How to Create a Mentally Healthy Population

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What Do I Mean by "a Mentally Healthy Population"

Has a diagnosis of mental health problem but copes well and positive mental wellbeing

No diagnosable mental health problem and positive mental wellbeing

Maximum Mental Health Problems

Minimum Mental Health Problems

Has a diagnosis of a serious mental health problem and poor mental wellbeing

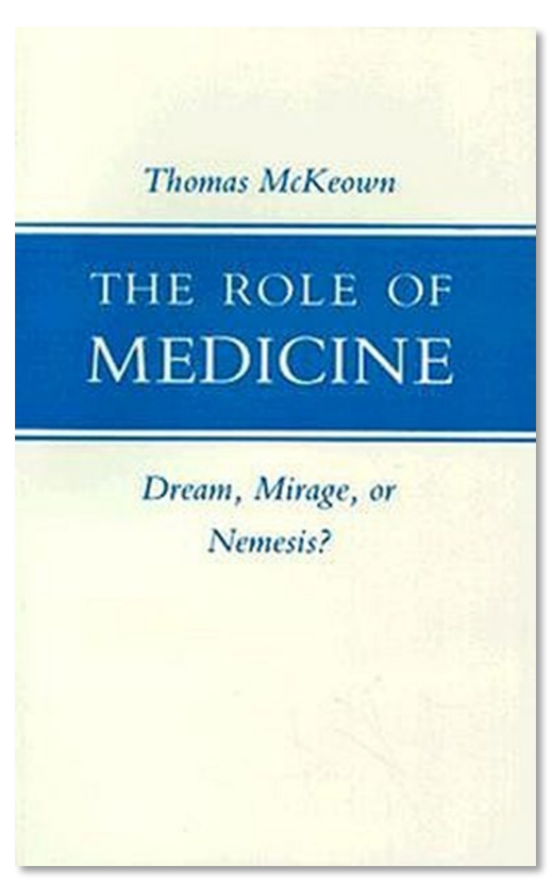
No diagnosis of a mental health problem but poor mental wellbeing

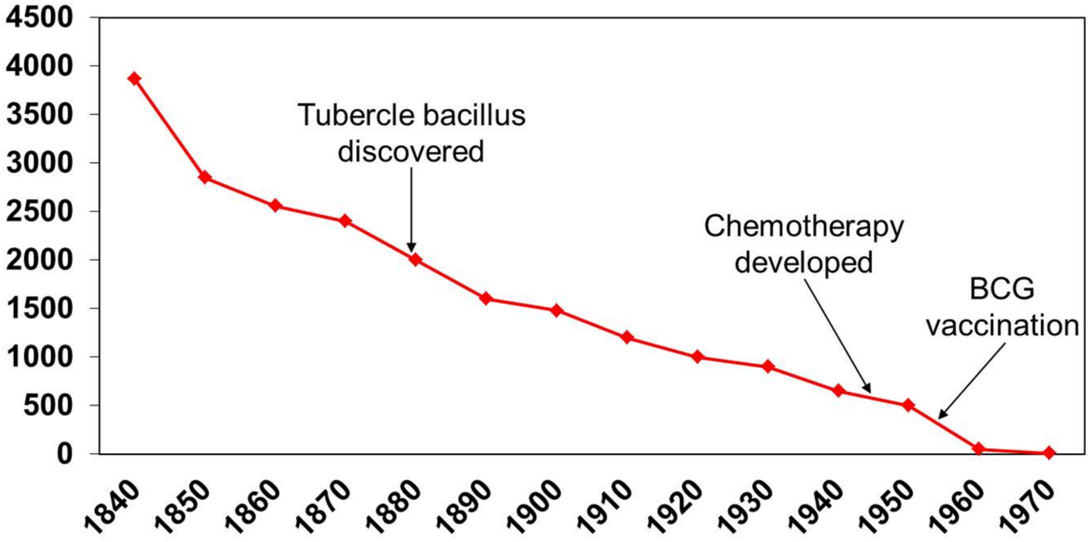
Minimum Mental Wellbeing

Two Perspectives on Health

Individual Perspective	Population Perspective
• What improves the health of patients/clients? • Methodologies: RCTs, health services evaluations	• What improves the health of a whole population? • Methodologies: population surveys, historical trends

How I Got Interested in the Population Perspective





News

BMJ readers choose the "sanitary revolution" as greatest medical advance since 1840

BMJ 2007 ; 334 doi: https://doi.org/10.1136/bmj.39097.611806.DB (Published 18 January 2007)
Cite this as: *BMJ* 2007;334:111

Article | Related content | Metrics | Responses

Annabel Ferriman

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More than 11 300 readers of the *BMJ* chose the introduction of clean water and sewage disposal—"the sanitary revolution"—as the most important medical milestone since 1840, when the *BMJ* was first published. Readers were given 10 days to vote on a shortlist of 15 milestones, and sanitation topped the poll, followed closely by the discovery of antibiotics and the development of anaesthesia.

What Do We Know About Population Mental Health?

- Mental disorders are common
- They are a major source of disability in the population
- The burden of mental disorders occurs at young ages
- Mental disorders are mainly untreated

Mental Disorders Are Common

International Journal of Epidemiology, 2014, 476–493
doi: 10.1093/ije/dyu038
Advance Access Publication Date: 19 March 2014
Original article

Original article

The global prevalence of common mental disorders: a systematic review and meta-analysis 1980–2013

Zachary Steel,[1,2]* Claire Marnane,[1] Changiz Iranpour,[1] Tien Chey,[2] John W Jackson,[3,4] Vikram Patel[5,6,7] and Derrick Silove[1,2]

- National mental health surveys in many countries have found that the prevalence is high.
- Depression and anxiety disorders are major contributors.

Mental Disorders Are a Major Source of Disability in the Population

THE LANCET

Global mortality, disability, and the contribution of risk factors: Global Burden of Disease Study

Christopher J L Murray, Alan D Lopez

Summary

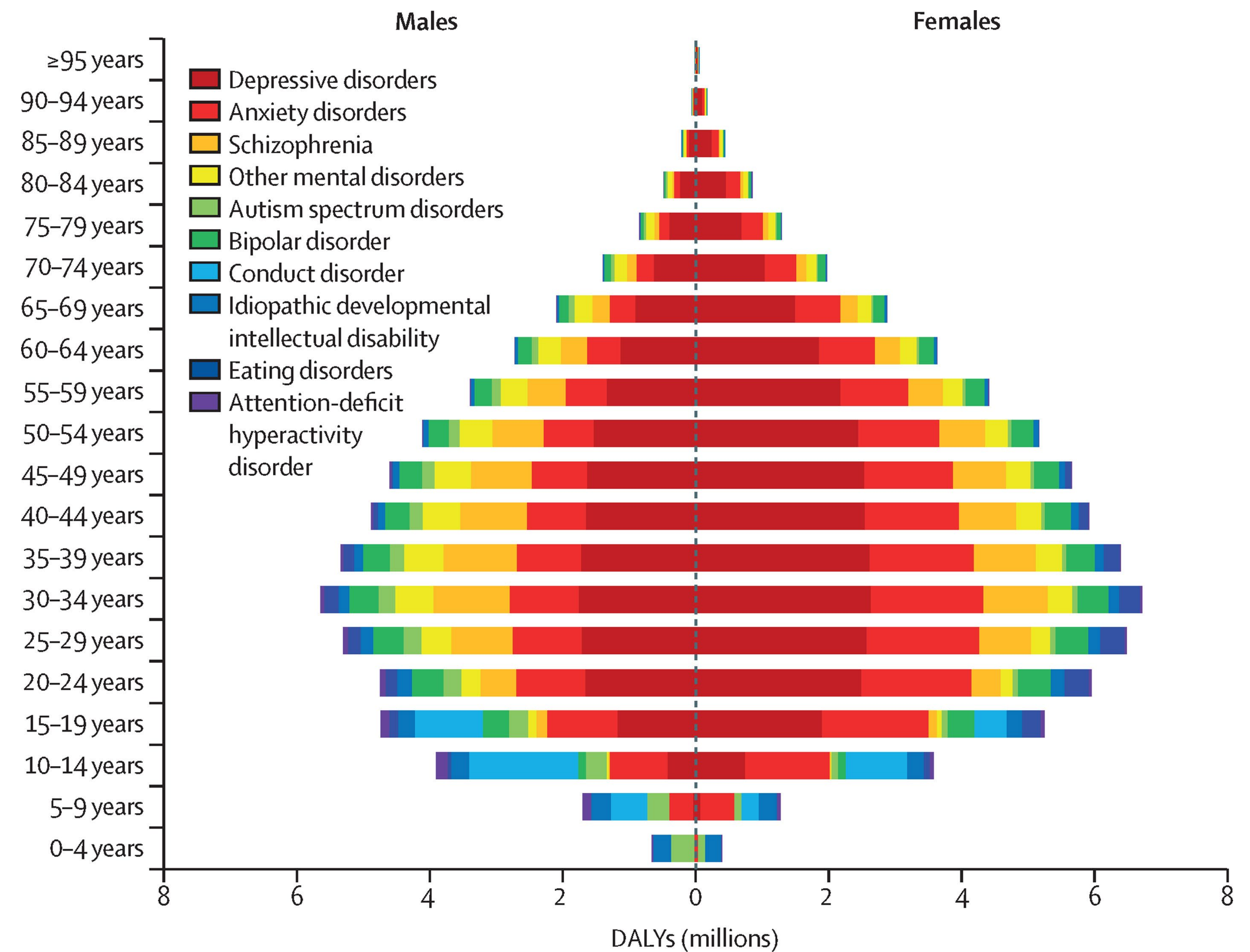
Background Prevention and control of disease and injury require information about the leading medical causes of illness and exposures or risk factors. The assessment of the public-health importance of these has been hampered

taken into account, our list differs substantially from other lists of the leading causes of death. DALYs provide a common metric to aid meaningful comparison of the burden of risk factors, diseases, and injuries.

Lancet 1997; **349**: 1436-42

- Disease impact traditionally measured by mortality.
- Mental disorders found to be a minor source of mortality but the major source of disability.
- This is because they have onset early in life and disrupt ability to function.

Burden of Mental Disorders Occurs at Young Ages



Mental Disorders are Mostly Untreated

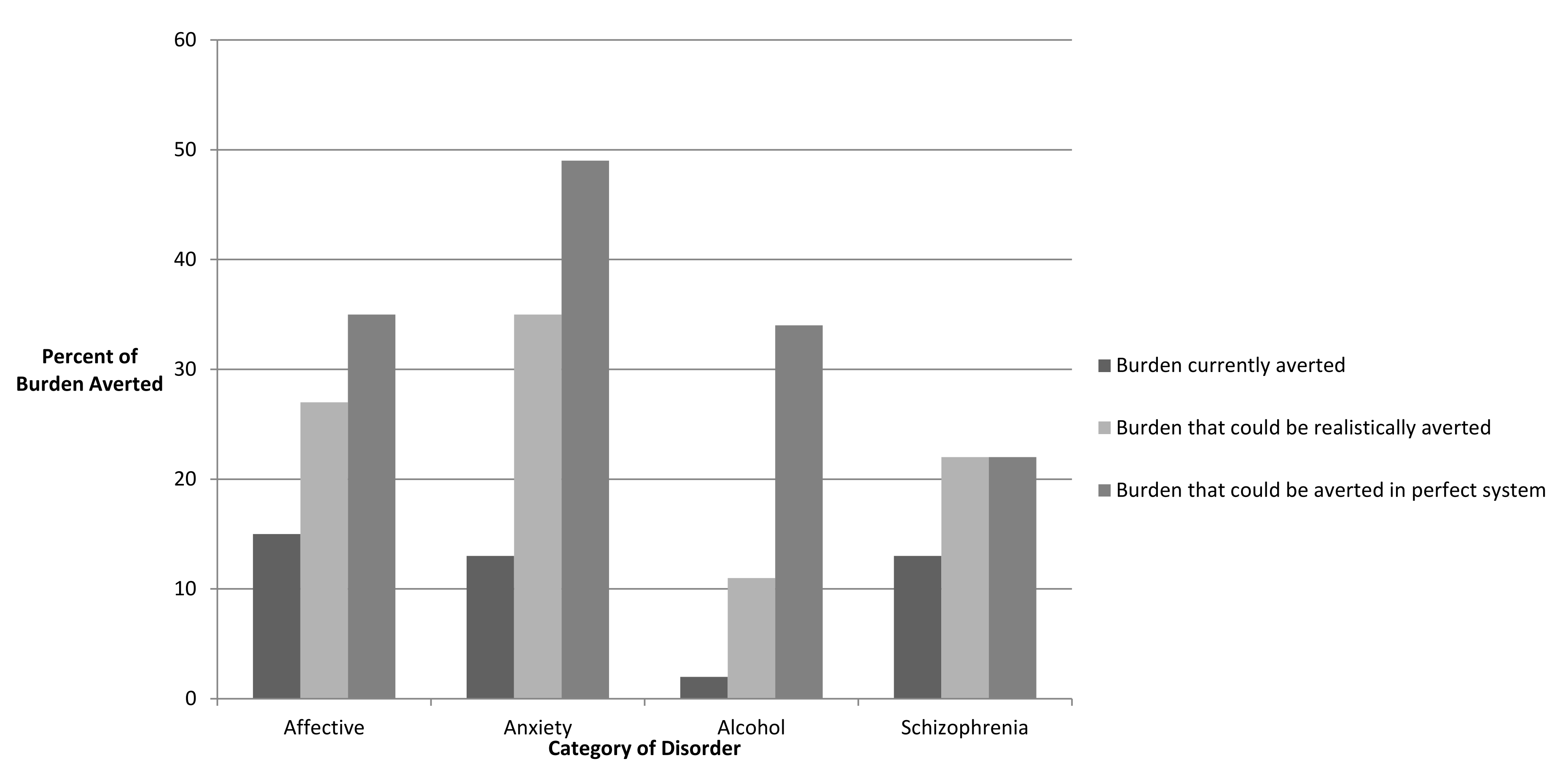
World Psychiatry. 2010 Oct;9(3):169–176. doi: 10.1002/j.2051-5545.2010.tb00305.x

Reducing the treatment gap for mental disorders: a WPA survey

VIKRAM PATEL [1], MARIO MAJ [2], ALAN J FLISHER [3], MARY J DE SILVA [1], MIRJA KOSCHORKE [1], MARTIN PRINCE [4]; WPA Zonal and Member Society Representatives[*]

- The ‘treatment gap’ exceeds 50% for all countries.
- It is up to 90% in least resourced countries.

Could We Reduce the Burden of Mental Disorders by Closing the Treatment Gap? (Andrews et al, Brit J Psychiatry, 2004)



Increased Treatment Has Not Improved Population Mental Health

Has increased provision of treatment reduced the prevalence of common mental disorders? Review of the evidence from four countries

Anthony F. Jorm[1], Scott B. Patten[2], Traolach S. Brugha[3], Ramin Mojtabai[4]

[1]Melbourne School of Population and Global Health, University of Melbourne, Parkville, Victoria, Australia; [2]Department of Community Health Sciences, University of Calgary, Calgary, Canada; [3]Department of Health Sciences, College of Medicine, Biological Sciences and Psychology, University of Leicester, Leicester General Hospital, Leicester, UK; [4]Department of Mental Health, Johns Hopkins Bloomberg School of Public Health, Baltimore, MD, USA

Many people identified as having common mental disorders in community surveys do not receive treatment. Modelling has suggested that closing this "treatment gap" should reduce the population prevalence of those disorders. To evaluate the effects of reducing the treatment gap in industrialized countries, data from 1990 to 2015 were reviewed from four English-speaking countries: Australia, Canada, England and the US. These data show that the prevalence of mood and anxiety disorders and symptoms has not decreased, despite substantial increases in the provision of treatment, particularly antidepressants. Several hypotheses for this lack of improvement were considered. There was no support for the hypothesis that reductions in prevalence due to treatment have been masked by increases in risk factors. However, there was little evidence relevant to the hypothesis that improvements have been masked by increased reporting of symptoms because of greater public awareness of common mental disorders or willingness to disclose. A more strongly supported hypothesis for the lack of improvement is that much of the treatment provided does not meet the minimal standards of clinical practice guidelines and is not targeted optimally to those in greatest need. Lack of attention to prevention of common mental disorders may also be a factor. Reducing the prevalence of common mental disorders remains an unsolved challenge for health systems globally, which may require greater attention to the "quality gap" and "prevention gap". There is also a need for nations to monitor outcomes by using standardized measures of service provision and mental disorders over time.

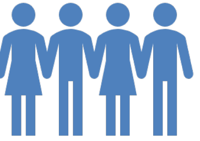
Key words: Common mental disorders, depression, anxiety disorders, prevalence, antidepressants, psychological therapies, treatment gap, quality of treatment, prevention

(World Psychiatry 2017;16:90–99)

Lack of Impact of Reducing the Treatment Gap (Australian Data)

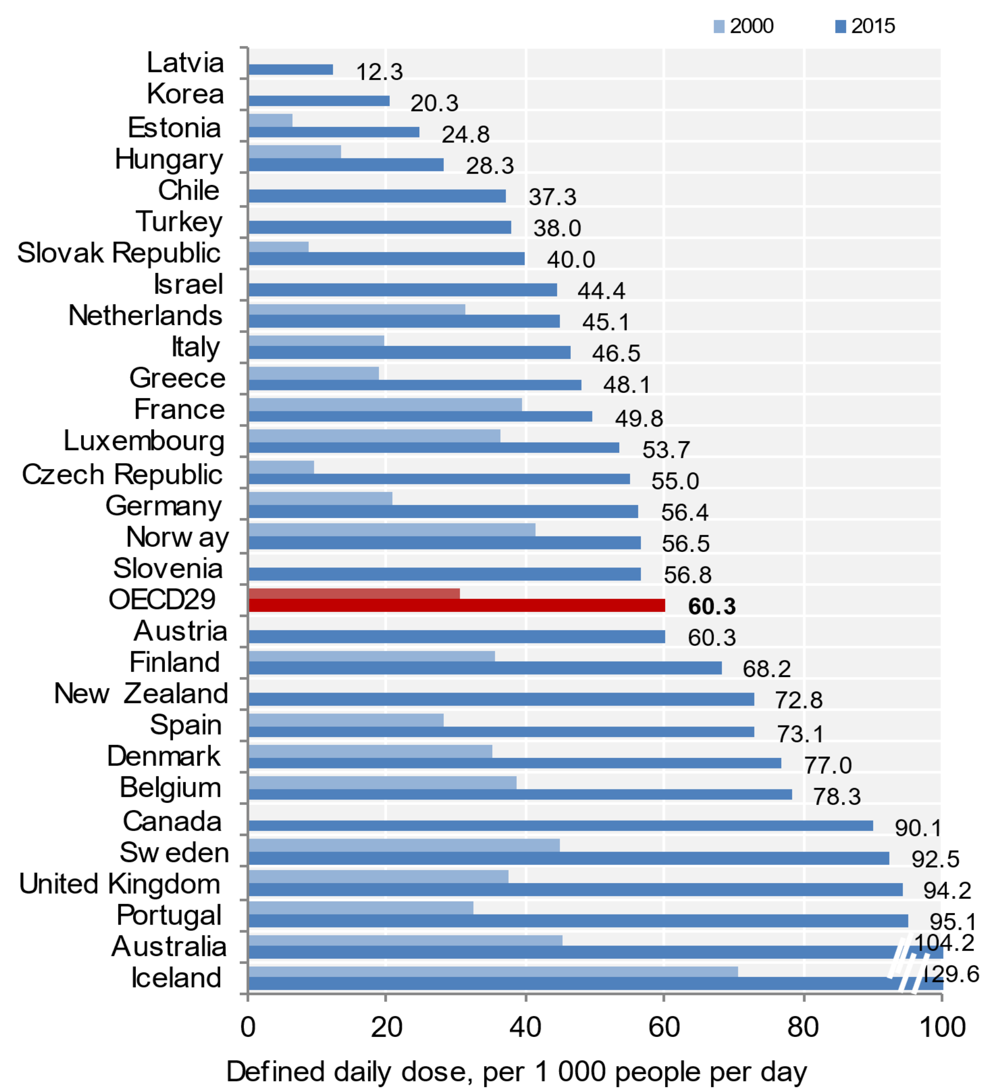
Psychotropic medication use (particularly antidepressants) has steadily increased.

Since 2006, there has been a massive increase in psychological services.

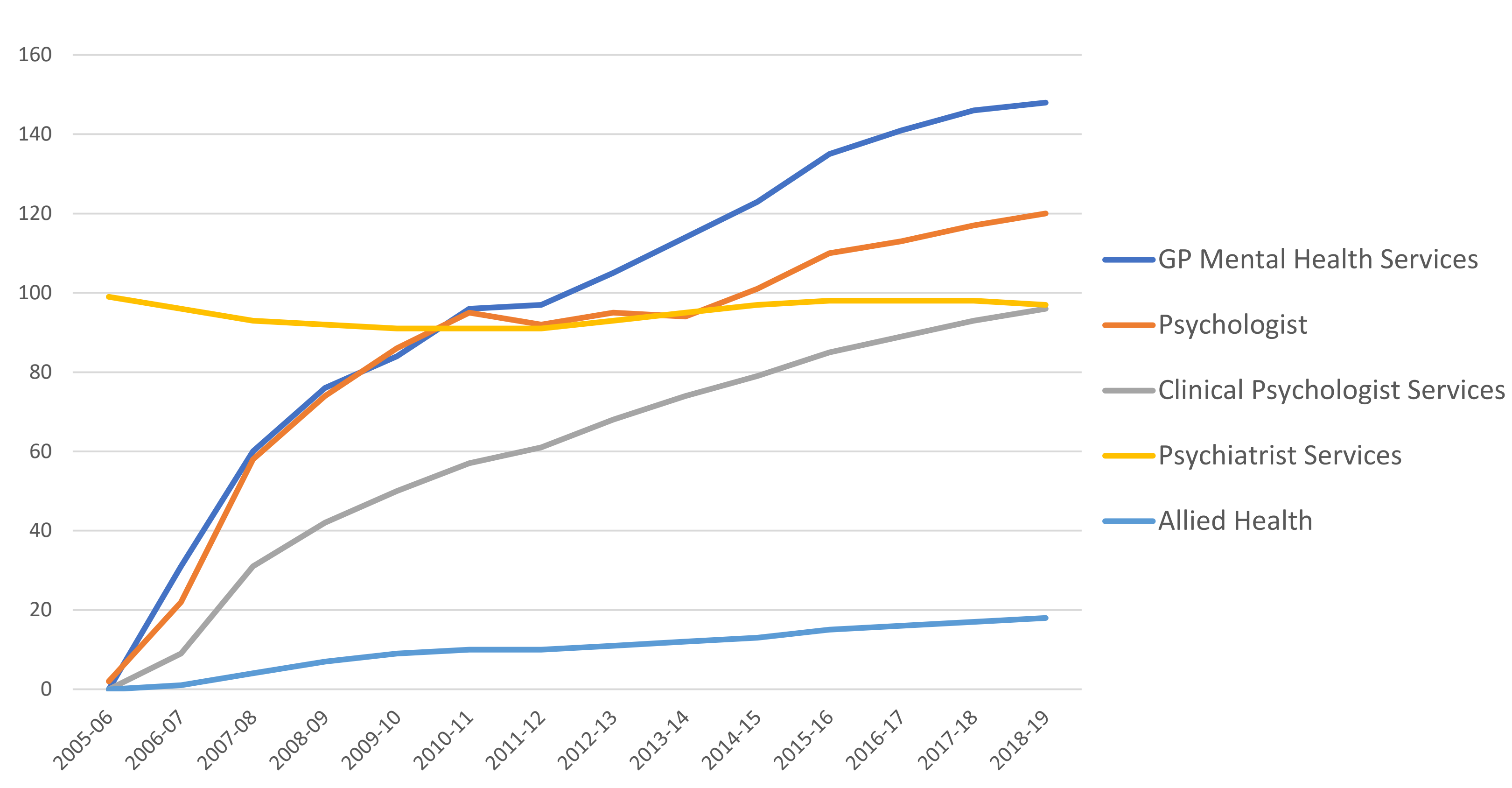


Prevalence has been steady since the mid-1990s.

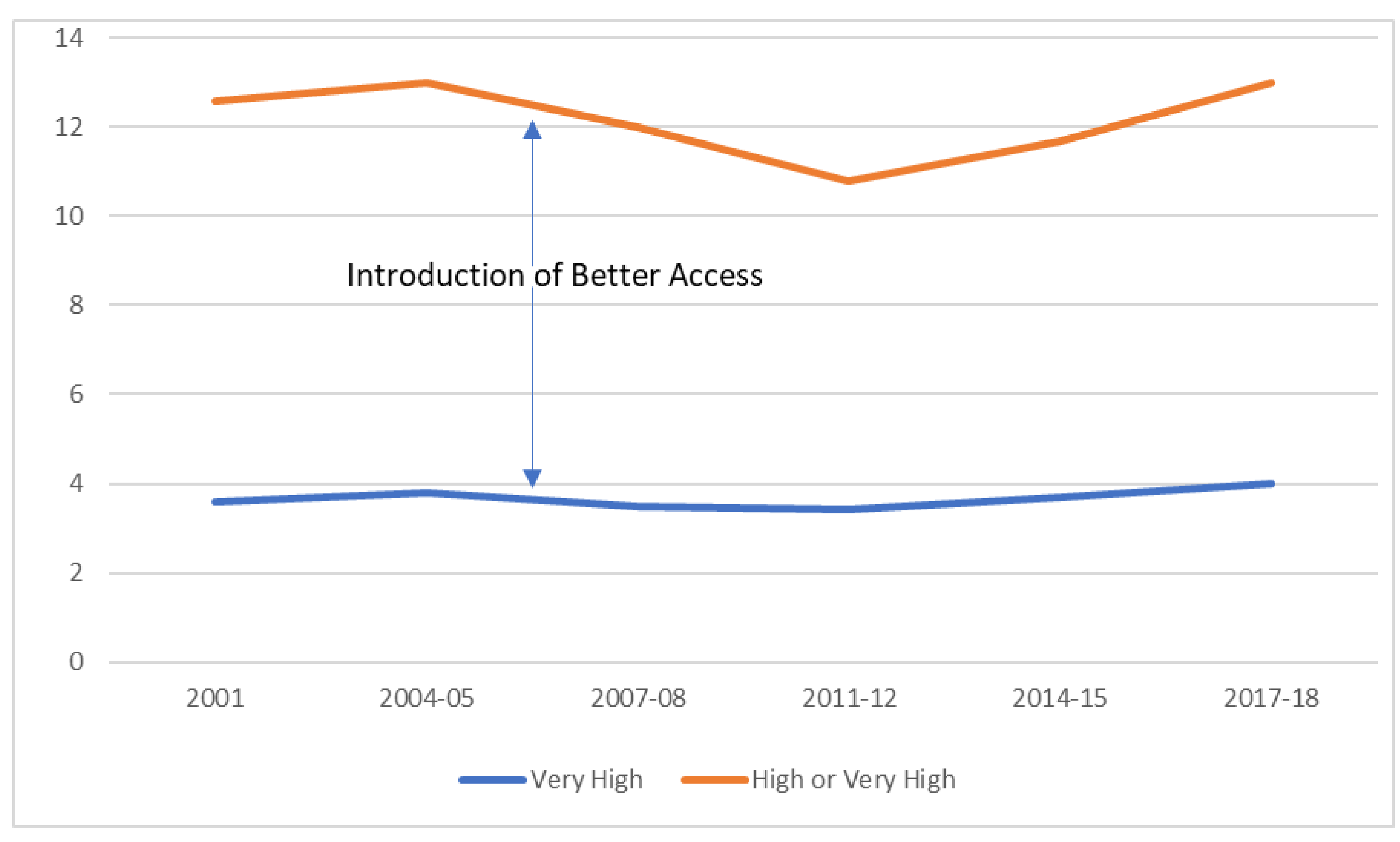
Antidepressant Consumption 2000 and 2015



Medicare Mental Health Services (per 1,000 persons): 2006-2015



Prevalence (%) of Psychological Distress (K10): 2001 to 2017-18

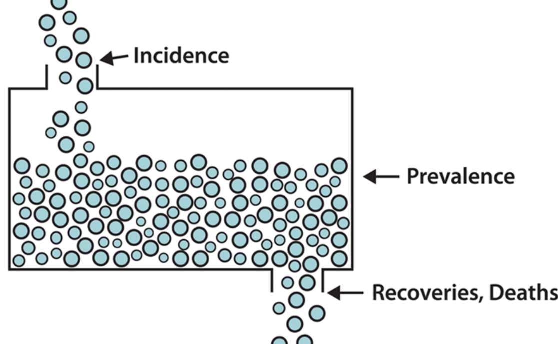


Why Didn't It Work? The Quality Gap

- There is abundant evidence from RCTs that treatments for mental disorders work.
- Treatments that work under trial conditions may not work as well in practice, due to poor targeting or poor implementation.
- Antidepressants are not being used with the right people.
- Psychological services are often too brief.

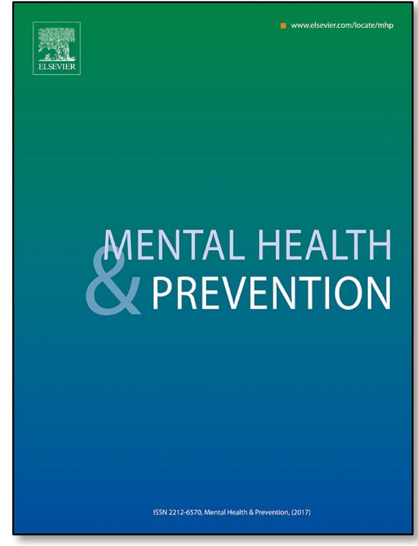
Why Didn't It Work? The Prevention Gap

- Prevalence is a function of incidence and duration of disorders.



- Services are primarily aimed at duration.
- We may need to put more emphasis on decreasing incidence.

What Should a Nation Do to Prevent Mental Disorders?



Risk factors to reduce

- Child maltreatment and other adverse childhood experiences
- Poor parental mental health and substance misuse
- Parenting risk factors
- Socioeconomic factors (e.g. debt, unemployment, homelessness)
- Bullying
- Loneliness
- Inequality (gender, income)

Protection factors to promote

- Social and emotional skills
- Social supports
- Positive parenting (e.g. warmth)
- Positive school climate
- Positive workplace factors (e.g. job control, team and management support)
- Affordable high-quality childcare

Early intervention and mental health literacy

- Treatment of people at high risk
- Screening
- Improving mental health literacy

Enabling factors

- Sustainable identified funding
- Building workforce capacity
- Population monitoring of outcomes
- Research and knowledge translation
- Enabling policies
- Whole-of-government approach

Does Prevention Make Economic Sense?

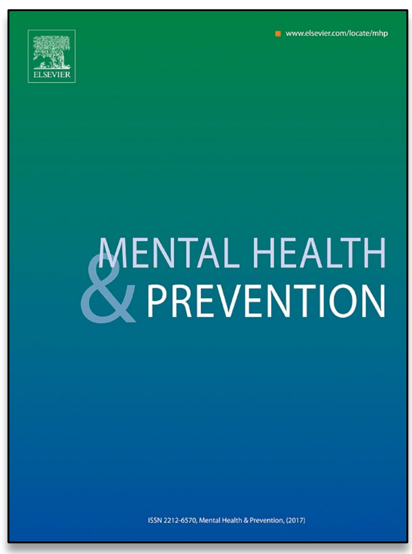
Table 1: Results of interventions ranked by ROI with total costs and total savings

ROI	Intervention	Target population	Length of costs and benefits	Total costs of intervention	Total savings
3.06	e-Health interventions for the prevention of anxiety disorders in young people	School students aged 11–17 years	10 years	$6.2M	$18.8M
2.87	Educational interventions to reduce older persons' loneliness	Women aged 55 years and above residing in the community	5 years	$25.2M	$72.4M
2.54	Exercise programs for the prevention of post-natal depression	Women at least 4 weeks post birth	5 years	$5.5M	$14.0M
2.40	Parenting interventions for the prevention of anxiety disorders in children	Preschool children aged 4–5 years	3 years	$3.7M	$8.3M
2.14	e-Health interventions to reduce older persons' loneliness	Lonely older adults aged 65 and above enrolled into the Community Visitors Scheme	5 years	$2.2M	$4.7M
1.63	Psychological interventions for the prevention of post-natal depression	Pregnant women	5 years	$14.6M	$23.3M
1.56	School based interventions for bullying prevention	School students aged 8-11 years	10 years	$66.8M	$103.9M
1.19	School based psychological interventions to prevent depression in young people	School students aged 11-17 years	10 years	$31.1M	$37.1M
1.05	e-Health workplace intervention for the prevention of depression	Employees aged over 18 years	11 years	$6.2M	$6.5M
0.28	Face to face psychological workplace interventions for depression prevention	Employees aged over 18 years	11 years	$166.6M	$45.8M

WELLBEING ECONOMY GOVERNMENTS (WEGO)

The Wellbeing Economy Governments partnership (WEGo) is a collaboration of national and regional governments interested in sharing expertise and transferrable policy practices to advance their shared ambition of building Wellbeing Economies. Membership of the group has grown organically since its launch in 2018 and currently involves the governments of Scotland, Iceland, New Zealand, Wales and Finland, with Canada actively participating.

- Action in these areas often falls outside health sphere.
- Some governments are moving towards a ‘well-being economy’ which sees well-being as the ultimate society goal.
- A first step is development of national well-being frameworks– these need to involve national monitoring of mental health.



Inclusion of positive well-being and mental ill health measures of adults in national and regional well-being frameworks.

Country/ Region	Positive Well-Being Measure	Mental Ill-Health Measure
Australian Capital Territory	Personal Wellbeing Index	Self-rating of mental health, Psychological distress
Bhutan	Life satisfaction, Positive emotions	Psychological distress, Negative emotions
Canada	Life satisfaction, Sense of meaning and purpose	Self-rating of mental health
Estonia	-	Mental and behavioural disorders, Suicides
Germany	-	-
Israel	Life satisfaction, Able to deal with problems	-
Italy	Life satisfaction, Leisure time satisfaction, Judgement of future perspectives	Mental Health Index
Japan	Subjective happiness	Suicide rate, Suicidal ideation, Degree of stress, Number of patients with depression
Luxembourg	Life satisfaction	Prevalence of mental problems, Suicide rate
Netherlands	Life satisfaction, Feeling in control of own life	-
New Zealand	Life satisfaction, Sense of purpose in one's life	Psychological distress, Suicide rate
Scotland	Warwick-Edinburgh Mental Well-Being Scale	-
Slovenia	-	-
United Kingdom	Warwick-Edinburgh Mental Well-Being Scale, Life satisfaction, Happiness rating, Sense of purpose in one's life	Anxiety rating, General Health Questionnaire-12
Wales	Warwick-Edinburgh Mental Well-Being Scale	-
OECD	Life satisfaction, Affect balance*	-

This is a Big Agenda - Where to Start?

Viewpoint

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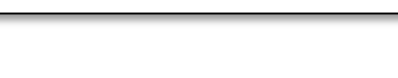

Prevention of mental disorders requires action on adverse childhood experiences

Anthony F Jorm[1] and Roger T Mulder[2]

Taking Action on Adverse Childhood Experiences

What we know

- Exposure is common across the world
- They are risk factors for most categories of mental disorder
- They are risk factors for poorer physical health
- Their effects persist across the lifespan
- They tend to cluster in families

What we can do

- Strengthen economic supports to families
- Change social norms to support positive parenting
- Provide quality care and education early in life
- Enhance parenting skills to promote healthy child development
- Intervene to lessen harms and prevent future risk
- Broaden public and professional understanding of links between ACEs and mental disorders
- Train clinicians to routinely enquire about childhood experiences to inform treatment

In Summary

- Mental disorders are common, disabling and often untreated (the Treatment Gap).
- Closing the treatment gap has not improved population mental health.
- Possible reasons are that there is a Quality Gap and a Prevention Gap.
- There is much that can be done for prevention, but it requires a whole-of-government approach.
- A good place to start would be action on adverse childhood experiences.

A Final Thought: “Good Parenting is the Clean Water of Mental Health”