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Who should own Public Mental Health?

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Historically public mental health seems to have formed within interested groups of academic psychiatrists separately from the main stream of public health medicine, with the unusual exception of the aptly termed 'mental hygiene' group based at the Johns Hopkins Medical School in Baltimore with its highly successful and still thriving Masters Programme (Hiscock & Gruenberg 1950). Recent decades have seen two healthy developments: an interest in specialising in mental health among a small growing number of public health specialists and the merging of psychiatric expertise into large scale survey, medical statistics and epidemiology research teams. But public health is about action (Gruenberg 1959) and in spite of Ernie Gruenberg's repeated reminders, little action has followed since. As other contributors will no doubt remind readers psychiatric epidemiology has triumphed in its use of large scale surveys to deliver numerous cross country and cross continental, increasingly directly comparable estimates of the prevalence of a wide range of clearly defined and consistently assessed mental disorders (Alonso et al. 2004; Demyttenaere et al. 2004). Mental disorders can be found in substantial numbers in all populations and societies, not just in mental hospitals. In most countries the only doctor who sees and sometimes also treats persons with mental disorders is the primary care physician. But rates are not falling in spite of at least two fold increases in the use of supposedly highly effective pharmacological treatments (Brugha et al. 2004), which begs the question: how do we control this epidemic? Evidence that socio-economic factors affect mental health has been picked on by policy makers arguing for universal social and economic policies to enhance the happiness rather than just the wealth of a society as well as advocating a wider availability of psychological treatments for depression (Layard 2006). But is prevention an option? Research on determinants has highlighted the importance of gender, social inequalities (Fryers et al. 2002), poor early parenting (Heider et al. 2006) and adversity interacting with developmental and hereditary influences (Kendler et al. 2006). Not only are the supposed causes complex but at the present time intervening to prevent the development of disorders such as anxiety and depression in early or later adulthood seems a daunting task. Nevertheless there is beginning to be some encouraging progress particularly with interventions in childhood. For example interventions that involve at risk parents have shown promising effects for their teenage children (Wolchik et al. 2002). Cognitively based interventions in adolescents at risk of developing depression also show promise (Clarke et al. 2001). Such programmes are highly costly (Lynch et al. 2005) and unlikely to be within the reach of most global communities until low cost alternatives emerge. Evidence from syntheses of sufficient numbers of small (underpowered) trials suggests that postpartum depression may be amenable to preventive effects (Cuijpers et al. 2005). Seven studies on prevention of depressive disorder resulted in a RR of 0.72 (95 % CI, 0.54–0.96). Interestingly there was an increased risk of developing post traumatic stress disorder with an early post trauma intervention. The authors recommended large trials but also selective studies on subgroups at risk. This policy is in contrast to the widely quoted views of Rose who advocated universal prevention interventions as benefiting far more members of society (Rose 1993). Rose paid particular attention to the dimensional nature of the common mental disorders like depression, drawing an analogy with blood pressure arguing that an intervention that targets everyone will also lower rates at the upper ('pathological') extreme (Brugha 2002). A stepped care approach to the management of depression, with different recommendations for different levels of severity, is already officially recommended in Great Britain by the National Institute for Clinical Excellence (http://www.nice.org.uk/page.aspx?o=235213). This is important for public health and policy information users and decision makers to consider because most (but not all) published prevalence tables for depressive disorder are unable to take account of these clinically significant distinctions and their value in estimating what intervention resources are needed where in society. Ideally mental health surveys should embody dimensional as well as categorical definitions of outcome but such information is routinely provided only in the British Psychiatric Morbidity survey programme (Singleton et al. 2001). But if we are to develop population wide interventions and make widely available relatively complex and costly psychological interventions our societies will need to manage such changes in professional practice and service design strategically. But how? An important step is the development and dissemination of clinical guidelines that address different levels of severity of disorder but there is little evidence that alone these are sufficient to produce change. This challenge requires more imaginative approaches to the threat of poor mental health to the public health. Paradoxically we may need to consider the demedicalisation (Stein et al. 2007) of all but the most severe forms of mental disorder so that society as a whole takes responsibility for its mental wellbeing. We are just at the beginning of acquiring the knowledge that will allow us to establish the future of public mental health. The question is do we have what it takes to forge a new beginning that is fit for purpose?

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