two WHO-developed interventions adapted for HCWs: Doing What Matters in Times of Stress (DWM) and Problem Management Plus (PM+). Each intervention lasted 5 weeks and was delivered remotely by non-specialist mental health providers. HCWs reporting psychological distress after DWM completion were invited to continue to PM+. The primary endpoint was self-reported anxiety/depression symptoms (Patient Health Questionnaire-Anxiety and Depression Scale) at week 21.

WHAT IS ALREADY KNOWN ON THIS TOPIC

⇒ Evidence-based psychological interventions for healthcare workers in crisis settings are scarce.

WHAT THIS STUDY ADDS

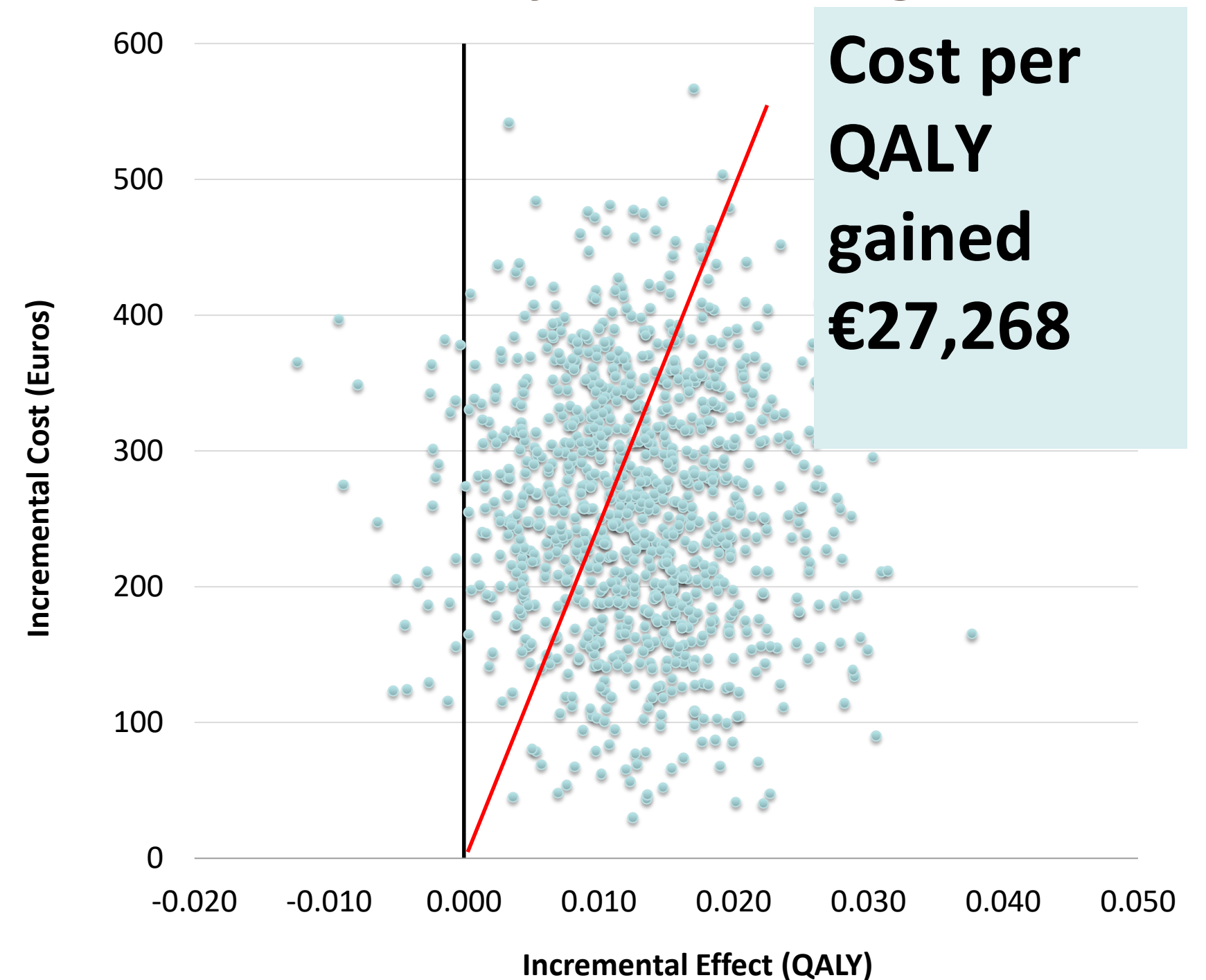
⇒ This is the first randomised controlled trial to provide evidence on the short-term and midterm effectiveness of a remotely delivered, scalable, stepped-care programme to reduce anxiety, depression and post-traumatic stress symptoms among healthcare workers.
⇒ This is also the first trial to explore the effectiveness of the guided self-help intervention called Doing What Matters in Times of Stress.

HOW THIS STUDY MIGHT AFFECT RESEARCH, PRACTICE OR POLICY

⇒ This stepped care is free, safe, effective and potentially scalable, and can already be implemented in health services at a larger scale.

BMJ Ment Health: first published as 10.1136/bmjment-2023-300697 on 1 June 2023. Downloaded from <http://mentalhealth.bmj.com/> on Jan

Economic analysis also being conducted



Social Return on Investment of €1.51 for every €1 invested

Value of very brief psychological therapy

Wang et al. *BMC Psychiatry* (2022) 22:547
<https://doi.org/10.1186/s12888-022-04192-8>

BMC Psychiatry

RESEARCH

Open Access

Cost and effectiveness of one session treatment (OST) for children and young people with specific phobias compared to multi-session cognitive behavioural therapy (CBT): results from a randomised controlled trial

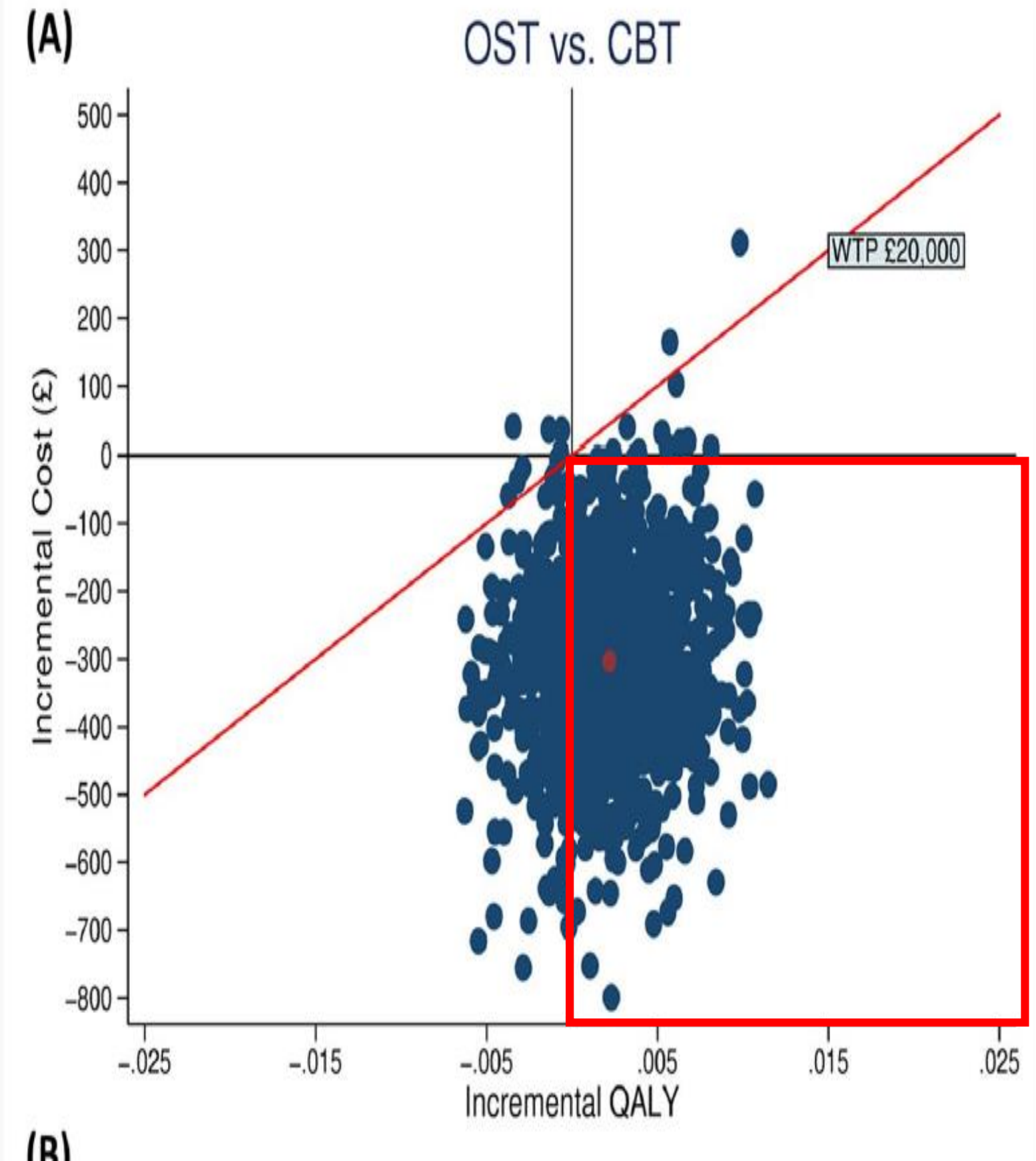
Han-I. Wang^{1*}, Barry Wright^{1,2}, Lucy Tindall², Cindy Cooper³, Katie Biggs³, Ellen Lee³, M. Dawn Teare⁴, Lina Gega^{1,5}, Alexander J. Scott⁶, Emily Hayward², Kiera Solaiman³, Thompson Davis^{7,8}, Dean McMillan^{1,5}, Simon Gilbody^{1,5} and Steve Parrott¹

Abstract

Background: In the UK, around 93,000 (0.8%) children and young people (CYP) are experiencing specific phobias that have a substantial impact on daily life. The current gold-standard treatment—multi-session cognitive behavioural therapy (CBT) – is effective at reducing specific phobia severity; however, CBT is time consuming, requires specialist CBT therapists, and is often at great cost and limited availability. A briefer variant of CBT called one session treatment (OST) has been found to offer similar clinical effectiveness for specific phobia as multi-session CBT. The aim of this study was to assess the cost-effectiveness of OST compared to multi-session CBT for CYP with specific phobias through the Alleviating Specific Phobias Experienced by Children Trial (ASPECT), a two-arm, pragmatic, multi-centre, non-inferiority randomised controlled trial.

Methods: CYP aged seven to 16 years with specific phobias were recruited nationally via Health and Social Care pathways, remotely randomised to the intervention group (OST) or the control group (CBT-based therapies) and analysed ($n=267$). Resource use based on NHS and personal social services perspective and quality adjusted life years (QALYs) measured by EQ-5D-Y were collected at baseline and at six-month follow-up. Incremental cost-effectiveness ratio (ICER) was calculated, and non-parametric bootstrapping was conducted to capture the uncertainty around the ICER estimates. The results were presented on a cost-effectiveness acceptability curve (CEAC). A set of sensitivity analyses (including taking a societal perspective) were conducted to assess the robustness of the primary findings.

Results: After adjustment and bootstrapping, on average CYP in the OST group incurred less costs (incremental cost was $-\pounds 302.96$ (95% CI $-\pounds 598.86$ to $-\pounds 28.61$)) and maintained similar improvement in QALYs (QALYs gained 0.002 (95% CI -0.004 to 0.008)). The CEAC shows that the probability of OST being cost-effective was over 95% across all the WTP thresholds. Results of a set of sensitivity analyses were consistent with the primary outcomes.



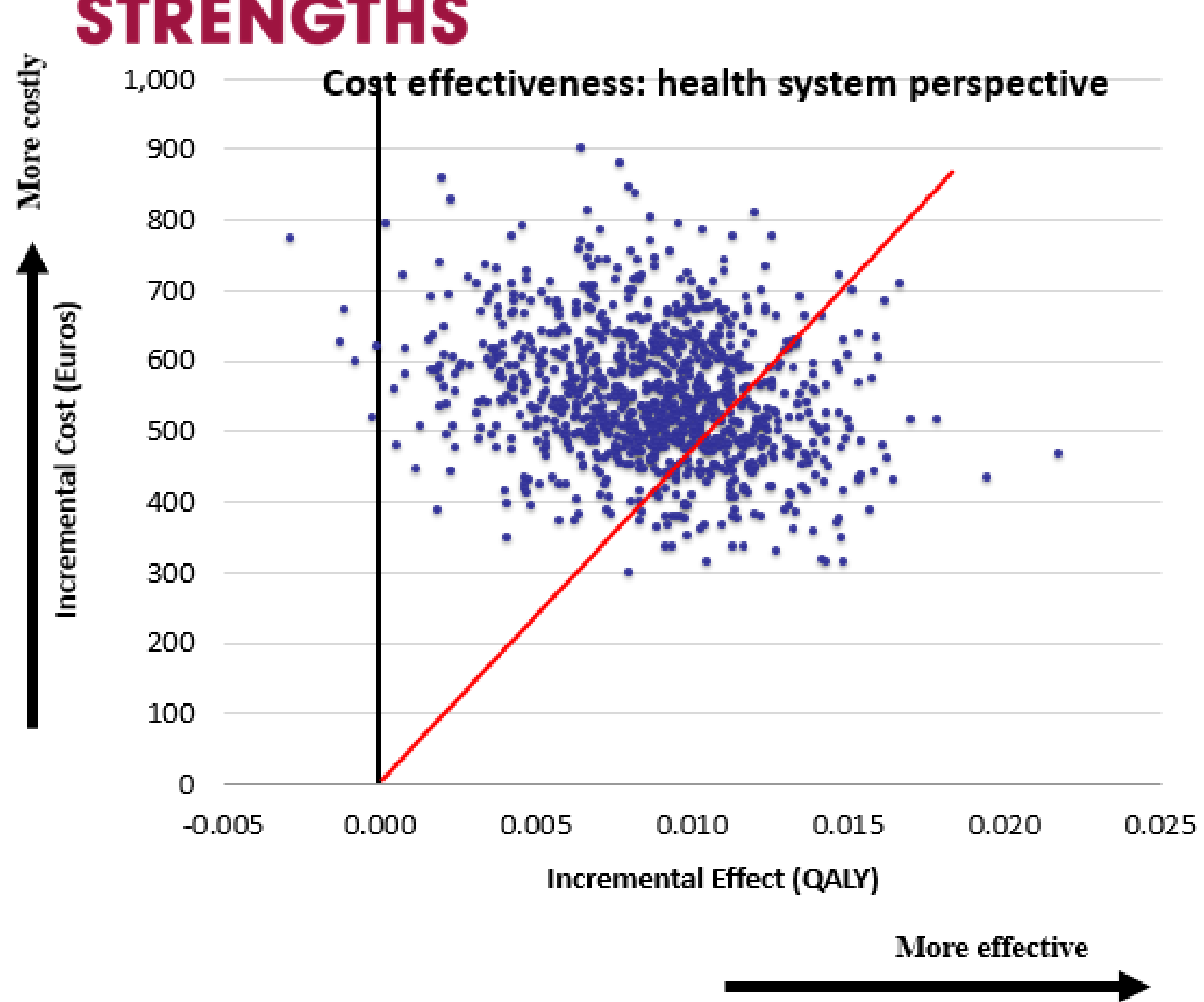
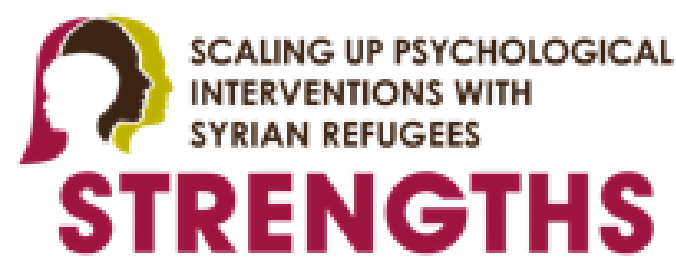
Economic evaluation of PM+ Implementation

- Economic evaluation **embedded into implementation trials** of PM+
 - Estimate **resource use and costs of implementation**, impacts on **health service utilisation**, as well as **productivity losses** for trial participants and family members.
 - Using primary trial outcome data, but also calculating **impacts on quality of life** to generate cost per quality adjusted life year gained estimates that are used by many health systems for **reimbursement/funding decisions**.
 - **Modelling scale up** and benefits if impacts sustained
-
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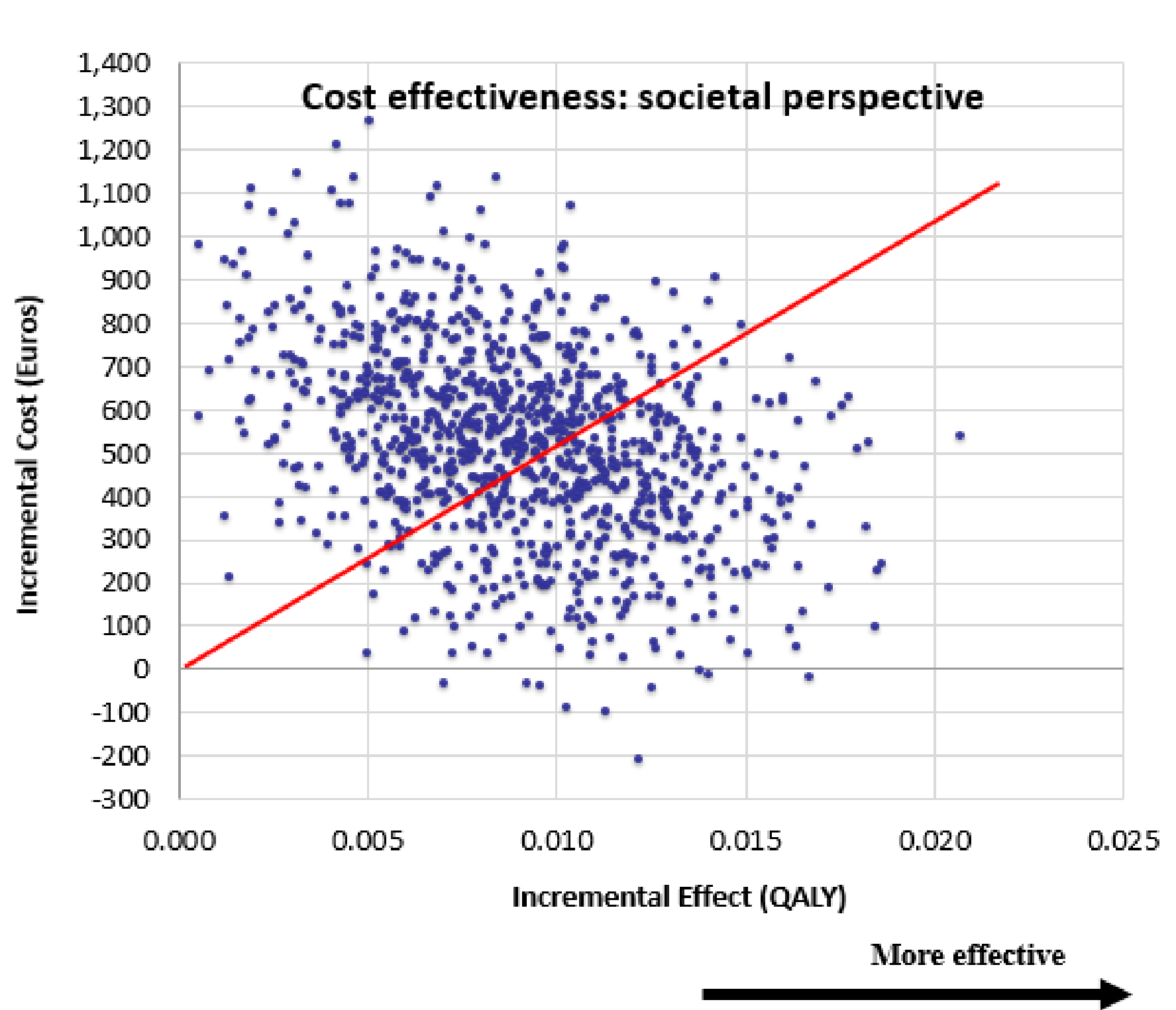
Economic analysis : Netherlands

- Individual PM+ led to significantly improved mental health outcomes compared to care as usual
 - **Quality of life also significantly improved in PM+ group** compared to usual care group $p=0.011$
 - No impact on immediate health service utilisation / costs, **but PM+ group have double the contact time with GPs** at 3 month follow up – 37 minutes vs 17 minutes $p=0.024$
 - Modelling scenarios indicate **potential for increased cost effectiveness over longer time periods with reduced implementation costs**
-

Economic analysis main trial Netherlands

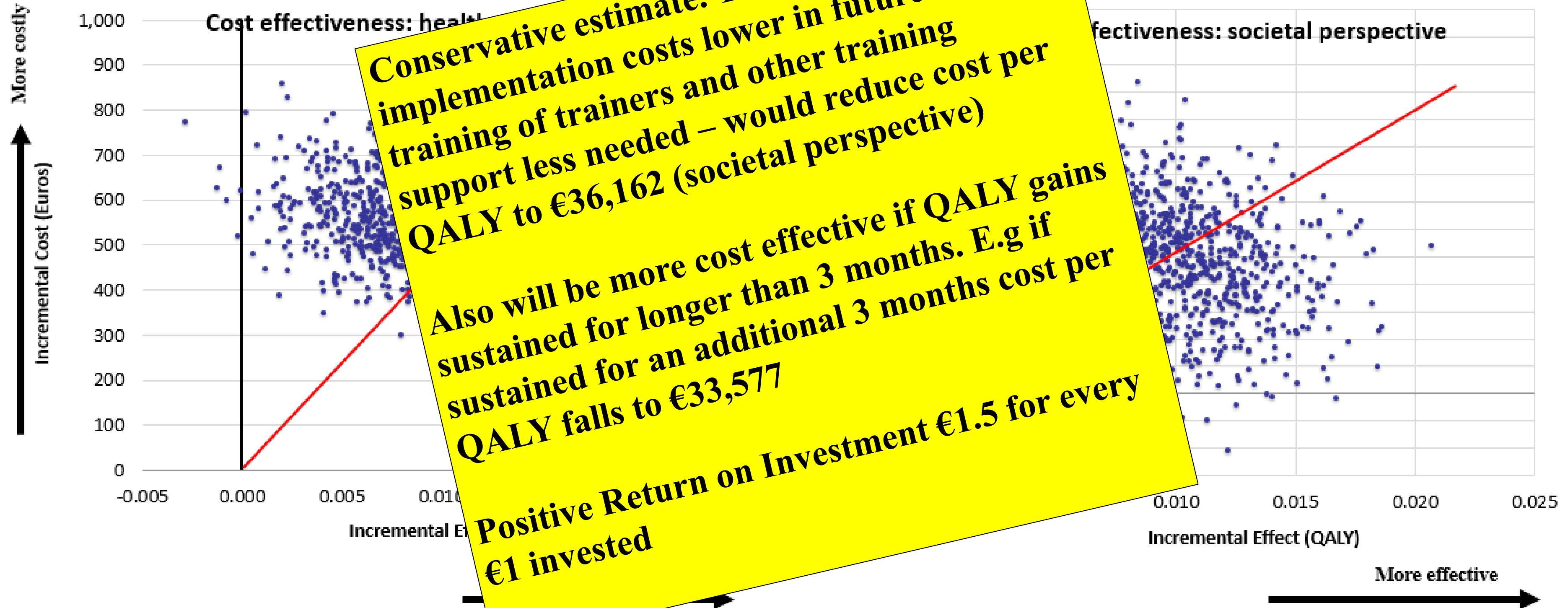


Expected cost per QALY gained €62,000



Expected cost per QALY gained €58,686

Economic analysis main trial Netherlands



Conservative estimate. Training and implementation costs lower in future as training of trainers and other training support less needed – would reduce cost per QALY to €36,162 (societal perspective)

Also will be more cost effective if QALY gains sustained for longer than 3 months. E.g if QALY falls to €33,577

Positive Return on Investment €1.5 for every €1 invested

Expected cost per QALY gained €62,000

Expected cost per QALY gained €58,686

Modelling scale up and long-term impacts of PM+ Implementation

- **Modelling tools used to help address issues of uncertainty and look at potential longer-term costs and impacts of health care strategies**
 - **End users can adjust assumptions: for example about short term and longer term effectiveness, intervention implementation costs, impacts on service use, uptake rates etc**
 - **Made use of data from country specific STRENGTHS trials over 3 months and 12 months to inform model development**
 - **Return on investment approaches increases used to inform policy making**
 - **Return on investment generated, including monetary benefits of any improvements in quality of life.**
-

iPM+ costs (Local currency values)

[Return to main menu](#)

	Value	Insert your own values below, otherwise default values used
Initial / Updated Training Costs	20.00	
Screening / Identification Costs	3.00	
Implementation Costs of iPM+ (per participant)	100.00	

Other costs (Local currency values)

	Value	Insert your own values below, otherwise default values used
Community health workers (per consultation)	130.00	
Primary care doctor (per consultation)	158.00	
Psychiatrist (per consultation)	370.00	
Psychologist	256.00	
Social worker	200.00	
Physiotherapist	125.00	
Psychiatric Inpatient Stay (Per Day)	700.00	
Other Inpatient Stay (Per Day)	500.00	
Outpatient Psychiatric Consultation	370.00	
Other Outpatient (Per consultation)	245.00	
Emergency Department (Per Visit)	5.00	
Lost earnings: daily cost	140.00	

Other model assumptions

	Inputs	Insert your own values below, otherwise default values used
Prevalence of psychological distress	0.31	
Probability of iPMplus dropout	0.20	
Ratio quality of life gain per three months with treatment (usual care = 1)	1.03	
Predicted future change in quality of life gain per month	1.00	
% of eligible refugees treated	0.50	
Ratio service utilisation with intervention (usual care = 1)	0.95	
Ratio productivity loss with intervention (usual care = 1)	0.95	
Discount rate (costs)	0.03	
Discount rate (outcomes)	0.03	
Number of refugees	1,000	

1.01

A conservative 1% increase in quality of life gains with PM+

Costs, costs averted (national currency 2020 values)

Selected Area: Switzerland

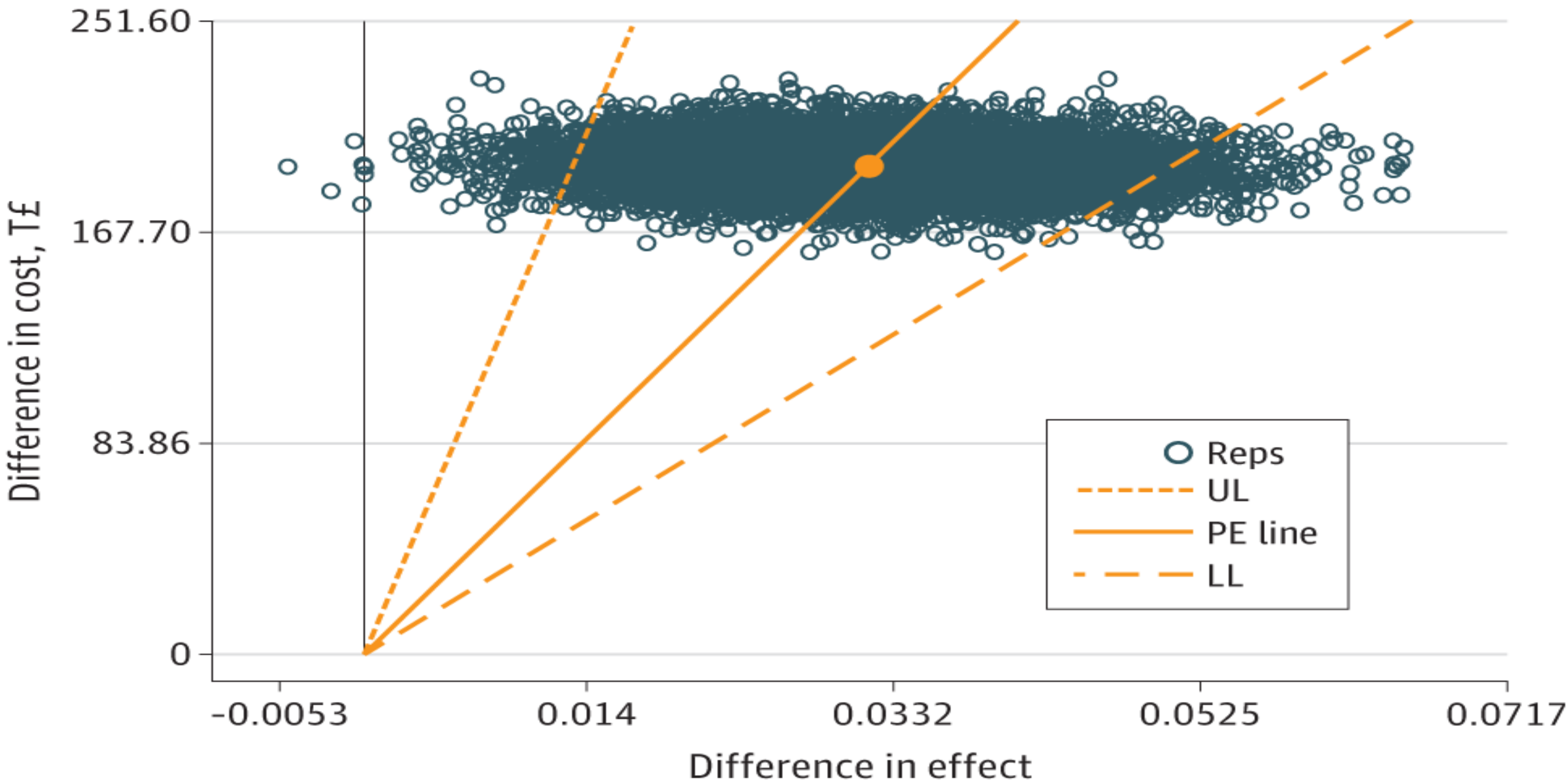
**Positive Return on
Investment: 6 months CHF
1.60 for every CHF
invested. CHF 3.10 ROI by
12 months.**

	3 months	6 months	9 months	12 months	18 months	24 months	30 months	Total
Cost of delivering iPM+	20,050	0	0	0	0	0	0	20,050
Number of refugees assessed	500							
Number of refugees receiving service	155							
Use of primary and community health care services	-5,036	-4,889	-4,745	-4,606	-4,340	-4,089	-3,853	-31,558
Use of secondary inpatient health care services	-736	-715	-694	-673	-634	-598	-563	-4,614
Use of secondary outpatient health services	-78	-75	-73	-71	-67	-63	-59	-486
Loss of paid/unpaid activity - service user	-163	-158	-153	-149	-140	-132	-125	-1,020
Loss of paid/unpaid activity - family/ friends	0	0	0	0	0	0	0	0
Total cost (saving if negative value)	-6,013	-5,836	-5,665	-5,499	-5,181	-4,882	-4,600	-37,677
Return on investment	0.30	0.59	0.87	1.15	1.41	1.65	1.88	1.88
Total cost (saving) including net monetary benefits of QALYs gained	-16,243	-15,766	-15,304	-14,855	-13,997	-13,188	-12,426	-101,780
Social Return on Investment	0.81	1.60	2.36	3.10	3.80	4.46	5.08	5.08
Quality Adjusted Life Years Gained	0.34	0.33	0.32	0.31	0.29	0.28	0.26	1.31
Net Monetary Benefit	10,230	9,930	9,639	9,356	8,816	8,306	7,826	64,104

Effectiveness of Self-Help Plus for Syrian Refugees in Turkey

- **Preventive SH+ programme:** 5-session (2 hours each), group-based, stress management course in which participants learned self-help skills for managing stress by listening to audio sessions. Facilitated by briefly trained, non-specialist individuals.
 - **RCT – 627 community dwelling refugees in Southern Turkey with 6-month follow-up. SH+ group significantly less likely to have mental disorders (22% vs 41% $p < 0.001$). Quality of life also improved in SH+ group compared to usual care group $p = 0.001$ (Acarturk et al World Psychiatry 2022; 21:88-95)**
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Cost effectiveness of Self-Help Plus for Syrian Refugees in Turkey



Incremental cost per QALY gained TL 6,068 (\$1,147).

Cost effective in Turkish context;

Positive Return on Investment 4:1



Overview Review

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Making an economic argument for investment in global mental health: The case of conflict-affected refugees and displaced people

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Abstract

Mental health expenditure accounts for just 2.1% of total domestic governmental health expenditure per capita. There is an economic, as well as moral, imperative to invest more in mental health given the long-term adverse impacts of mental disorders. This paper focuses on how economic evidence can be used to support the case for action on global mental health, focusing on refugees and people displaced due to conflict. Refugees present almost unique challenges as some policy makers may be reluctant to divert scarce resources away from the domestic population to these population groups. A rapid systematic scoping review was also undertaken to identify economic evaluations of mental health-related interventions for refugees and displaced people and to look at how this evidence base can be strengthened. Only 11 economic evaluations focused on the mental health of refugees, asylum seekers and other displaced people were identified. All but two of these intervention studies potentially could be cost-effective, but only five studies reported cost per quality-adjusted life year gained, a metric allowing the economic case for investment in refugee mental health to be compared with any other health-focused intervention. There is a need for more consistent collection of data on quality of life and the longer-term impacts of intervention. The perspective adopted in economic evaluations may also need broadening to include intersectoral benefits beyond health, as well as identifying complementary benefits to host communities. More use can be also made of modelling, drawing on existing evidence on the effectiveness and resource requirements of interventions delivered in comparable settings to expand the current evidence base. The budgetary impact of any proposed strategy should be considered; modelling could also be used to look at how implementation might be adapted to contain costs and take account of local contextual factors.

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- Review of global health databases, non-English databases and usual medical databases
- Just 11 economic evaluation on mental health interventions
- 5 in low and middle-income countries; 6 in EU
- 9 potentially cost-effective
- 7 use QALYs as outcome
- Longer time frames of evaluation needed
- In contrast more than 70 studies available on economic case for screening for communicable diseases

To Sum Up

- Consequences of poor mental health can be profound. **Long-lasting adverse impacts on mental health** (depression, anxiety, trauma);
- **Long-term evidence of adverse economic costs** to HIC hosts of not intervening early.
- Brief psychological interventions **can be (cost) effective in short term– but context dependent**. Some delivered within primary care / by peers
- More **long term follow up/ booster programme evaluation needed**. Small sustained positive impacts on outcomes can strengthen case for action.
- Look for multiple benefits: consider if services **can also benefit multiple populations, e.g. not just** refugees but also host population; other groups at higher risk of poor mental health (e.g. healthcare workers)