

Economic Costs Associated with Untreated Mental Illness

Introduction:

Tens of billions of dollars are spent annually on treatment of and economic costs associated with behavioral health disorders. Health care costs and lost productivity make up the largest share of dollars spent. Depression, substance abuse, schizophrenia, and bipolar disorder are some of the most costly behavioral health issues and are widely prevalent in society (Goetzel, Hawkins, Ozminkowski & Wang, 2003). Estimates place the total economic cost of untreated behavioral health issues between \$150 and \$200 billion per year (Rampell, 2013). This figure has been growing, but the Affordable Care Act's expansion in coverage may help to reduce it.

Depression:

As of 2010, 19 percent of Americans have been diagnosed with depression at some point in their lives. This is considered a conservative estimate, as between 30 and 50 percent of individuals express depressive symptoms occasionally but do not meet criteria for a diagnosis of depression (Leahy, 2010).

Depression is a leading cost of medical disability for people aged 15-44 (Sanders, 2007). Depressed individuals are more likely to acquire a chronic condition, less likely to experience a positive disease progression, less likely to follow a medication or dietary regimen and more likely to experience bone loss (Gunn et al., 2012; Kale, Agaoglu & Tanik, 2010; Grenard et al., 2011; Wu, Liu, Gallegos-Orozco & Hentz, 2010). The costs associated with untreated depression account for a \$26.1 billion expense to the health care industry and a total economic loss of over \$83 billion (Leahy, 2010; Greenberg et al., 2003).

In the workplace, depressed individuals account for \$51.5 billion in losses (Greenberg et al., 2003). This is calculated by the loss of 5.6 hours of productivity per week, 1.5-3.2 more days of short-term disability per month and 2.17 times greater risk of taking a sick day for depressed people (Leahy, 2010). Those with depression are seven times more likely to be unemployed (Leahy, 2010). Between 45 and 98 percent of employer treatment costs for depression are offset by a significant increase in productivity by those without depression (Gallew, Haltiwanger, Sowers, & van den Heever, 2004).

Substance Abuse:

Individuals who abuse substances are 3.5 times more likely to experience an accident in the workplace, five times more likely to file a worker's compensation claim and more likely to miss work. In addition, 21 percent of employees report their productivity being negatively affected by a co-worker's drinking.

In 2005, 58 percent of substance abuse costs, or \$216 billion, were health care related. Medical consequences from abuse episodes account for 98 percent of those costs (Clark et al., 2010). The costs of tobacco, alcohol, and illicit drugs totaled \$96 billion, \$30 billion and \$11 billion, respectively. Individuals with substance use disorders are more likely to use acute services, less likely to adhere to treatment regimens, and incur higher annual Medicaid costs (Clark et al., 2010; Mancuso et al.). Substance abuse is also a key risk factor in hypertension and cardiovascular disease. In 2008, substance abusers with hypertension who sought treatment were subjected to \$2,322 higher annual Medicaid costs on average. If untreated, they incurred \$4,909 more in Medicaid expenses (Mancuso, et al.).

Schizophrenia and Bipolar Disorder:

A 2010 estimate by the National Institute of Mental Health found that 7.7 million people in the United States, or about 3.3 percent of the population, suffer from schizophrenia or bipolar disorder. In a given year, 40 percent of individuals with schizophrenia and 51 percent of individuals with bipolar disorder are undiagnosed. These individuals have a relatively high incidence of violence (often as victims) and incarceration. The economic costs associated with bipolar disorder and other psychotic illnesses total between \$33 and \$38 billion per year (Treatment Advocacy Center). Alone, bipolar disorder is the most expensive mental health condition to treat and the sixth leading cause of disability in the world. A single bipolar episode costs upward of \$11,720 (Rapoport, Basselin, Kim & Rao, 2009).

Conclusion:

The prevalence of behavioral health diseases places an economic and emotional burden on society. The costs associated with medical care, missed work, low productivity and low morale are estimated to be over \$150 billion a year and rising. Depression, substance abuse, schizophrenia and bipolar disorder all contribute significantly to this expense. Recent legislation is aimed at mitigating these costs and relieving some of the pressures these conditions exert.

References:

References:

Leahy, R. (2010). The Cost of Depression. *The Huffington Post*. Retrieved November 21, 2013 from http://www.huffingtonpost.com/robert-leahy-phd/the-cost-of-depression_b_770805.html

Greenberg, P, et al. (2003). The economic burden of depression in the United States: How did it change between 1990 and 2000? *Journal of Clinical Psychiatry*, 64(12), 1465-1475.

Rampell, C. (2013). The Half-Trillion-Dollar Depression. *New York Times*, MM14.

Clark E., O'Connell, E., & Samnaliev M., . (2010). Substance Abuse and Healthcare Costs Knowledge Asset. *Robert Wood Johnson Foundation's Substance Abuse Policy Research Program*. Retrieved March 21, 2014 from http://saprp.org/knowledgeassets/knowledge_detail.cfm?KAID=21

Mancuso, D., Shah, M., Huber, A., & Felver, B. (n.d.). The Health Impact of Substance Abuse: Accelerating Disease Progression and Death. *Pioneer Human Services*. Retrieved November 21, 2013 from http://www.pioneerhumanservices.org/wp-content/uploads/2012/01/Health-Impact-of-Substance-Abuse_DSHS1111.pdf

Consequences of Non-treatment. (n.d.). *Treatment Advocacy Center*. Retrieved November 25, 2013, from <http://www.treatmentadvocacycenter.org/resources/consequences-of-lack-of-treatment/violence/1384>

Goetzel, R. Z., Hawkins, K., Ozminkowski, R. J., & Wang, S. (2003). The health and productivity cost burden of the "top 10" physical and mental health conditions affecting six large US employers in 1999. *Journal of occupational and environmental medicine*, 45(1), 5-14.

Sanders, S. (2007). Depression cited as the top cause of medical disability. *American Medical News*. Retrieved March 21, 2014 from <http://www.ama-assn.org/amednews/2007/04/02/hlsb0402.htm>.

Rapoport, S. I., Basselin, M., Kim, H. W., & Rao, J. S. (2009). Bipolar disorder and mechanisms of action of mood stabilizers. *Brain research reviews*, 61(2), 185-209.

Gallew, H. A., Haltiwanger, E., Sowers, J., & van den Heever, N. (2004). Political action and critical analysis: Mental health parity. *Occupational Therapy in Mental Health*, 20(1), 1-25.

Gunn, J. M., Ayton, D. R., Densley, K., Pallant, J. F., Chondros, P., Herrman, H. E., & Dowrick, C. F. (2012). The association between chronic illness, multimorbidity and depressive symptoms in an Australian primary care cohort. *Social psychiatry and psychiatric epidemiology*, 47(2), 175-184.

Kale, N., Agaoglu, J., & Tanik, O. (2010). Neuropsychiatric manifestations in multiple sclerosis: correlation of fatigue and depression with disease progression. *Neurological research*, 32(2), 221-223.

Grenard, J. L., Munjas, B. A., Adams, J. L., Suttorp, M., Maglione, M., McGlynn, E. A., & Gellad, W. F. (2011). Depression and medication adherence in the treatment of chronic diseases in the United States: a meta-analysis. *Journal of general internal medicine*, 26(10), 1175-1182.

Wu, Q., Liu, J., Gallegos-Orozco, J. F., & Hentz, J. G. (2010). Depression, fracture risk, and bone loss: a meta-analysis of cohort studies. *Osteoporosis international*, 21(10), 1627-1635.