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Mens sana in societate sana

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We all know the Latin quotation "Mens sana in corpore sano" (D. Iunius Iuvenalis, Satura X, 365[1]*), most often translated as "A sound mind in a sound body". Although the original connotation is that health of mind and body is good in itself and to be rightly desired, as opposed to beauty, wealth and power, its most general usage is to express the concept of a healthy balance in one's way of life.*

Society's role in and contribution to the mental health of populations is the common line of thought throughout several of the contributions to the Speaker's Corner *(Brugha 2007; Perrig-Chiello 2007; Piko 2007; Rutz 2007). In the Speaker's Corner experts are petitioned to submit their opinion on mental health in public health. There is no doubt that mental health problems account for an important proportion of the global burden of disease and it is likely that this burden will increase in the future (WHO 2001; Saraceno 2007). Not only Europe, but the whole world has gone/is going through important transitions that touch the connective tissue of society. Both the demographic and societal transitions have a profound impact on the population's mental health. Rutz (2007) uses the term 'Community syndrome', related to the level of the stress load in societies following societal transitions. The demographic and societal transitions have changed the way of organizing and building society. Although these are not new phenomena (other times, other manners), current transitions have a substantial impact. They affect household structure and composition. The cohesion of the family, a cornerstone of society, crumbles. The way we organize our economy and enterprises, together with the globalization affect the relationship between workers and solidarity on the one hand and the relationship between workers and employers on the other (Cooper 2007; Conne-Perréard 2007), thus creating a society with a greater mental frailty. A positive note is that the negative input of society on the mental health of populations, as it is currently experienced, can be turned around. It can be altered not by medicalization (Brugha 2007) but rather by empowering people, by supporting social connectedness, family cohesion, spiritual values, by facilitating identity and dignity (Rutz 2007). It can be reversed, not by focusing on high risk groups but as suggested by G. Rose (1993) by focusing on the society as a whole. This population approach opens perspectives for public health policy toward a society that takes responsibility for its mental wellbeing:* ***"Mens sana in societate sana"****.*

Self-directed violence is one major mental health outcome influenced by the societal transition. The frequency of self-directed violence can be considered as an indicator of the mental wellbeing of a population. In this issue two papers present two different population based surveillance systems of self-directed violence, specifically of suicide, suicide attempts and suicidal ideation. The first paper describes the use of a continuous survey methodology (Computer Assisted Telephone Interviewing) to estimate the prevalence of self-reported suicidal ideation and the association of suicidal ideation with social and demographic risk factors (Taylor 2007). The second paper presents a sentinel surveillance network of general practitioners (GPs) used to estimate the incidence of suicide and suicide attempts together with socio-demographic information on the cases, the method used and the survival (Bossuyt & Van Casteren 2007). Both systems allow for the evaluation of changes of health outcomes over time. In both papers the methodological strengths and weaknesses of each of the surveillance systems are discussed.

Suicidal ideation, suicide attempts and suicide are health

[1] www.thelatinlibrary.com/juvenal/10.shtml

outcomes on a continuous severity scale. Measuring these health outcomes is challenging. Both methods of surveillance combined are covering the whole continuum, which can not be achieved by one data collection system alone. Mortality data and the counts of suicides is still in many countries the only source (WHO 2002). Information from other sources is necessary to estimate non-fatal events. These sources often have the advantage that they also are able to provide additional information on e. g. determinants, methods used, circumstances leading to events. This additional information allows for getting a better insight on why some populations are mentally healthy and others not. The health care system can be an important source, mainly for data on suicide and suicide attempts but less likely for suicidal ideation. A main issue related to the data from the health care system is the selection process that determines whether an event is recorded (Bossuyt & Van Casteren 2007). The surveillance system in this paper uses the primary care level. GPs are able to identify some but not all events for which the first contact is outside the primary health care systems. It is remarkable to notice that the selection process towards a level of health care is different in function of the method used in the (attempted) suicide. Selection bias should also be considered in survey methodology (Taylor 2007). Subsamples of the population which are harder to be reached are likely to have a different frequency of health outcomes. There may also be differential reporting bias based on gender, age, socio-economic status, etc. Further in the development of a survey one has to take into account the limited number of the variables on one topic that can be collected during a single interview session. But even on the background of these limitations, the two papers are examples of the initial steps needed towards the prevention of suicide, suicide attempts and suicidal ideation according to the public health approach which begins with a description of the magnitude and impact of the problem.

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