Addressing social injustice: a key public mental health strategy

VIKRAM PATEL

London School of Hygiene and Tropical Medicine,
London, UK; Public Health Foundation of India,
Gurgaon 122002, India

The primary goal of public mental health is to reduce the burden of mental disorders, scaling up an array of evidence-based interventions aimed at the prevention and treatment of these disorders. Given the absence of evidence that the treatment of mental disorders, unlike many other health conditions, can reduce their population burden, one must pin one's hopes on interventions aimed at mental health promotion and the prevention of these conditions.

Much of the discourse in public mental health, and the emphasis of Wahlbeck's paper (1), is to put into practice interventions that meet the widely accepted criteria of "evidence", which, with a few notable exceptions, is defined by efficacy proven through randomized controlled trials or, at the very least, some other controlled evaluation. However, these research designs are unable to evaluate interventions which act at levels higher than individuals or relatively small clusters of individuals (such as schools), and thus it is not surprising that most of the recommended interventions target individuals (e.g., parenting interventions) or small groups of individuals (e.g., life skills training in schools). The few exceptions lie in regulatory interventions at the national level, such as alcohol taxes or restriction of methods for suicide, where time-series analyses can allow causal inferences with some confidence, as there are unlikely to be other confounders in the context of the immediate impacts of these interventions.

It is not surprising, then, that even though "the societal determinants of mental health often lie in non-health policy domains" (1), most actions which are promoted by public mental health practitioners tend to focus on individu-

als. This commentary urges us to also pay as much attention to actions which need to be taken higher up the causal pathway, targeting the structural (or societal) determinants operating at the national, regional and global levels.

The rich literature from social epidemiology shows us that the most pressing determinants of mental health in all populations are structural: poverty (both absolute and relative), gender inequality, social exclusion and conflict. For obvious reasons, interventions targeting these determinants do not lend themselves easily to experimental evaluation, and when they do (as has become increasingly evident with the application of experimental methods to evaluate poverty alleviation interventions), mental health outcomes are rarely measured (2). However, this does not mean that the strong, cross-national, observational evidence which is available should not be acted upon.

With few exceptions, the vast body of the epidemiological studies consistently demonstrates that mental disorders are commoner in people who are socially disadvantaged, exposed to violence and conflict, or displaced for one reason or another (3). The global economic system has led to a massive increase in global wealth and a remarkable reduction in levels of absolute poverty in most countries. But, at the same time, the rapid growth of the global economy – particularly fierce in the new millennium as several large, previously low-income, countries accelerate their march towards "development" and global financial markets are deregulated – has also led to the worsening in several other determinants: increase in financial instability for countries, sometimes leading to unexpected and dramatic economic collapses; a gathering pace of climate change and environmental degradation fuelling increasing uncertainty in livelihoods; conflicts driven by the need to control

fossil fuels and other natural resources; growing insecurity of employment as businesses operate globally, moving to any location where they can minimize the cost of labour; and the massive growth in income inequality in most countries creating deeply divided societies. These changes are not the ingredients for promoting public mental health.

It is arguable whether, in the face of such a large scale onslaught on the basic values which underpin a healthy society, individual interventions to promote mental health can have any meaningful population level impact. It is for this reason that public mental health must champion policy interventions which address structural determinants that operate within and across all countries. We should expect that interventions which successfully address structural determinants such as absolute and relative poverty or gender based violence or conflict prevention will produce downstream beneficial effects on population mental health. And there is an evidence base, derived from country level case studies (since structural determinants are typically addressed at the national level), that such interventions can improve mental health outcomes. The dramatic reduction in suicide rates in China over the past decade has, at least in part, been attributed to improved living conditions in rural areas and greater empowerment of young women (4). The higher rates of self-reported well-being and lower rates of mental disorder and substance use in countries with lower levels of income inequality is another case in point (5). And surely one does not need an experimental study to demonstrate that people who live free of war and hunger enjoy better mental health.

Public mental health is as much about politics and ideology as medicine and science. A world in which

the wealth of a few is privileged over the welfare of the majority and where social justice and equity, both within and between nations, are not considered pre-eminent values to promote healthy populations, is one in which mental health problems will inevitably become more common. Public mental health must not only equip people and communities to better cope with the stressors created by a dysfunctional world, but also target the very drivers of this dysfunction.

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Public mental health: evidence to policy

SALLY C. DAVIES, NISHA MEHTA

Office of the Chief Medical Officer, Department of Health, London SW1A 2NS, UK

Public mental health is difficult to define, because there are contested boundaries and terminology. In producing the Chief Medical Officer's Annual Report 2013 (1), we became increasingly concerned about the lack of consensus over fundamental issues in public mental health in England, including: a) the definition and key components of public mental health; b) the relation of concepts within mental health to one another; c) how mental health variations of importance are measured and experienced; d) the value placed on mental health and its consistency across society; e) our approach to the generation, accumulation and use of evidence in policy.

Public mental health came into focus in England in 2008, when the Government Office for Science published the Foresight Report on the topic of "mental capital" and "wellbeing" (2). That report provided a major impetus for political and policy interest in framing mental health policy in terms of "wellbeing", which continues to gather pace. Foresight suggested that "achieving a small change in the average level of wellbeing across the population would produce a large decrease in the percentage with mental disorder, and also in the percentage who have sub-clinical disorder (those 'languishing')" (2).

With the tempting prospect of a "wellbeing" approach to public mental health potentially promising the primary prevention of mental disorder, the "wellbeing" agenda and a diversity of associated narratives have since been prominently embedded throughout mental health policy in England. A necessary concurrent step in the rapid ascendancy of wellbeing would obviously need to be the production of a robust supporting evidence base, using clear and agreed definitions and metrics. We reviewed the evidence in depth and found it wanting (3).

Concerns have crystallized that wellbeing is difficult to define, difficult to measure and therefore difficult to integrate in any meaningful way into public mental health (4-6). When combined with contested boundaries within mental health and the widespread use by researchers and policy makers of an array of unvalidated proxy wellbeing measures of varying lengths and sophistication, the production of a body of wellbeing related evidence that is scientifically robust enough to support policy making is difficult. In particular, we reject the use of items validated for measurement of disorder – most notably the General Health Questionnaire (GHQ) – as a measure of wellbeing (7-10).

The psychometric relationships between "positive" and "negative" mental health variations of importance in populations are not yet sufficiently un-

derstood, but they almost certainly do not exist on a continuum (3). This is a complex field, and those promoting a wellbeing approach to mental health simply must engage with new combinations of items. Furthermore, we cannot say with confidence that wellbeing narratives are safe for low scorers on the widely used wellbeing scale, the Warwick Edinburgh Mental Wellbeing Scale (WEMWBS), in which psychiatric distress in terms of probable GHQ morbidity remains a key unresolved question (3).

A further cause for concern is that an approach to mental wellbeing that incorporates measures of disorder has spawned a policy agenda in which terms describing very different populations are used interchangeably. The result is inconsistent blurring of the boundaries between population approaches to positive mental health and wellbeing promotion, prevention of mental illness, and treatment and rehabilitation, with little or no thought about the interrelated concepts in question. This has resulted in much of the wellbeing evidence review literature, on which public mental health policy in England has been built, inappropriately describing the results of studies in more established disciplines into the prevention and treatment of mental illness as part of a "wellbeing" evidence base to which they cannot scientifically be said to apply. "Proxy" outcomes are