Is psychiatry different? An economic perspective

Compared with the general health system, the mental health system faces distinct challenges. Perennial flashpoints include issues of stigma, coercive treatment, and nosology, which generate heated ethical and policy debates. Often overlooked, however, is another characteristic of the mental health sector: its financial dependence on the public purse.

People with chronic behavioural health needs rarely have the means to afford their own care. Mental disability inhibits workforce entry, limiting the income available to cover private and out-of-pocket health-care costs. Moreover, long-term mental health treatment requires different, often more complex resources than other health treatments. Public financing of these costs is therefore common and necessary.

Governments around the world usually pay for mental health services regardless of whether the rest of the health sector is publicly or privately financed. The extent of public general health financing predicts the general bed supply by 6%, whereas the extent of public mental health financing predicts the psychiatric bed supply by almost 40% (author’s calculation; figure). In other words, how much a government spends on health usually does not determine the overall supply of care. Conversely, in the mental health sector, more government spending is associated with more care.

I analysed general and mental health markets in terms of the relationship between public spending, estimated by general government health expenditure and public mental health expenditure, and supply, estimated by the number of hospital beds (an adequate indicator in both markets). Data sources are the WHO Mental Health Atlas2 and Organisation for Economic Co-operation and Development (OECD) data at OECD.Stat. There is no correlation between the general health-care supply and public spending (figure A). However, there is a positive correlation between mental health-care supply and public mental health spending (figure B).

To promote better practice, providers, researchers, and policy makers should first acknowledge psychiatry’s dependence on public investment. The allocation of additional government resources to behavioural health will help to attract and retain providers and expand consumer access to long-term treatments. A robust supply of services is otherwise impossible to achieve.

I declare no competing interests.

Isabel M Perera
iperera@upenn.edu
Department of Medical Ethics and Health Policy, Perelman School of Medicine at the University of Pennsylvania, Philadelphia, PA 19104, USA

Early intervention for depression in young people: a blind spot in mental health care

It was with a great anticipation we read the Personal View by Christopher Davy and Patrick McGorry. We would like to raise some points that might be worth considering.

Subthreshold depression might be misleading or inaccurate in predicting actual depression and might confer simply to depressive affect. Given the adolescent index population, delineating such in a relatively mood-labile group might lead to overdiagnosis in cases that are on the threshold. Within older patient groups, we should be careful to distinguish between depressive symptoms without clinical depression and moderate or severe depressive disorder, including symptoms related to physical issues.

A systematic review suggests that there is little differentiation between depressive symptoms or depression as an entity when viewed by clinical staff and researchers. It is unclear whether a clear predictive relationship exists between the incidence of subthreshold depression and resultant depression severity. A review has suggested that clinical tools assessing risk for emergence of severe disease are suboptimal, do not account for the natural history of depression with psychosis, only delay emergence of diagnosis, and have negligible success.

A second point concerns the demographics of the index cases referenced and discordant low intervention rate. This might indicate a paucity of true prevalence; however, these data might not be as marred by insufficient surveillance but poor public health education, in that patients do not perceive their symptoms as problematic. If this is the case, perhaps early intervention should focus on educational resources as well as disengagement and low achievement as early indicators of deteriorating mental state. Early intervention could play a key role. We would tentatively suggest that an efficacious programme designed to detect early depression would have to account for a variance in cultural expressions of psychopathology, present a clear approach to ruling out simple depressive affect, assess differences in the natural history of disease after intervention, and justify the programme economically. One way to achieve these things would be a community-driven approach focusing on educational and social markers of decline as early intervention criteria, which would account for all diagnoses considered. However, because such frameworks have little sensitivity for diagnosis, this might be a difficult task to justify clinically or fiscally, and efforts might be better spent in addressing aetiology before symptoms.

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Benjamin Martin Janaway, Mukesh Kripalani
benjamin.janaway@nhs.net

Chase Farm Hospital, Barnet, Enfield and Haringey Mental Health Trust, London EN2 8JL, UK

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Authors’ reply

We thank Benjamin Janaway and Mukesh Kripalani for their interest in our Personal View. We agree that subthreshold depression might not be an accurate term, both because it can refer to the isolated experience of low mood and because no clear demarcation exists between subthreshold and full-threshold depression. We also agree that early intervention should focus on culturally sensitive interventions that include psychoeducation and address disengagement from education and work.

One of our motivations for writing our Personal View is our belief that early intervention for depression needs to expand beyond its narrow focus on subthreshold depression to include early episodes of depression, which can be uncomplicated or marked by severe symptoms and complex comorbidity. The lines of division between these subgroups are less important than the availability of a range of interventions that are appropriate to the young person’s clinical stage.

In general, we support the notion of providing care to young people who are experiencing distress, irrespective of whether they meet formal criteria for a diagnosis. Mild symptoms will often respond to interventions of lower intensity, which might include psychoeducation, reassurance, and watchful waiting. Young people with moderate symptoms should be offered evidence-based psychotherapy and other psychosocial supports. And when the symptoms are particularly severe and accompanied by poor psychosocial functioning, we argue that more specialist care is required, which is best delivered by a multidisciplinary team.

Janaway and Kripalani also suggest that targeting early evidence of symptoms with clinical and psychosocial support might be an inefficient use of resources, and that perhaps we should target aetiological factors rather than directly intervening to help manage the young person’s symptoms. We do not disagree that focusing on the social determinants of mental disorders is important, but...