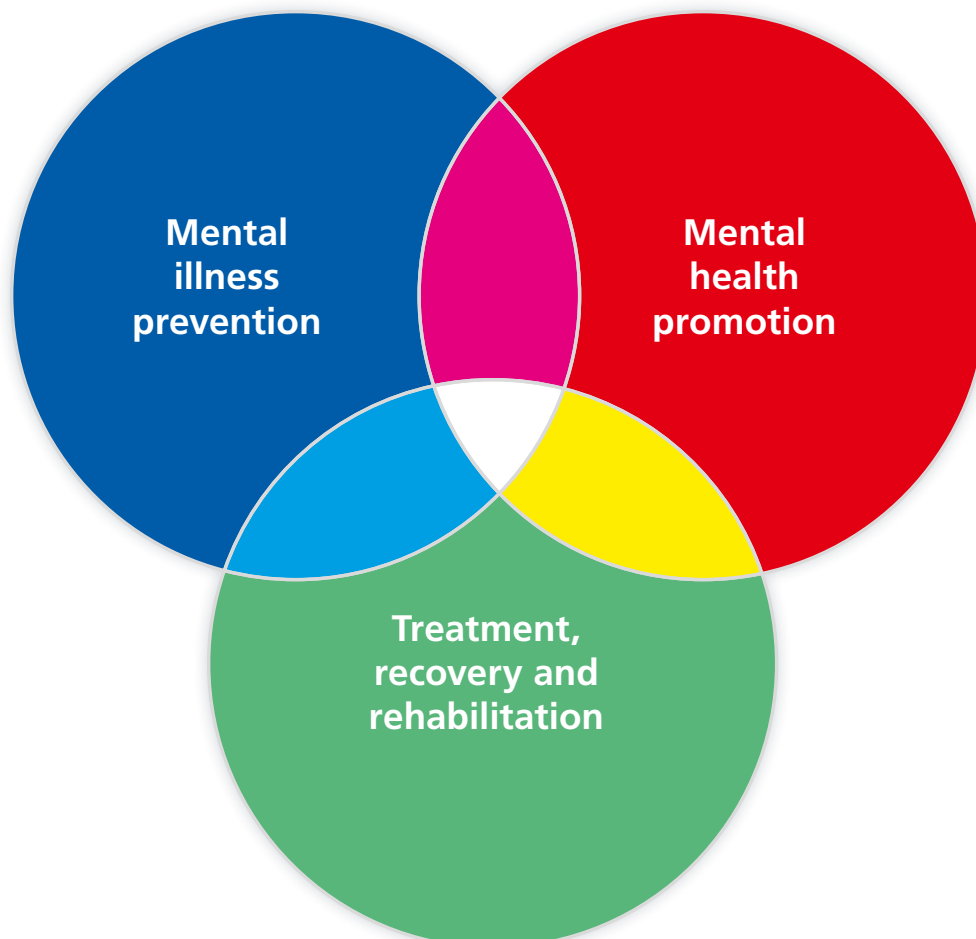


Annual Report of the
Chief Medical Officer 2013

Public Mental Health Priorities:
Investing in the Evidence

Public mental health: evidence based priorities

Chapter 2 – summary



Key messages

- This summary provides a brief introduction to, and presentation of, the key points in Chapter 2, *Public mental health: evidence based priorities*, of the CMO's annual report for 2013 ('Advocacy' volume).
- 'Public mental health' is taken to mean: *a public health or population health science approach to mental health and the mental health variations exhibited by populations.*
- The organisational and conceptual division between physical and mental health is a barrier to the improvement of health more generally.
- The chapter is intended to provide a framework for public mental health, based on the WHO (World Health Organization) model, to inform future local research and investment strategies.
- There is extensive evidence of effective interventions in public mental health as modelled on the WHO framework, which is built on the concepts of mental health promotion and mental illness prevention, treatment and rehabilitation.
- However, the concept of 'mental well-being' as it is currently used in this field is still characterised by a lack of clarity over boundaries, definitions and tools for evaluation and by a lack of evidence of 'what works'.
- Unless and until robust evidence of effectiveness is forthcoming, interventions based on the concept of 'mental well-being' should not be funded.

Clarity in terminology

There is a proliferation of terminology around mental health, some of which arises from disagreements about models of mental health. Such variation in language can lead to confusion and lack of understanding. For example:

- People who have, are or may use mental health services have been referred to as 'patients', 'service users', 'consumers', 'customers', 'clients', 'people with experience of mental health issues/problems/distress' etc.
- Their experience has been described as 'mental health problems', 'mental health illness', 'mental disorder', 'mental distress', being 'in recovery' and other terms, some of which wholly reject a medical model of this experience.
- The state of positive mental health and positive functioning has been described as 'good/positive mental health', 'well-being' 'hedonic well-being', 'eudaemonic well-being', 'positive psychological functioning', 'flourishing' etc.

It is important to acknowledge the different traditions and perspectives which give rise to differences in language. However, to achieve greater clarity, it is necessary to use accurate and precise terminology which promotes maximum understanding of the population health variations in question and where clearly defined usage is supported by an evidence base.

The concept of 'well-being'

The concept of well-being has increasingly been used both in the field of public mental health and in public policy. The current level of interest in the concept of well-being and its relation to mental health in England followed publication of the Foresight Report in 2008. Based on a hypothesis by Geoffrey Rose about effective public health interventions, Foresight predicted that:

'Achieving a small change in the average level of wellbeing across the population would produce a large decrease in the percentage with mental disorder, and also in the percentage who have sub-clinical disorder (those 'languishing').'

This hypothesis was accepted as proven without question. It is now generally accepted in policy, voluntary sector and some research circles that improving 'well-being' will improve mental health and reduce the prevalence of mental illness in the population. Nonetheless, there is, as yet, no good evidence that a population approach to mental well-being, however defined, will 'shift the curve' of population mental disorder. In other words, evidence has not yet been forthcoming that the Rose/Foresight hypothesis applies in this field.

Indeed, there is still a lack of consensus over fundamental questions such as:

- what mental well-being is
- how it relates to public mental health and illness
- what value is placed on it across society.

Mental well-being and mental disorder/mental illness should not be seen as positions on a continuum but as distinct concepts, not to be defined in terms of each other. It is entirely possible to have a mental illness, and simultaneously to enjoy high levels of subjective well-being – and vice versa.

Defining and measuring well-being

Because of the interest in the concept of 'well-being', there have been a number of recent attempts to define the concept and to measure the well-being of the population. However, such attempts have tended to assume an implicit relationship between mental illness and well-being before such a relationship has been psychometrically defined. Based on this assumption, it has been assumed that a measure of mental illness in individuals can also be a measure of levels of well-being in the population and vice versa. This is a potentially dangerous and methodologically baseless assumption.

An approach to mental well-being which incorporates measures of mental illness may have inadvertently given rise to terms describing very different populations within

public mental health being used interchangeably across different disciplines. The result is inconsistent blurring of the boundaries between:

- population approaches to positive mental health promotion
- prevention of mental illness
- treatment and rehabilitation of mental disorder.

This in turn has resulted in much of the summary literature on which public health policy in England is built inappropriately describing the results of intervention studies in more established fields of research about clinical disorder as part of a 'well-being' evidence base to which they cannot be said to apply. 'Proxy' outcomes are unscientifically rebadged as 'well-being' outcomes, critically compromising the strength of the evidence base on which policy is subsequently built.

In light of the above, policy-makers, practitioners of and researchers in public mental health should avoid using measures of psychiatric disorder in individuals and other proxy measures to describe well-being in populations.

The evidence for well-being interventions

Much of the commonly cited evidence base for well-being intervention evaluations in England as related to mental health is found in the 'grey' literature i.e. papers and reports which have not been subjected to independent peer-review and which are often published by the organisation which carried out the intervention. Although frequently cited, such evidence cannot hold its own against peer reviewed scientific evidence in other social science fields. One problem with the use of grey literature is the widespread adoption of scientific sounding statements from well-funded but poor quality studies based on flawed methodology.

Robust quantitative research evidence can be complemented by evidence from alternative methodologies in a field such as well-being. An example of this is qualitative research methodology which has agreed standards for what constitutes scientific robustness. However, in the field of well-being as related to mental health there is frequent use of poor quality qualitative evaluations, not reaching agreed standards for the field, and further detracting from the credibility of the evidence base. There are better quality reviews, but these have all highlighted problems of definition and measurement, heterogeneity (non-comparable differences) of included studies and lack of effect sizes (the extent of the difference made by an intervention).

Such evidence as exists in relation to well-being in mental health is largely restricted to a small number of specific interventions to improve the social and emotional well-being of children and young people. Much of this evidence has been incorporated into helpful and practical NICE Guidelines.

Well-being and 'quality of life'

Well-being has a much longer and scientifically robust tradition within 'quality of life' research. In the health psychology literature, well-being is generally regarded as a pillar of quality of life. Thus many established measures of broader, health-related and disease-specific quality of life include domains measuring well-being. Strong correlations between these quality of life and life satisfaction (part of well-being) measures have been reported. It makes sense to build on this research rather than reinventing the wheel by starting again with a new concept of mental well-being in mental health outcomes.

Prioritising interventions

It is important to fund interventions in public mental health only in those areas for which there is real evidence of effectiveness. 'Well-being' approaches to mental health can be seen as one small strand of a wider approach, but at the moment, 'well-being' policy in relation to mental health is running ahead of the evidence.

The first priority for well-being research should be to develop workable definitions and appropriate metrics. Once these are available for the concept of well-being as used in public mental health, it will be possible to consider what interventions might be effective in improving mental well-being.

Public mental health – a WHO framework

Key reports by the WHO in 2004 and 2005 recognised that mental health:

- is more than the absence of illness
- is intimately connected with physical health
- forms an integral part of health.

Those messages were forerunners of current policy priorities for mental healthcare in England. A key message is that the organisational and conceptual division between physical and mental health is a barrier to the improvement of health more generally.

The WHO recognised that mental health and mental illness were viewed as sitting outside the tradition of public health. The WHO suggested instead that:

'The twin aims of improving mental health and lowering the personal and social costs of mental ill-health can only be achieved through a public health approach.'

In 2013 the WHO developed this further and published the Mental Health Action Plan 2013–2020, which incorporated the following concepts into a roadmap for global mental health:

- *mental health promotion*, which is primarily concerned with the determinants of mental health
- *mental illness prevention*, which is concerned with the causes of disease
- *treatment and rehabilitation*.

There have been other attempts to define public mental health, some of them contradictory. Some definitions have made unwarranted assumptions about the relationship between mental health and mental illness. Some have incorporated references to ill-defined or vaguely conceived notions of 'well-being'. The WHO framework brings clarity to the field. It suggests a model for public mental health in England as illustrated below.

There are ample opportunities for mental illness prevention and treatment of and recovery from common mental disorder for which there is a sufficient evidence base to make a real and sustained public health impact, using the WHO framework. We should invest in these opportunities rather than being side-tracked by ill-defined approaches to 'well-being' which currently go well beyond existing evidence.

Commissioning in public mental health – summary

Public mental health should be framed according to the WHO model of mental health promotion, mental illness prevention and treatment and rehabilitation.

'Well-being' should not be funded in public mental health but considered as one poorly-evidenced strand within the WHO model.

'Well-being' has not been sufficiently defined and measured to be used to evaluate and allocate health resources.

Further national work is required to clarify the psychometric relationships between measures of mental wellbeing and measures of mental disorder/illness. Until this work is done, local government cannot be held to account for 'improving well-being'.

The NHS and Public Health England should not commission services under the description of 'supporting well-being', but should focus on commissioning services for which there is evidence framed according to the WHO model.

'Well-being' social marketing campaigns for public mental health should not be rolled out unless and until there is robust evidence for their effectiveness.

Figure 2.1 Public mental health: a conceptual model derived from the WHO framework and illustrated with evidence based examples

