Public mental health: science or politics?

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The history of public health intervention arguably began when the handle was removed from the pump supplying cholera-infected water to one side of a street in London in 1854. It was based on careful medical observation and hypothesis testing, it was effective and it was certainly timely. In relation to infection control, subsequent successful measures were the introduction of proper sewerage and the regulation of standards in food hygiene. Public health doctors continue to be specialists in exactly these areas, and their success has transformed life expectancy especially for babies and young children almost everywhere.

So, what is the equivalent of the pump handle and what will be the consequences of removing it in the field of mental health? Is the time really ripe for translation of evidence into practice in the field of public mental health, as K. Wahlbeck (1) suggests in this issue of the journal?

Clearly this requires that we already have interventions for immediate application to key public mental health improvement. A meta-analysis (2) cited by Wahlbeck implies that primary prevention of “mental illness” in children and young people at risk – a 40% reduction – is indeed possible. If true, this would be very good. However, that meta-analysis reported only 161 new episodes of illness in total across seven rather small psychotherapy trials. Given the increasingly recognized bias in the way such trials are conducted and analyzed (3), the reported effect is improbably high and anyway applies to short-term outcomes and minor illness. Such psychotherapy is also labour intensive and potentially expensive. It is difficult to see how current models of provision could ever provide a population level approach even if the therapy did work. Indeed, all the examples cited by Wahlbeck seem to me to highlight how weak our current evidence base is, how much more certain we need to be that our understanding of causes and treatments of illness is correct, and how impractical the proposed interventions are likely to be unless delivered electronically.

Wahlbeck goes a further step in emphasizing the importance of wellbeing and mental health promotion not only as an end in itself but also as a solution to mental illness. However, where the evidence base is developing (and allowing us the little confidence we do have in causes and solutions) is in research on mental illness, not mental health. Take the sociology of research funding: compared with other illnesses, spending remains low in proportion to the societal burden of mental illness. But we know that because we can measure the burden of mental illness. We do not infer it by measuring the population’s average wellbeing. This is equally true of the evidence used to advocate “mental health promotion”. Is it not simply an inversion

of what we know causes mental illness/distress? Thus we know that “good enough” early experience is critical to the normal development of children because sexual and physical abuse, neglect and loss lead to mental illness in later life. We do not infer this from the good outcomes of people with exceptional parents or even the average outcomes of people with average parents. And how good is the evidence that we can improve societal outcomes by intervening in the normal parenting of average children? It is only in deprived settings that improving parenting skills is associated with better outcomes. This is irrelevant to the broader societal context in developed countries. It again depends on an inversion of the evidence to imply that everyone needs a government enforcer to improve their parenting skills. So there is no reason to believe that turning mental illness into a mental health question – a public health approach according to Wahlbeck – can improve our evidence base or promote better research.

What areas really do provide a current public mental health challenge where governments can intervene? Wahlbeck opines: “Substance abuse disorders can be prevented by universal policy actions aimed to reduce the availability of alcohol and drugs. Effective regulatory interventions include taxation, restrictions on availability and total bans on all forms of direct and indirect advertising”. Really? So is this a pump handle issue, a no-brainer for public health campaigners? Well, no, actually. Prohibition of alcohol in the U.S. (the extreme of reduced availability) provides a worked historical example of what a disaster some universal policy actions can be. Make alcohol more expensive or ban it and you will immediately create an illegal market for its distribution (i.e., organized crime), risk poisonous contamination of the product and criminalize those in society who wish to be free to drink it. On the other hand, as currently being argued out (4), take a drug like cannabis which is currently criminalized and legalize it, as is happening in piecemeal fashion “for medical use”, and you risk the business efficiency of legal private industry increasing availability, desirability and strength of effect. Big marijuana could be quite like big tobacco. A public health approach must engage with the risks and benefits and think them through; the failure to do so means the argument becomes at best frivolous, at worst fantasy.

Indeed, what of the whole thesis that mental health should necessarily concern itself not only with mental illness, but also health and wellbeing? The argument is that this is necessary to make mental health a matter “of interest to everybody”. The burden of psychiatric illness and its under-resourcing should be de-emphasized to make this

alternative formulation. This is propaganda, not science. Mildly supportive research evidence may often be made to suffice in a transient political dispute, but it is regrettable when made the basis for a public mental health agenda. However, the primacy of the politics does explain why the argument ends up by moving so seamlessly to support for fashionable models of service provision, casual dismissal of the “medical model” and uncritical support for a “recovery-oriented system of balanced care”.

In the UK, this kind of approach has held sway for at least 15 years. There have been consequences (5). We have seen a proliferation of managers and providers of specialist services all of whom spend immense amounts of time in meetings. The key expression is “clinical governance”: managers not doctors lead services, in so far they are led at all. We have seen an irresponsible reduction in bed numbers, which makes inpatient care a routinely unpleasant experience. The role of diagnosis and specialist treatment is seen as something to be delegated and now divided. It tends to be replaced with something vacuous and imprecise. The role of the psychiatrists in this system is to be simultaneously marginalized, but they remain responsible when things go wrong. Recruitment into psychiatry has plummeted (6) and remains extremely problematic.

Read the following amazing piece of prose (7), which addresses a method (probably now discarded, I am not sure) for changing how psychiatrists work. For those of you who may adopt the “Birmingham model” or whatever our system is called in translation, you can expect a lot of this sort of thing: “New Ways of Working is what it says – new ways of working – rather than a single service model or structure that has to be adopted. It recognizes that services catering for the different types of needs of service users across their lifespan and differing demographics and geography will need different configurations to manage their task most effectively. However, the underlying principles relating to using the skills of the workforce in the most productive way are common. It is about achieving cultural

change; a shift in the way teams think about themselves, the skills of the individuals within them, and the reasons they are there. However, cultural change is difficult to achieve and it is difficult to measure the extent to which it has been achieved”.

It has the charm of a pamphlet extolling the virtues of a Soviet collective farm. When I get an outstanding medical student express an interest in psychiatry, would I be wise to have him read these inspiring words, ending as they do with a sentence that embodies exhaustion and futility?

So, is public mental health really about pump handle breakthroughs, or the construction of a convenient fig leaf of superficial data to hide the political nature of the arguments that have so often intruded into the diagnosis and treatment of mental illness? It will be obvious that I see it as the latter. I commend the public handle standard instead.

References

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