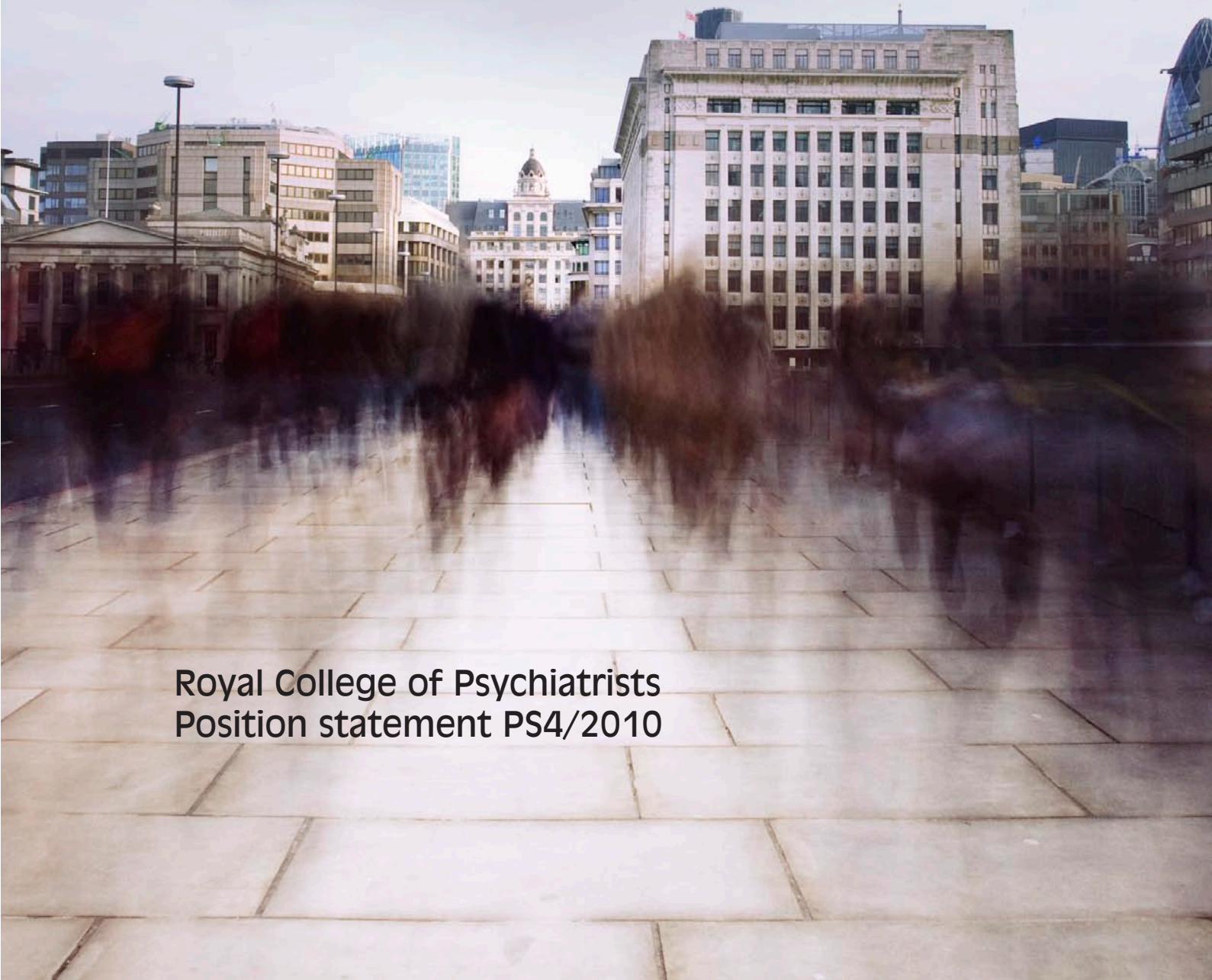
No health without public mental health

the case for action



Royal College of Psychiatrists
Position statement PS4/2010

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Preface

In the past two decades there emerged evidence to suggest that over three-quarters of psychiatric disorders develop below the age of 25. We also know that some childhood disorders will lead to ongoing problems in adulthood. It is important that psychiatrists and other mental health professionals be aware of strategies related to prevention at all levels, whether on the primary, secondary or tertiary level. As psychiatrists, we must take the lead in educating the public, patients and their carers about these issues. I welcome the proposed *Public Health White Paper*, which will have mental health strategy at its core. I am delighted and proud that the Royal College of Psychiatrists has led the way in developing a public mental health strategy in partnership with various stakeholders. I would like to thank all those who contributed to this, in particular Professor Kamaldeep Bhui, the College Lead on Public Health, and Dr Jonathan Campion, for their hard work in developing this Position Statement.

Professor Dinesh Bhugra
President of the Royal College of Psychiatrists

Public mental health focuses on wider prevention of mental illness and promotion of mental health across the life course.

The Royal College of Psychiatrists believes that mental health is a central public health issue and that it should be a priority across all government departments. This position statement sets out the contribution that public mental health makes to a wide range of health and social outcomes for individuals and society.

Executive summary and recommendations

Mental health is a public health issue. Mental illness is the largest single source of burden of disease in the UK. No other health condition matches mental illness in the combined extent of prevalence, persistence and breadth of impact.[1] Mental illness is consistently associated with deprivation, low income, unemployment, poor education, poorer physical health and increased health-risk behaviour. Mental illness has not only a human and social cost, but also an economic one, with wider costs in England amounting to £105 billion a year.[2]

Despite the impact of mental illness across a broad range of functional, economic and social outcomes, and despite ample evidence that good mental health underlies all health, mental health is not prominent across public health actions and policy. Public health strategies concentrate on physical health and overlook the importance of both mental illness and mental well-being. Positioning mental health at the heart of public health policy is essential for the health and well-being of the nation. It will lead to healthy lifestyles and reduce health-risk behaviours, thereby both preventing physical illness and reducing the burden of mental illness.

Most mental illness begins before adulthood and often continues through life. Improving mental health early in life will reduce inequalities, improve physical health, reduce health-risk behaviour and increase life expectancy, economic productivity, social functioning and quality of life. The benefits of protecting and promoting mental health are felt across generations and accrue over many years. Promotion and prevention is also important in adulthood and older years, with people in later life having specific mental health needs. Effective population mental health strategies will improve well-being, resilience to mental illness and other adversity, including physical illness. Targeted strategies will also prevent future inequalities and reduce existing inequalities.

All sectors of society have a role to play in improving the mental and physical health of the population and doctors are an important group to facilitate this.[3] Many psychiatrists already adopt a public mental health approach in their work such as when assessing the needs and assets of their local populations, informing commissioners of the expected prevalence of specific disorders and anticipating levels of service provision, as well as opportunities for health promotion. Clinical engagement in commissioning for public mental health is essential to ensure that effectiveness, quality and safety are prioritised and waste of resources is avoided. Psychiatrists could have a key role as advocates and leaders for public mental health. All health professionals should be involved in informing local and national policies and actions and in local implementation of public health policy.

For all these reasons significant investment to promote public mental health is needed. As well as reducing associated personal and social costs, such investment will lead to significant economic savings which also have an important role in wider economic recovery. Significant costs arise from the lack of such investment. Cost-effective interventions exist to both prevent mental illness and to promote wider population mental health, initiatives that complement the treatment of mental illness. Effective public mental health action will reduce the present and future disease burden and cost of mental illnesses.

The Royal College of Psychiatrists' work on public health

As a consequence of the College's commitment to public mental health, the College hosted five stakeholder seminars in 2009 covering public mental health across the lifespan. These were organised jointly with other partners, including the Department of Health, the NHS Confederation and the Faculty of Public Health. The conclusions from these seminars have been incorporated into this position statement. Subsequently, Professor Kamaldeep Bhui was appointed College Lead on Public Health and, with Dr Jonathan Campion, Ms Katie Gray, Dr Jo Nurse, Dr Laurence Mynors-Wallis and members of the College Policy Unit, particularly Dr Rowena Daw, produced this document. Recommendations in this position statement are drawn from the evidence base set out below and build on the public health seminars.

Recommendations

Mental illness is the largest single source of burden of disease in the UK. It has an impact on every aspect of life, including physical health and risk behaviour. There are large personal, social and economic costs associated with mental illness. Cost-effective interventions exist to both prevent mental illness and promote wider population mental health. The Royal College of Psychiatrists urges the Government to prioritise public mental health as part of their public health policy.

Key points and features that should be part of a public mental health strategy:

1 There is no public health without public mental health. Investment is needed to promote public mental health. This will enhance population well-being and resilience against illness, promote recovery, and reduce stigma and the prevalence of mental illness.

2 The Royal College of Psychiatrists strongly supports the findings of the Marmot Strategic Review of Health Inequalities in England post 2010. It recognises that inequality is a key determinant of illness, which then leads to even further inequality. Government policy and actions should effectively address inequalities to promote population mental health, prevent mental ill health and promote recovery.

3 Physical health is inextricably linked to mental health. Poor mental health is associated with other priority public health conditions such as obesity, alcohol misuse and smoking, and with diseases such as cancer,

cardiovascular disease and diabetes. Poor physical health also increases the risk of mental illness.

4 Interventions which apply across the life course need to be provided. Since the majority of mental illnesses have childhood antecedents, childhood interventions which protect health and well-being and promote resilience to adversity should be implemented. If mental health problems occur there should be early and appropriate intervention. Strategies to promote parental mental health and effectively treat parental mental illness are important since parental mental health has a direct influence on child mental health.

5 Older people also require targeted approaches to promote mental health and prevent mental disorder, including dementia. Action is needed to promote awareness of the importance of mental health and well-being in older age as well as ways to safeguard it. Ageist attitudes need to be challenged and values promoted that recognise the contributions older people make to communities, valuing unpaid, voluntary work as we do economic productivity.

6 An effective public health strategy requires both universal interventions, applied to the entire population, and interventions targeted at those people who are less likely to benefit from universal approaches and are at higher risk, including the most socially excluded groups. Such groups include children in care or subject to bullying and abuse, people of low socioeconomic status, those who are unemployed or homeless, those with addictions or intellectual disability, and other groups subject to discrimination, stigma or social exclusion. Health promotion interventions are particularly important for those recovering from mental illness or addiction problems. Those with poor mental health as well as poor physical health require effective targeted health promotion interventions.

7 The prevention of alcohol-related problems and other addictions is an important component of promoting population health and well-being. The College supports the development of a minimum alcohol pricing policy and a cross-government, evidence-based addictions policy.

8 Smoking is the largest single cause of preventable death and health inequality. It occurs at much higher rates in those with mental illness, with almost half of total tobacco consumption and smoking-related deaths occurring in those with mental disorder. Therefore, mental health needs to be mainstreamed within smoking prevention and cessation programmes.

9 A suicide prevention strategy should remain a government priority and should include strategies to address and reduce the incidence of self-harm.

10 Collaborative working is required across all government departments in view of the cross-government benefits of public mental health interventions across a range of portfolios, such as education, housing, employment, crime, social cohesion, culture, sports, environment and local government. Actions to combat stigma related to mental illness should be included in these strategies.

11 Doctors can be important leaders in facilitating local and national implementation of public mental health strategies. Many psychiatrists

already adopt a public mental health approach in their work and influence national and local strategy. Psychiatrists should be supported in assessing the needs of their local population for health promotion.

12 Psychiatrists should be engaged in the commissioning process and inform commissioners of the expected prevalence of specific disorders to anticipate levels of service provision and unmet need, and to help prioritise resource allocation. Support and training are required to facilitate this.

13 Commissioners should take into account the effects of mental health and mental illness across the life course as well as the economic benefits of protecting and promoting mental health and well-being.

14 Commissioners should consider the existing arrangements and adequacy of services for comorbid disorders and unexplained medical symptoms where cost-effective interventions could be provided.

1 Epidemiology and impact of mental illness

In the UK, one in four people will experience mental illness in their lifetime, whereas one in six will experience mental illness at any one time. Mental illness is the single largest source of burden of disease in the UK.

Impact of mental illness

In 2004, 22.8% of the total burden of disease in the UK was attributable to mental disorder (including self-inflicted injury), compared with 16.2% for cardiovascular disease and 15.9% for cancer, as measured by Disability Adjusted Life Years (DALYs).[a,4] Depression alone accounts for 7% of the disease burden, more than any other health condition. It is predicted that by 2030, neuropsychiatric conditions will account for the greatest overall increase in DALYs.[5]

Population levels of different types of mental illness are presented in Box 1.

Mental Illness over the life course

Half of all lifetime cases of diagnosable mental illness begin by age 14[16] and three-quarters of lifetime mental illness arise by mid-twenties. However, 60–70% of children and adolescents who experience clinically significant mental health problems have not been offered evidence-based interventions at the earliest opportunity for maximal lifetime benefits.[17] Furthermore, in a UNICEF survey in 2007 the UK ranked at the bottom on children's well-being compared with North America and 18 European countries,[18] and ranked 24th out of 29 European countries in another survey in 2009.[19]

Unlike other health problems such as cancers and heart disease, most mental illness begins early and may persist over a lifetime, causing disability when those affected would normally be at their most productive. Approximately 11 million people of working age in the UK experience mental health problems and about 5.5 million have a common mental disorder. A significant proportion of the population experience subthreshold symptoms,

a DALYs are a measure of the total length of time over which a specific illness is disabling to an individual over the course of their lifespan. One DALY can be thought of as one lost year of 'healthy' life.

Box 1 Mental illness in England

- 10% of children and young people have a clinically recognised mental disorder: of 5- to 16-year-olds, 6% have conduct disorder,[6] 18% subthreshold conduct disorder[7] and 4% an emotional disorder[6]
- 17.6% of adults in England have at least one common mental disorder and a similar proportion has symptoms which do not fulfil full diagnostic criteria for common mental disorder[8]
- postnatal depression affects 13% of women following childbirth[262]
- in the past year 0.4% of the population had psychosis[8] and a further 5% subthreshold psychosis[9]
- 5.4% of men and 3.4% of women have a personality disorder;[10] 0.3% of adults have antisocial personality disorder[8]
- 24% of adults have hazardous patterns of drinking, 6% have alcohol dependence, 3% illegal drugs dependence[10] and 21% tobacco dependence[11]
- 25% of older people have depressive symptoms which require intervention: 11% have minor depression and 2% major depression;[12] the risk of depression increases with age – 40% of those over 85 are affected
- 20–25% of people with dementia have major depression whereas 20–30% have minor or subthreshold depression[13]
- dementia affects 5% of people aged over 65 and 20% of those aged over 80[14]
- in care homes, 40% of residents have depression, 50–80% dementia and 30% anxiety[12]
- a third of people who care for an older person with dementia have depression[15]

which, although not meeting criteria for diagnosis of mental illness, have a significant impact on their lives.

Risk factors for mental illness

The World Health Organization's (WHO's) Commission on the Social Determinants of Health highlighted the importance of social circumstances in influencing health and well-being and the structural factors at wider policy and economic levels that lead to health inequities.[20] A public health approach recognises the importance of addressing wider determinants across the life course to both prevent mental illness and promote well-being.

Risk factors for mental illness in childhood can be grouped as child, parental and household factors. Regarding parental factors, alcohol, tobacco and drug use during pregnancy increase the likelihood of a wide range of poor outcomes that include long-term neurological and cognitive–emotional development problems.[21] Maternal stress during pregnancy is associated with increased risk of child behavioural problems,[22] low birth weight is associated with impaired cognitive and language development, poor parental mental health with four- to five-fold increased risk of emotional/conduct disorder[17] and parental unemployment with two- to three-fold increased risk of emotional/conduct disorder in childhood. Child abuse and adverse childhood experiences result in several-fold increased risk of mental illness and substance misuse/dependence later in life.[23] Looked-after children, those with intellectual disability and young offenders are at particularly high risk.

Risk factors for poor mental health in adulthood include unemployment,[24] lower income,[8] debt,[25] violence,[26] stressful life events,[24] inadequate housing,[8] fuel poverty[27] and other adversity. Poor mental health is also associated with increased risk-taking behaviour and poor lifestyle choices. In particular, smoking is responsible for a large proportion of the excess mortality of people with mental illness.[28]

Higher-risk groups

Risk factors disproportionately affect the mental health of people from higher-risk and marginalised groups. Those at higher risk include looked-after children, children who experienced abuse, Black and minority ethnic individuals,[b,29–31] those with intellectual disability and homeless people. Prisoners have a twenty-fold higher risk of psychosis,[32] with 63% of male remand prisoners having antisocial personality disorder,[33] compared with 0.3% of the general population.[8] Such groups are also at a higher risk of stigma and discrimination. Targeted intervention for groups at higher risk of mental illness can prevent a widening of inequalities in comparison with the general population.

Poor mental health underlies risk behaviours, including smoking, alcohol and drug misuse, higher-risk sexual behaviour, lack of exercise, unhealthy eating and obesity. Risk factors and behaviours cluster in particular groups. For instance, low income and economic deprivation is particularly associated with the 20–25% of people in the UK who are obese or continue to smoke.[34] This population also experiences the highest prevalence of anxiety and depression.[24] Clustering of health-risk behaviours in childhood is a particular problem that leads to greater lifetime risks of mental illness, as well as social, behavioural, financial, and general health problems.

Consequences of poor mental health

Health and social outcomes

Mental ill health has a significant impact on a range of outcomes. In the case of children and young people, this includes poor educational achievement, and a greater risk of suicide and substance misuse, antisocial behaviour, offending and early pregnancy.[35]

Poor mental health in childhood and adolescence is further associated with a broad range of poor health outcomes in adulthood, including higher rates of adult mental illness, as well as lower levels of employment, low earnings, marital problems and criminal activity.[36] In particular, conduct disorder is associated with increased risk of subsequent mental illness, including mania, schizophrenia, obsessive–compulsive disorder,[37] depression and anxiety,[7,35] suicidal behaviour,[35,38] and substance misuse.[35] Conduct disorder is associated with increased risk of personality disorder, with 40–70% of children with conduct disorder developing antisocial personality disorder as adults.[33]

b Black and minority ethnic individuals have a three-fold increased risk of psychosis[29] (seven-fold increased risk in African–Caribbeans[30]) and a two- to three-fold increased risk of suicide.[31]

Reduced life expectancy and increased physical illness

Individuals with mental illness experience increased levels of physical illness and reduced life expectancy (Box 2).

Suicide and self-harm

Suicide remains a significant cause of death and its prevention is a major public health issue.[49] Higher rates of suicide and self-harm occur in particular groups. For instance, increased rates of suicide have been found in those with severe mental illness (twelve-fold increase),[50] those with previous self-harm (thirty-fold increase)[50] and groups with high rates of mental illness such as prisoners (five-fold increase for male prisoners and twenty-fold increase for female prisoners).[51] Young men and some Black and minority ethnic groups (African–Caribbean and African young men and middle-aged and older South Asian women) are also at higher risk.[31] Self-harming behaviour is highest among those with a mental disorder. It contributes to poor physical health and compounds social isolation.[49] The rate of self-harm, especially among young people, has risen significantly over the past decade and now accounts for at least 200 000 hospital admissions per year in England.

Alcohol misuse

Over a fifth of men (21%) and 14% of women in England drink more than twice the recommended guideline amounts of, respectively, 3–4 units daily and 2–3 units daily at least one day a week.[10,52] The risk of hazardous drinking increases following two or more stressful life events.[54]

Box 2 Life expectancy and physical illness in individuals with mental illness

- Depression is associated with 50%-increased mortality after controlling for confounders,[39] with 67% increased mortality from cardiovascular disease, 50% increased mortality from cancer, two-fold increased mortality from respiratory disease and three-fold increased mortality from metabolic disease[40]
- Depression almost doubles the risk of later development of coronary heart disease after adjustment for traditional factors [41]
- Increased psychological distress is associated with 11%-increased risk of stroke after adjusting for confounders[42]
- Prospective population-based cohort studies also highlight that depression predicts colorectal cancer,[43] back pain[44] and irritable bowel syndrome[45] later in life
- People with schizophrenia and bipolar disorder die an average 25 years earlier than the general population, largely because of physical health problems.[46] A recent UK study found that of those living with schizophrenia in the community, men experience 20.5 years' reduced life expectancy and women 16.4 years' reduced life expectancy, although the study did not include those with comorbid substance misuse or the more severely unwell in long-stay hospital settings[47]
- Schizophrenia is associated increased death rates from cardiovascular disease (two-fold), respiratory disease (three-fold) and infectious disease (four-fold).[48]

In adolescence, conduct disorder is associated with a four-fold greater risk of drinking alcohol at least twice a week, whereas emotional disorder is associated with almost two-fold higher risk of drinking at least twice a week.[6] Childhood sexual and physical abuse are significant factors for the development of alcohol problems in women.[55] A third of suicides in young people are associated with alcohol intoxication, whereas 65% of adult suicides are associated with excessive drinking.[54] Heavy drinking may be a factor in one in four cases of dementia.[56] Excessive consumption of alcohol is also associated with higher levels of depressive and affective problems, schizophrenia and personality disorders.[57]

Smoking

Smoking is the largest cause of preventable illness in the UK. Smokers in the general population die, on average, 10 years earlier than non-smokers: a half of smokers die 15 years earlier and a quarter die 23 years earlier than non-smokers.[58] In 2008, almost one in five deaths (83 900) in England were attributable to smoking.[11] Rates of smoking are much higher for individuals with mental disorder compared with the general population (21%): 70% for those in in-patient mental health units,[59] 80% for those attending methadone maintenance treatment clinics[60] and 80% for prison inmates.[61] Almost half of total tobacco consumption is by those who have a mental disorder.[62,63] Smoking is an even more significant cause of morbidity and the largest cause of health inequality in these groups than for the general population, with almost half of the total number of deaths from tobacco by those with mental disorder.[64]

As most smoking starts before adulthood, adolescents, especially those with emotional and behavioural disorder, are at much greater risk; six times higher smoking rates are found in those with conduct disorder and four times higher rates are found in those with emotional disorder.[6] Prevention and early intervention in adolescents with such disorders will also reduce the uptake of smoking.

Obesity

Mental illness, intellectual disability and physical disability increase the risk of obesity.[65,66] Obesity is more common in people with major depression, bipolar disorder, panic disorder and agoraphobia.[67]

Crime

Overall, children who had conduct disorder or sub-threshold conduct problems in childhood and adolescence and whose problems are not treated contribute disproportionately to all criminal activity.[68] Nearly half of children with early-onset conduct problems experience persistent, serious, life-course problems including also crime, violence, drug misuse and unemployment.[35] Moreover, these risks continue throughout adult life and are passed down through the generations so that a child of a mother with depression has a five-fold increased risk for conduct disorder[17] and an increased risk of mental illness as an adult. However, those with mental illness are much more likely to be a victim of crime than a perpetrator.

Violence

People with a mental disorder are more likely to be a victim of violence than a perpetrator and more likely to be a victim than the general population.[69] The risk of violence is only significantly increased among those who misuse alcohol and drugs.[70] The population-attributable risk for violence associated with hazardous drinking is 46.8%; for drug use it is 36.8%; 26.4% for any personality disorder; 23.4% for alcohol dependence; 14.9% for antisocial personality disorder; 10.3% for any affective disorder; 1.2% for any psychiatric admission and 0.7% for psychosis.[71] Although the risk of violence is very small for those with psychosis, it is 40 times higher for those not engaged with mental health services than for those fully engaged.[72] Early intervention in people with psychosis reduces the risk of very serious offences such as homicide[73] as well as reducing the risk of suicide.[74]

Unemployment

Unemployment is one of the most important causes of social exclusion among adults of working age. It is usually associated with low income, which has a key influence on social isolation and low self-esteem. Because of financial difficulties experienced, unemployment can have an adverse effect on diet and lead to unhealthy behaviours such as smoking and alcohol consumption. Prolonged unemployment is linked to worsening mental and physical health, including an increased risk of suicide and premature death.

Mental illness is associated with increased risk of unemployment, with only 20% of specialist mental health service users either in paid work or full-time education.[75] Common mental disorder is associated with a three-fold increased risk of unemployment[24] as well as a reduced level of well-being.[76] People in debt are more likely to experience depression and to die by suicide than those who are solvent.[25,77]

Employment

Work provides a range of benefits such as increased income, social contact and a sense of purpose.[78] However, work can also have negative effects on mental health, particularly in the form of stress.[79] Working environments which increase the risk of stress are those with high demands and lack of control or support to manage such demands. Working in environments that are insecure, low paid and stressful is associated with increased risks of poor physical and mental health.[79] In the UK, approximately 11 million people of working age experience mental health problems and about 5.5 million have a common mental disorder. In 2008/2009, 11.4 million working days were lost in Britain due to work-related stress, depression or anxiety.[80]

Patterns of employment both reflect and reinforce the social gradient and there is inequality of access to labour market opportunities.[81] Reducing sickness absence and promoting an early return to work following an episode of illness are important strategies as part of a public mental health policy. Dealing with 'presenteeism' (going to work when unfit to work) and managing work environments so that they become healthier is also a significant challenge in a harsh economic climate where unemployment is a threat.

People with mental illness have a lower rate of employment than other groups with disabilities yet they are more likely to want to be in

employment.[24,82–4] Discrimination in the workplace can drive the low employment rate among people with severe mental illness.[85,86] Employment for people with mental illness is important in promoting recovery and social inclusion and can have a positive effect on mental health,[78] although benefits depend on the nature and quality of work. Unpaid voluntary work in the community and carer work are often undervalued. This work, primarily undertaken by older people, needs to be fully recognised and valued for its significant contribution to society.

Stigma and discrimination

Stigma is cited by mental health service users above poverty, isolation and homelessness as a main source of social exclusion in both people with current and those with previous mental health problems.[87] The overall attitudes towards such people remain, in most respects, as profoundly negative as they were a decade ago despite the improvements in public awareness and knowledge about mental illness.[88] For some individuals, the problems are compounded by additional discrimination on the grounds of their ethnicity, cultural background or sexuality.[89,90] As many as nine out of ten people using mental health services say they experience discrimination in more than one area of life.[91]

A label of having a mental illness makes it harder to get life, personal or holiday insurance and can affect access to leisure facilities and other community activities.[92] Negative attitudes to mental ill health can adversely affect policy development, usually through omission of relevant mental health issues. In the media, mental illness is typically represented in distorted stereotypes, which can foster fear and stigma among the general public. It also contributes to false and extremely damaging perceptions of the violence caused by people with mental health problems.[89]

Social exclusion

Individuals with mental health problems are often excluded from key areas of social life, such as consumption (exclusion from material resources), production (exclusion from socially valued productive occupation), social interaction (exclusion from social relations and neighbourhoods), political engagement (exclusion from civic participation), as well as health and health service engagement (service exclusion).[93] Exclusion thereby results in inequality, which is also a determinant of mental illness (see Chapter 2). For older people, impaired mobility and lack of transport can limit inclusion as can poorly designed buildings, poor town planning, ageist social attitudes and low expectations.

2 Mental health and inequalities

The annual cost of social and economic inequality in England is £56–58 billion, with those living in poorest neighbourhoods dying seven years earlier than people living in the richest neighbourhoods.[82] The country is facing significant financial austerity following the recession. Studies show that health tends to get worse during times of recession, with the poorest affected the most. In the UK, inequality between the rich and the poor is continuing to widen.

Social and economic inequality is a major determinant of mental illness and underlies other risk factors. The greater the level of inequality, the worse the health outcomes.[82] Higher income inequality is linked to higher rates of mental illness, decreased rates of trust and social interaction, and increased hostility, violence and racism, as well as lower well-being scores.[94,95] Mental illness is also a factor contributing to inequality as it is consistently associated with deprivation, low income, unemployment, poor education, poorer physical health and increased health-risk behaviour.

Parental unemployment is associated with a two- to three-fold greater risk of emotional or conduct disorder in children.[17] In the UK, one in six children now lives in a workless household, the highest proportion of any country in Europe. Child poverty in the UK has also grown in recent years[96] and children from households with the lowest 20% of incomes have a three-fold increased risk of mental health problems than children from households with the highest 20% of incomes.[6] Poor mental health can affect anyone at any time across the lifespan, and critically, it can affect future generations, contributing further to cycles of inequality and ill health that run through some families.

Inequality also has an impact on adult mental health, with men from households with the lowest 20% of incomes being almost three times more likely to have a common mental disorder than those with the top 20%.[8] Similarly, self-harm is 3.2 times more common in men and 2.5 times more common in women from households with the lowest 20% of incomes, whereas dependence on any drug is 4.6 times higher for men and 33 times more common in those from the lowest 20% of household income.[8]

Health inequalities result in part from social inequalities, and the complex relationships between opportunity, individual and community characteristics. Since inequality is itself a major determinant of mental illness, interventions that directly address it will reduce mental illness and promote mental health. Such interventions also reduce inequality. Lifetime benefits for children extend to the child's future parenting abilities, thereby helping to break down intergenerational transmisson of inequalities.

3 Economic costs of mental illness

Mental health problems cost England approximately £105 billion each year and represent the largest single cost to the NHS.

Mental health problems have not only a human and social cost, but also an economic one, with wider costs in England amounting to £105.2 billion a year.[2] Mental illness is the single largest cost to the National Health Service (NHS) at £10.4 billion (10.8% of the NHS budget).[97] In 2007, service costs in England, which include the NHS, social and informal care, amounted to £22.5 billion and these costs are projected to increase by 45%, to £32.6 billion by 2026.[98] Annual cost of depression in England alone is £7.5 billion, of anxiety £8.9 billion, of schizophrenia £6.7 billion, of medically unexplained symptoms £18 billion and of dementia £17 billion.[14,98–100]

A review of economic evaluations of mental illness in childhood and adolescence, such as emotional and behavioural disturbances or antisocial behaviour, found mean costs to UK society to range from £11 030 to £59 130 annually per child.[101]

The costs of criminal activity related to conduct disorder in England and Wales alone amount to £22.5 billion each year, with a further annual cost of £37.5 billion attributable to subthreshold conduct disorder.[102] Lifetime costs of child conduct disorder in the UK for each 1-year cohort amount to £5.2 billion and for child subthreshold conduct disorder they amount to £23.6 billion.[1] The wider annual cost of violence and abuse is estimated at £40.1 billion a year, with annual cost of domestic violence at £15.4 billion and sexual violence £8.5 billion.[103–5]

The cost of work-related mental ill health is around £30.3 billion per year, nearly two-thirds of which can be accounted for by lost productivity.[2] Mental illness is the leading cause of incapacity benefit payment: 43% of the 2.6 million people currently on long-term health-related benefits have a mental or behavioural disorder as their primary condition.[106]

The total cost of alcohol misuse is estimated at £18–25 billion a year. This includes costs of treating alcohol-related disorders and disease, crime and antisocial behaviour, loss of productivity in the workplace, and social support for people who misuse alcohol and their families.[107] Annual NHS cost of treating alcohol-related harm in England is £2.7 billion.

Regarding smoking, 440 900 hospital admissions in 2007/2008 were directly attributable to smoking,[11] and the annual direct cost of smoking to the NHS was estimated at £5.2 billion.[108]

Relatively little economic evaluation has been done on the economic impact of good mental health on issues such as productivity at work and physical health.

4 Mental health underlies physical health

Mental health underpins our overall health. Mental illness is associated with increased risk of physical illness, arising in part from a less healthy lifestyle and more frequent health-risk behaviour, and conversely, physical illness increases the risk of mental illness.[109] Mental illness also contributes to health inequality.[109] It increases the risk of such illnesses as heart disease, stroke and cancer (Box 2, p. 14). Compared with the general population, individuals with mental illness die prematurely, particularly people with schizophrenia and bipolar disorder, who experience an average 25-year shorter life expectancy.[46] People with eating disorders also have an increased risk of premature death and a wide range of physical problems. The largest single cause of health inequality for individuals with mental illnesses is their higher rate of smoking.

The Disability Rights Commission's *Formal Investigation into Physical Health Inequalities Experienced by People with Learning Disabilities or Mental Health Problems* found a lack of support and information for such individuals in general and especially for those in all forms of residential care.[110] They called for 'accessible and appropriate support to encourage healthy living and overcome physical health disadvantages which come from their conditions or treatments'. They also recorded the differences between those with mental illness and those with an intellectual disability in terms of physical illnesses.

Rates of depression are double in those with diabetes, hypertension, coronary artery disease and heart failure, and triple in end-stage renal failure, chronic obstructive pulmonary disease and cerebrovascular disease.[111] The prevalence of depression among those with two or more chronic physical conditions is almost 7 times higher compared with healthy controls.[112] Physical illness can have profound social and emotional consequences and can result in mental health problems which impede recovery from the physical illness and increase mortality rates.

5 Effects of positive mental health and well-being

Mental well-being is fundamental to the good quality of life and productivity of individuals, families, communities and nations.[113] The health, social and economic benefits are not simply the result of the absence of mental illness but are also owing to positive mental health.[114] A public health approach includes enhancing protective factors for mental health, which is not equivalent to the absence of risk factors for mental illness. Some factors associated with positive mental health include personality traits, various demographic factors, income and socioeconomic status, emotional and social literacy, levels of trust, reciprocity, participation and cohesion within communities, purposeful activity including work, self-esteem, and values such as altruism.[115–19]

Positive mental health is associated with enhanced psychosocial functioning, improved learning and academic achievement, increased participation in community life, reduced sickness absence, improved productivity, reduced risk-taking behaviour, improved physical health, reduced mortality,[120–3] reduced health inequality as well as recovery from mental illness, and therefore it has relevance to a range of physical health issues discussed in the previous chapter.

Securing positive mental health and resilience

A public health approach considers protective factors for mental health as well as risk factors for mental illness. Important interventions include high-quality maternal care, nurturing upbringing and safe early experiences. Examples of specific interventions are parent training, school-based and work-based mental health promotion programmes.

The emphasis on well-being, community cohesion and productive, long working lives requires strategies to encourage and empower individuals to secure positive mental health. A public mental health strategy can enhance resilience and help individuals cope with the normal adversities in life as well as maximise their engagement with their community. It can help them adopt strategies to improve well-being, self-esteem and life choices, and achieve success in their roles as parent, carer and worker.

Good social, emotional and psychological health protects children against emotional and behavioural problems, violence and crime, teenage pregnancy and misuse of drugs and alcohol.[7,121,124,125] Resilience can be developed at individual, family and community levels, although parenting influence is particularly important. A survey by the Office for National

Statistics showed the significant effects of the child's resilience on both onset and persistence of emotional and conduct disorder.[126]

Current population levels of well-being

Levels of mental health, also called well-being, are low across populations; in a survey of over 18000 adults in north-west England only 20.4% had high levels of well-being;[127] similar figures were reported in Scotland[128] and the USA.[129] This shows there is a scope for increasing levels of population mental health with a wide variety of potential positive results. In this respect, mental well-being and mental health are not necessarily correlated with levels of mental illness. Levels of mental well-being in England are now being measured by the Department of Health (Health Survey for England).

6 Interventions to reduce mental illness and promote mental well-being

Public mental health focuses on wider prevention of mental illness and promotion of mental health across the life course.

Actions across the life course

A public mental health approach focuses on wider prevention of mental illness and promotes mental health across the life course. Prevention and promotion interventions are relevant at each life stage. Robust evidence exists for a wide range of interventions which prevent mental disorder, promote well-being and help strengthen resilience against adversity:

- interventions to improve parental health
- pre-school and early education interventions
- school-based mental health promotion and mental illness prevention
- prevention of violence and abuse
- prevention of suicide
- early intervention for mental illness
- alcohol, smoking and substance abuse reduction and prevention
- promoting healthy lifestyle behaviours
- promoting healthy workplaces
- prevention of mental illness and promotion of well-being in older years
- addressing social inequalities
- enhancing social cohesion
- housing interventions
- reduced stigma and discrimination
- positive mental health and recovery from mental illness.

Promoting mental health of children, adolescents and parents

Since the majority of lifetime mental illnesses develop before adulthood,[16] prevention targeted at younger people can generate greater personal, social and economic benefits than intervention at any other time in the life course (Box 3).

Interventions to improve parental health

Effective interventions to reduce maternal depression also improve the mental health of the whole family and include early identification and effective treatment. Parenting programmes are effective (Box 3), as is postpartum support provided by a health professional.[140] Home visiting programmes, peer support and telephone peer support for women at high risk of depression reduce rates of postnatal depression.[141–3] Health visitor training to improve detection also reduces levels of postnatal depression.[144] Reduced maternal smoking is associated with improved parental health as well as reduced infant behavioural problems and attention-deficit hyperactivity disorder, improved birth weight and physical health.[145] Breastfeeding is both associated with higher intelligence scores and lower incidence of hypertension, obesity and diabetes in later years.[146]

Pre-school and early education interventions

Systematic reviews of pre-school and early education programmes show their effectiveness in enhancing cognitive and social skills, school readiness, improved academic achievement and positive effect on family outcomes including for siblings,[147,148] as well as prevention of emotional and conduct disorder (Box 4).[149] Home visiting programmes improve child functioning and reduce behavioural problems.[141]

Sure Start centres provide multi-component interventions, including childcare up to the age of 5, health services, parenting support and employment and training support. A 3-year evaluation of the programmes

Box 3 Parenting support interventions: what the evidence shows

- Improved parental efficacy, self-esteem, partner relationships; reduced prenatal depression, anxiety and stress[130]
- Improved maternal sensitivity[131]
- Improved mental health of families[37]
- Improved child emotional and behavioural adjustment in children under the age of 3[132]
- Improved behavioural adjustment in children aged 3–10[133]
- Improved behaviour and prevention in high-risk children aged 2–11[134]
- Improved behaviour in children with subthreshold conduct disorder[135]
- Improved symptoms of attention-deficit hyperactivity disorder[136]
- Improved safety and reduced unintentional injury at home[137]
- Reduced antisocial behaviour[138]
- Reduced re-offending.[139]

Box 4 Impact of school-based mental health promotion and mental illness prevention

- Improved child well-being
- Prevention of depression[151–3]
- Prevention of conduct disorder and anxiety[149]
- Prevention of depression and anxiety through secondary school curriculum approaches to promote pro-social behaviours and skills[121]
- Reduced conduct problems and emotional distress[154,155]
- Reduced conduct problems and emotional distress, and improved social and emotional skills, attitude about self and social behaviour with US social and emotional programme[156]
- Improved long-term pro-social and behavioural skills through peer mediation[157–9]
- Programmes targeting at-risk children in the early years using parent training or child social skills training are the most effective to prevent conduct disorder, anxiety and depression before adulthood[160]
- 'Triple P' positive parenting progamme produces sustainable behavioural improvements for high-risk children aged 2–11 who have subthreshold disorder.[134]

showed better social behaviour, greater independence and self-regulation in children, whereas the outcomes for families were less negative parenting, better home learning environments and making more use of child and family support services.[150]

Violence against self and others

Prevention of violence and abuse

Interventions which prevent violence and abuse reduce subsequent risk of mental ill health and promote resilience. At a family level, these include parental mental health promotion, parent training and early intervention for child emotional and behavioural disorders. At a school level, they include school-based mental health promotion, violence prevention,[161] bullying prevention[162] and social and emotional learning programmes.[156] School-based interventions can also prevent sexual abuse.[163] Among the benefits of school-based violence prevention programmes are reductions in aggressive behaviour, conduct problems and attention span problems, as well as improvements in social skills and social relationships, school performance, school attendance, and attitudes towards violence and bullying.[164] At a community level, effective interventions are, for example, improved street lighting, increased social cohesion and safer community spaces. Other interventions include those targeted at alcohol misuse, multi-agency information sharing and identification of at-risk individuals.

Prevention of suicide

In 2002, the national suicide prevention strategy for England set a target to reduce the death rate from suicide and undetermined injury by at least 20% by 2010. Between 2006 and 2008, the suicide rate fell by 15.2%

from baseline and the target will be met if the trend of the past 10 years is maintained. The goals of the strategy are to reduce risk in key high-risk groups, promote mental well-being in the wider population, reduce availability and lethality of suicide methods, improve reporting of suicidal behaviour in the media, promote further research and improve monitoring. Effective interventions are:

- restricting access at suicide 'hot spots'[165]
- restricting the sale of amount of certain drugs such as paracetamol[166]
- collapsible fittings in psychiatric in-patient units
- education programmes for general public and health professionals[167,168]
- improved media reporting.

Suicide prevention strategies in Scotland and Wales expressly include actions relating to self-harm, including the training of front-line staff. Although specific interventions exist to prevent suicide, other interventions which address self–harm, promote resilience and reduce mental illness will also contribute to prevention.

Early intervention for mental illness

Good evidence of effectiveness exists for a range of mental illness, such as conduct disorder,[135] child subthreshold emotional disorder,[169] pre-psychosis[170] and psychosis.[171] Improved availability of early intervention services for children and young people could prevent 25–50% of adult mental illness.[172] Early diagnosis and intervention particularly benefit those affected by mental illnesses such as depression and dementia as well as their carers. Early treatment of dementia is effective and improves quality of life.

Early diagnosis and treatment of physical conditions are also important.

Alcohol, smoking and substance abuse reduction and prevention

There is a clear relationship between mental health and health-risk behaviour, including alcohol and substance misuse. Therefore, interventions to promote mental health and reduce the incidence of mental illness will reduce such risk behaviour. School-based mental health promotion programmes are likely the best investment for prevention.[154]

For alcohol misuse, National Institute for Health and Clinical Excellence (NICE) guidance postulates that making alcohol less affordable is the most effective way of reducing alcohol-related harm.[173] Reducing the number of places selling alcohol and effective licensing are also effective. Prevention and reduction of alcohol use is possible in children and young people.[174] Both brief and motivational interventions are effective.[175–7]

For smoking, NICE advocates interventions to prevent the uptake of smoking in children and young people, which is important since smoking mostly begins in adolescence.[178,179] Such interventions require targeted approaches for children and adolescents with emotional and behavioural disorder, who are at a much higher risk of taking up smoking.

Effective smoking cessation interventions do exist, although individuals with mental illness are less likely to be offered these despite experiencing much greater levels of smoke-related harm.

Finally, NICE guidelines on substance misuse stress prevention and reduction in young people.[180,181] Good evidence exists for contingency management, psychosocial interventions and medication.[182–4]

Promoting positive health

A healthy lifestyle

It is possible to reduce the higher morbidity experienced by people with mental illness through intervening early to promote healthy lifestyle and behaviour change and to reduce health-risk behaviours. In particular, smoking cessation improves mental health, reduces the risk of physical illness, reduces depressive symptoms, allows for a reduction in doses of some psychiatric medications by up to 50% and reduces financial stress.[185,186] Because smoking is the largest cause of health inequality in people with mental illness, strategies aimed at smoking cessation are the single most effective way of reducing health inequality.

The side-effects of psychiatric medication which cause weight gain can be alleviated by a healthy diet. Physical activity results in improved subthreshold, mild and moderate depression and improves well-being;[187] in school-aged children it leads to better cognitive performance[188] and in older people to better mental health outcomes.[189]

Positive mental health and recovery from mental illness

Well-being and resilience can be enhanced through a balance between mental and physical activity and a number of other activities, such as education and lifelong learning,[190] psychological therapies, positive psychology interventions,[191] mindfulness interventions,[192] spirituality, leisure activities,[193] participation in arts and developing creativity,[194] and participation in worthwhile activities such as volunteering.

Leisure activities enhance well-being by increasing competency, relaxation, social inclusion and support as well as distracting from difficulties.[193] However, whereas active leisure is associated with well-being, passive leisure activities such as watching television and playing video games have been associated with reduced well-being.[195,196] Large prospective studies highlight an association between television watching and subsequent poor health, greater risk of attention problems and intellectual disabilities.[197–9]

Interventions which promote well-being also play an important part in recovery from mental illness. For instance, there is evidence that art can assist recovery from mental illness.[200] Further, mindfulness interventions are recommended for prevention of relapse in recurrent depression,[187] whereas spirituality is associated with recovery and reduced symptoms of illness.[201] A meta-analysis of 147 studies involving almost 100 000 individuals found that religious involvement was also associated with reduced depression, particularly for stressed populations.[202] Social inclusion and participation are important for recovery and improving the outcomes for people with mental illness.

Promoting healthy workplaces

Promoting the well-being of those who become unemployed and facilitating their return to work can result in reduced depression and distress as well as increased employment.[203] Workplace screening and early intervention can reduce levels of depression and sickness absence.[204,205] It is estimated that British businesses could save up to £8 billion a year if mental health at work was managed more effectively.[206] Supported employment for those recovering from mental illness reduces re-hospitalisation by 52%.[207]

Prevention of mental illness and promotion of well-being in older years

Effective interventions which help maintain mental health in later years include psychosocial interventions, high social support in times of adversity, prevention of social isolation, walking and physical activity programmes, multi-agency violence prevention, addressing sensory deficit such as deafness, promoting learning, adequate heating, psychoeducational interventions for carers and poverty reduction.[208–16] Interventions which prevent dementia include physical activity, social engagement, cognitive exercises and treatment of hypertension.[217–21] As older people contribute £234 billion to the economy each year, there is also a direct economic benefit of promoting mental health and preventing mental illness in this population.[222]

Mental health promotion interventions for higher-risk groups

Groups at higher risk of developing mental health problems include Black and minority ethnic individuals, prisoners and asylum seekers, and those already experiencing mental illness and addiction problems. It is important not only to target those with the most severe illness but also to address the needs of larger populations with common mental disorders and those with a subthreshold disorder. This has particular relevance to the public health agenda because of higher levels of health-risk behaviour and physical illness among those individuals. Targeted interventions for higher-risk groups are required to prevent the widening of their inequality and the worsening of their health.

Addressing social inequality issues

Inequalities

Taxation policies and welfare benefits are key ways of addressing inequality and its impact on health. Interventions for parents and young children are effective in breaking down intergenerational transmission of inequality. Other interventions include debt advice, which can improve mental health,[223] as better financial capability, which reduces depression and anxiety and improves well-being and satisfaction.[224]

Housing interventions

Housing improvement benefits mental health and housing support for people recovering from mental illness can lower readmission rates.[225,226] Adequate

heating and insulation also reduces the risk of depression and anxiety.[215] For older people, appropriate housing can promote social contact, personal independence and freedom of movement.

Enhancing social cohesion

Social networks are important in promoting well-being and resilience, and preventing mental illness.[24,227] Communities with higher levels of social capital have lower rates of crime, better health, higher educational attainment and better economic growth.[203] Social networks and social support promote a sense of belonging. Social health is associated with reduced mental health problems in children,[126] reduced mortality,[228] including mortality from cancer,[229] reduced coronary artery disease[230] and reduced cognitive decline.[231] There are numerous interventions to promote social mental health, for example volunteering, group programmes,[232] individual and community empowerment,[233] peer support,[142] prescribing of social interventions,[234] adult learning,[235] community arts, neighbourhood improvement and access to safe, green community spaces.[236]

Reducing stigma and discrimination

In better connected and tolerant communities stigma and discrimination are less prevalent. Strategies to reduce discrimination have been categorised into education, contact and protest, although anti-discrimination legislation has also been important. Education is most used for the general public and includes mass media campaigns, although evidence suggests it needs to be combined with other strategies to be effective. Anti-stigma campaigns can produce significant improvements in the attitudes of the public.[237] Interventions for groups at risk of stigma include social network facilitation, mentoring and community organisation.[238] Interventions which use social contact or a combination of contact and education are effective with respect to knowledge, attitudes and intended behaviour across a range of specific target groups which may hold stigmatising attitudes, such as police officers, school students, journalists and the clergy.[239–40] Educational programmes aimed at increasing awareness of mental illness in selected groups have reported positive changes of attitudes with the police force and school students at 6-month follow-up.[242] A systematic review found that stigma and discrimination related to mental illness had financial repercussions owing to effects on employment, income, public views about resource allocation and healthcare costs.[243]

7 Cost-effectiveness of prevention and promotion

The UK is facing severe financial challenges which will not only affect individuals and communities, but also place many public sector services under increasing pressure to deliver more with less. Public sector services, including the NHS, are facing severe contractions in their finances, with an estimated £15–20 billion of real-term cuts likely in the 3 years from 2011.[244] At the same time, costs of mental illness will double in real terms over the next 20 years[98] and it is also expected that demand for health and mental health services will increase as a result of unemployment, personal debt, home repossession, offending and other forms of 'economic fallout'.[245] A strategy which invests in promotion, prevention and early intervention not only can reduce the burden of mental ill health and inequality but also makes sound economic sense.[246]

Mental health promotion and mental disorder prevention can be effective strategies to reduce the burden of mental disorders, and can bring about health, as well as social and economic development.[21,247] Economic savings can result across a wide range of areas in both the short and longer term. There is a growing evidence base that demonstrates the cost-effectiveness of investing in mental health promotion, prevention and early intervention strategies. In particular, a number of studies have demonstrated significant cost benefits from early-years interventions, especially for long-term outcomes,[248] with savings achieved mainly through reduced welfare and criminal justice costs, and higher earnings. Because half of lifetime mental illness arises by the age of 14, prevention and promotion interventions during childhood and adolescence are particularly cost-effective, with economic returns of early childhood intervention programmes exceeding cost by an average ratio of 1:6.[33]

Cost–benefit analyses highlight the economic returns of investment in parenting programmes for individuals whose children have conduct disorder,[37] health visitor interventions to reduce postnatal depression, school-based programmes,[122] including those for the prevention of violence and bullying, prevention of offending and re-offending,[249] screening and brief intervention for alcohol problems,[250] well-being promotion at work,[251] early detection of depression at work,[252] supported employment for those recovering from severe mental illness,[207] supported housing for those recovering from mental illness, cognitive–behavioural therapy for those with medically unexplained symptoms, early intervention in psychosis,[253] early detection of pre-psychosis,[254] suicide prevention,[255] debt advice, physical activity programmes in older people,[256] and anti-stigma campaigns.[257] A significant proportion of savings accrues in areas outside health.

There is an economic cost to *not* providing services for people with mental illness and the consequent loss of mental capital.[258,259] The cost of preventative interventions must be considered within the context of the costs of not conducting such programmes.[260] Prevention of even a small percentage of mental and substance abuse problems will result in substantial cost savings and improved quality of life for individuals, families and communities.

Prevention and promotion also have a key role in reducing the burden of mental illness, particularly because optimal treatment at optimal coverage only averts 28% of that burden.[261] Prevention and promotion complements the treatment of mental illness with a strategic, sustainable population approach, which reduces both the burden and cost of mental illness, promotes well-being and reduces inequalities.

8 Conclusions

Need for effective cross-departmental strategies

Given the multifaceted nature of public mental health, we need a cross-departmental strategy at government level and broader collective action nationally and locally. Government departments should review how far their policies improve or damage the mental well-being of the people affected by them. The view of the Royal College of Psychiatrists is expressed in the *Future Vision*[246] report:

> Without addressing the promotion and protection of a diverse population's mental health across government, not only are individuals poorly served, but many government goals and commitments on physical health, social cohesion and productivity are simply not achievable. Investment across the board will more than pay for itself, not just in terms of suffering avoided and quality of life gained, but also through a reduced need for public services and an increased opportunity for people with mental health conditions to contribute socially and economically.
>
> But this should not be achieved by diverting funds from the care and support of people who have mental health problems. The prevention and treatment of mental ill health are complementary endeavours, and should not compete for funding. In fact, we believe that those departments which stand to benefit from an improvement in well-being and a reduction in the burden of mental ill health should contribute to the roll-out of prevention and promotion initiatives.

This position statement sets out the case for public mental health, the evidence base for interventions, the benefits to society, and touches on the implications for psychiatrists and other mental health professionals. Prevention and promotion should complement the treatment of mental illness with a strategic, sustainable population approach. Inequality is a key underlying determinant of mental illness and as such it must be addressed in a public mental health strategy. Mental health promotion and mental illness prevention offer an important opportunity to reduce the burden of mental illness with the potential for large-scale prevention of human suffering and associated significant economic benefits.

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