Guest Editorial

Promoting mental health in the United Kingdom: a case study in many parts

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... for Mack, who excels at the art of connecting.

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In the UK, the term public mental health is beginning to take precedence over mental health promotion:

public mental health (of which mental health promotion is one element), provides a strategic and analytical framework for addressing the wider determinants of mental health, reducing the enduring inequalities in the distribution of mental distress and improving the mental health of the whole population. (Friedli, 2004)

This may be a tactical, rather than a conceptual shift, as public health is enjoying a renaissance, stimulated by a series of Treasury reports on the economic benefits of prevention (Wanless, 2002; 2003) and the recent launch of Choosing Health, the English public health White Paper (Department of Health, 2004).

Over the past decade or so, mental health promotion has inspired strong commitment, gained an impressive range of advocates and is beginning to lose its marginal status, hence the title of an international conference held in Dublin earlier this year: Mental Health Promotion: Going from Strength to Strength (http://www.charity.demon.co.uk/dublin/). What might be called the mental health promotion movement has contributed to a marked shift in the debates about mental health, from a...
predominant focus on mental illness to an analysis of the importance of mental health and well-being (Jané-Llopis & Anderson, 2005). This shift is evident in UK and European policy, notably the WHO Europe Helsinki Declaration, and has been informed by a number of significant developments:

- the shift from treatment to recovery - what people need in order to hold on to or regain a life that has meaning for them;
- evidence for the impact of mental health on physical health;
- interest in the relationship between social capital and health; and
- critiques of the use of economic development (GDP) as a sufficient indicator of national prosperity.

Although the reform of mental illness services and addressing the stigma, discrimination and denial of human rights and civil liberties experienced by people with mental health problems remain central, these goals are now also being considered in the context of public mental health.

Campaigns and other initiatives to achieve a society in which people with mental health problems are valued, accepted and included are more likely to be effective if they form part of a population based strategy to promote mental well-being. (Mental Health Foundation, 2005; Gale et al., 2004).

The WHO Europe Action Plan (WHO, 2005a), which sets out the commitments and responsibilities of both the WHO and national governments, stresses the need for:

- mental health activities capable of improving the well-being of the whole population, preventing mental health problems and enhancing the inclusion and functioning of people experiencing mental health problems.

It has 12 priority areas, with a strong public mental health focus, including:

- promotion of mental well-being;
- incorporation of mental health as a vital part of public health policy;
- reduction of stigma and discrimination;
- prevention of mental ill health and suicide; and
- access to good primary health care.

The extent to which public mental health will achieve better outcomes for people with severe and enduring mental health problems is an open question. In England, tackling discrimination and social exclusion have received a stronger focus than promoting mental health for all, notably with the publication of Mental Health and Social Exclusion by the Office of the Deputy Prime Minister and From Here to Equality, the National Institute for Mental Health’s (NIMHE) strategy for tackling stigma and discrimination on mental health grounds (NIMHE 2004; Social Exclusion Unit, 2004). Reasons for this include:

- the pressing need to address barriers to inclusion for people with mental health problems;
- lack of awareness of the relevance of mental health promotion to improved health and quality of life outcomes for people with mental health problems; and
- most stakeholders work within or use mental health services.

The launch of the national mental health promotion framework can be seen as an effort to provide greater leadership and support for a population wide approach to improving mental health.

Notwithstanding these developments, public mental health could hardly be described as mainstream. What is needed then, to support the mental health promotion community and perhaps more critically, what do those of us committed to public mental health need to do to strengthen both the quality and status of mental health promotion theory and practice? This was subject of a plenary at the Dublin conference, where the differences between the UK and Australia provided a basis for reflecting on these issues (see Jennie Parham’s guest editorial in this issue: Parham, 2005).

Based on what is happening in the UK and Europe, it seems to me that developing the art of connecting is a key strategy (see Figure 1), and that this needs to focus on three areas:

- public debate and engagement;
- policy and emerging ideas; and
- the values underpinning our practice.
Public debate and engagement

The focus on stigma and discrimination has tended to preclude a wider debate about factors that are toxic to mental health, whether or not one has a diagnosis. We have a wealth of data on public attitudes to mental illness, but very little on public knowledge of what harms and hinders mental well-being: the mental health equivalents of smoking and car exhaust fumes.

The extent of control that individuals have over factors that potentially damage their mental well-being varies considerably and in many cases will be very limited. But greater public awareness and understanding of mental health as a resource to be protected and promoted could contribute significantly to reducing structural barriers. For example, prior to the widespread introduction of smoke free workplaces, many people had no choice but to work where they were exposed to second hand smoke. As awareness of the dangers of passive smoking increased, demand from unions and employees contributed to the adoption of workplace smoking policies. Rather than perpetual hand wringing about the public’s stigmatising attitudes, perhaps we should focus on building the same public demand for mental health and well-being as has been achieved for smoke free public spaces.

Emerging ideas

Many different disciplines and intellectual traditions can (and should) contribute more centrally to our thinking: we need to form alliances with colleagues concerned about the environment, violence and political conflict, the rise of fundamentalism, human rights, civil liberties and the implications of bio-science. Three areas of very specific relevance to mental health promotion also merit attention – the economics of well-being, health assets and ongoing debates about evidence.

The economics of well-being challenges the equation of economic growth with life satisfaction and reminds us of the cost of economic growth, notably the psychosocial impact of inequality and materialism (Layard, 2005; Marks & Shah, 2004; New Economics Foundation, 2004). It draws on robust evidence that the structure and quality of social relations are fundamental to well-being and provides a context for analysing how the drivers of economic growth undermine individual and community efforts to remain or become connected. The focus is less on individual psychological and cognitive attributes and more on the relationship between the organisation of society and how we feel. In the UK, a cross government Whitehall Wellbeing Working
Group has been established to explore how policies might change with an explicit well-being focus (DEFRA, 2005). This is an interesting development in the current political climate, where the rhetoric of civic engagement, participation and inclusion coincides with a simultaneous discourse of suspicion, intolerance and vilification of more and more sectors of the population. A contradiction that will not be unfamiliar to Australian readers.

Health assets or salutogenesis is an approach to public health that focuses on assets and resilience, rather than solely on deficit and vulnerability. It aims to maximise assets within a community, not just to reduce need. In mental health terms, it is the equivalent of measuring positive mental well-being, as opposed to surveys of psychiatric morbidity. This is important because strategies that focus on need may (inadvertently) reduce health assets, for example through fostering high levels of dependence on professional input; conversely, an intervention that enhances health assets, for example social networks, may have no impact on disease. In other words, interventions to improve health may be entirely independent of interventions to prevent disease:

Salutogenesis asks, “What are the causes and distribution of health and well-being in this group, community or country population”. 
Epidemiology asks “what are the causes and distribution of disease and early death in this group, community or population”. (WHO Europe, 2005)

Emerging research on health assets can help in making a robust case for the importance of mental health and well-being, both in ethical and in public health terms. It can also contribute to current debates about evidence and effectiveness: who is defining success and what measures are they using? The demand for evidence-based practice is likely to remain fundamental, but questions about what counts as evidence are growing louder. Factors informing these questions include a growing emphasis on:

- the impact of psychosocial factors on health, for example social capital, social inclusion and quality of life;
- public/patient involvement and the need to take account of consumer views in deciding what success looks like; and
- user led research, drawing on people’s own expertise in living and coping with mental health problems.

Mental health promotion can contribute centrally to the development of measures and methodologies that can capture a wider range of domains than symptoms, and a wider range of stakeholder perspectives.

Values

Faced with the relentless pressure to ‘do and deliver’, it is never easy to reflect on the values underpinning our practice. This is particularly true in an environment unsympathetic to intellectual work: we look longingly across the Channel in that respect. But a robust debate about first principles has never been more pressing: one of which might be that neither prevention nor cure necessarily result in health. For mental health promotion, this means considering whether mental health problems are like polio. Are the characteristics, attributes, insights and experiences associated with, for example, what we call schizophrenia or depression, to be eradicated?

This question is central in considering some of the potential problems with ‘raising awareness’ campaigns. At root, these invite the public to adopt a medical explanation for their problems and to seek medical help, while also, usually through case studies or first person accounts, highlighting the consequences of the disorder: stigma and exclusion. They do not invite reflection on economic and environmental causes. Public health warnings rarely include ‘inequality and injustice seriously damage your mental health’ or ‘fear of foreigners really screws you up’. The reinterpretation of problems as medical suggests that we’re not well, but always, already, potentially (medically) sick. The data used to support our case for the importance of mental health: one in four (lifetime prevalence), one in seven (point prevalence), every family in the land etc., reinforce the myth that mental health problems are a random misfortune, as opposed to a consequence of risk factors that are well understood and strongly associated with social and material deprivation (Melzer, Fryers & Jenkins, 2004; Rogers & Pilgrim, 2003).
Conclusion

It’s been said that the mental health equivalents of drains and clean water are respect and justice. For our own mental health we need to be heard, believed, understood and respected. Justice is about the distribution of the good and bad things in life in a way that is felt to be fair. There is overwhelming evidence that inequality – a key indicator of injustice – erodes mental well-being and that this is one of the key pathways through which deprivation impacts on overall health.

In the UK, we are still recovering from an eighteen year period in which community resources and infrastructures for challenging inequality were systematically dismantled. In this period of potential recovery, mental health promotion needs to build alliances with those communities who are already critical of ‘how we live’ and its impact on care of children, care of the self and social relationships. Of course public mental health needs resources and strategic influence, but it also needs a grass roots movement, one which mobilises against global and local trends that are toxic to the mental health and well-being of all of us. A National Framework for Improving Mental Health and Well-being in England that can contribute to this would be well worth waiting for.

Notes

1. To date, Northern Ireland (DHSSPS, 2003; Friedli, 2004) and Scotland (the National Programme to Improve Mental Health and Well-being http://www.wellontheweb.org/well/well_MainTemplate.jsp?pContentID=77&p_applic=CCC&pMenuID=157&p_service=Content.show&) are the only countries in the UK that have a mental health promotion strategy.

2. The WHO European ministerial conference on mental health, in Helsinki in January 2005, brought together all 52 countries in the European region of the WHO. Organised in partnership with the European Union and the Council of Europe, the conference’s declaration and action plan will drive the policy agenda on mental health for the coming years (WHO, 2005a, 2005b).

References


