**Happiness: The greatest gift that I possess?**

Today sees the launch of the [**Centre Forum’s Mental Health Commission**](http://www.centreforum.org/index.php/mental-health) report *‘The Pursuit of Happiness: A New Ambition for our Mental Health’*.  I won’t be there, as by the time you read this I will be struggling on my bike up French hills, but having given evidence and seen the final version, the report is to be welcomed. This comes as no surprise as our previous President, Sue Bailey, was a commission member.

The report enthusiastically embraces the concept of public mental health. This is unequivocally ‘A Good Thing’, as Sellars and Yeatman would have said in *1066 and All That*.  And indeed, there are passages that might just as well have been lifted from the College’s own report [**No health without public mental health**](http://www.rcpsych.ac.uk/pdf/Position%20Statement%204%20website.pdf).

Mental health is an important public health issue (RCPsych, 2010) since mental disorder is responsible for an astonishing 23.6% of the years lost to disability in the UK – the second largest cause behind musculoskeletal disorders (Murray, 2013). Such a large burden of mental disorder is due to a combination of high prevalence, early onset in the life course, and broad range of impacts including in public health related areas. These impacts result in an annual cost to the English economy alone of £105 billion (Centre for Mental Health, 2010) and, looking further afield,  annual global costs of US$2.5 trillion (Bloom et al, 2011) and €532.2 billion in the European Union (Olesen et al, 2011). Vastly more importantly, this represents a wealth of human suffering.

We know that many of the problems we face can best be tackled taking the population as a whole. Hence the College has and will continue to support not just the development of alcohol treatment services (currently in some disarray), but also the policy of [**Minimum Unit Pricing**](http://www.rcpsych.ac.uk/pdf/RcPsych%20comments%20on%20delivering%20the%20government%27s%20policies%20to%20cut%20alcohol%20fuelled%20crime%20and%20anti-socal%20behaviours.pdf) - currently out in the long grass, but we hope to see it back in play.

Likewise, we know good public health depends on good information, which includes the local size, impact and cost of the intervention gap for treatment of mental disorder, prevention of mental disorder and associated physical illness, and promotion of wellbeing. The impact of this intervention gap is particularly large since only a minority of people with mental disorders (except psychosis) receive any intervention (McManus et al, 2009). Inclusion of such information in Joint Strategic Needs Assessments is vital to inform the decisions of CCGs and Health and Wellbeing Boards, although sadly it’s often missing. Nevertheless, the Department of Health deserves credit for authorising a repeat of the Adult Psychiatric Morbidity Survey, and we hope after some gentle pressure, its counterpart covering children and young people.

And we know that a public mental health approach shows the virtues of early intervention as well as the appropriate coverage of such interventions. So many of the disorders that wreak havoc in adults have their origins in early life - one review of research showed that half of all lifetime cases of diagnosable mental illness, other than dementia, have begun by the age of 14 [**(Kessler et al, 2007)**](http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1925038/)**.**  Thus the current major disparities in the provision of perinatal services, the subject of another major report published this week, is of concern not just because we need to provide good, timely, local management for mothers with mental disorders but because of the long term effects it has on the subsequent mental health of their children, as [**Lynne Murray’s work**](http://adc.bmj.com/content/77/2/99.full) and that of others has shown beyond all reasonable doubt.

There were many positive areas of focus, such as closing the treatment gap, making workplaces more ‘mental health friendly’, promoting early intervention and the mental health of children, and seeking parity of funding. However, one of the report’s recommendations stood out to me as a pillar of public mental health – encouraging a cross-governmental focus on the wider determinents of mental illness such as employment, housing, welfare and education.

Again, this is an issue firmly in our sphere – as Michael [**Marmot**](http://www.instituteofhealthequity.org/projects/fair-society-healthy-lives-the-marmot-review) has powerfully shown, inequality is a key determinant of both mental and physical illness. One of the reasons why many of us are uneasy (and if you think this is an example of British understatement, you might very well think so, but I couldn’t possibly comment) with the Health and Social Care Act is because so many of its provisions seemed designed to increase, not reduce, inequality.  Thus for example the proposal to remove GP practice boundaries in order to allow patients to choose their own GPs will actually widen inequalities under the mantra of ‘choice’ instead of reducing them - as I pointed out in the [**Guardian**](http://www.theguardian.com/commentisfree/2013/nov/19/any-gp-so-long-as-you-are-healthy) at the time.   Likewise, as we debate the ‘care.data’ mess, one of the reasons that I am personally strongly opposed to moving to ‘opt in’ is again because it will disadvantage the poor, ethnic minorities, the marginalised, and those with mental health problems.

A commitment to public mental health also means a commitment to evidence.  It is one thing to create a mass of correlations, vulnerability factors, predictors of outcome and so on, but it is much harder to know what to do about it.  Back in the Dark Ages when I was studying at the London School of Hygiene and Tropical Medicine, it was drummed into us that collecting evidence was at the heart of all public health, and a commitment to high standards was essential.  It is thankfully policy that no NHS screening programme can be introduced without evidence from high quality RCTs -  an excellent decision.

And we should insist on the same standards for public mental health interventions as well. If we look at the history of broad social interventions, and look for the best evidence, their impact on mental disorders is erratic. Take for example, the extraordinary decade long study [by Kessler](https://jama.jamanetwork.com/article.aspx?articleid=1835504) in which 4604 families were randomised and basically moved from a poverty stricken neighbourhood to one that was distinctly more salubrious.  Indeed, looking at the girls in the study, the results were good - less conduct disorder and less major depression.  Unfortunately the opposite was true for the boys – more PTSD, more depression and more conduct disorder.

At the same time public mental health is also being included in a wider social issue- the current debate loosely around what we might call the ‘wellbeing agenda’.  Few people, and probably no members of this College, can, or will, deny the importance of strong communities, families and relationships, to name but three, to our general sense of well-being.   But in my opinion we need to be a little more cautious about mixing public mental health with this ‘dash for happiness’ – and its various facets such as positive psychology, well-being and optimism.

There are several reasons for a more careful approach.  All of us want to be happy.  Whether or not this is the fundamental purpose of government is perhaps more contentious -  should government be more concerned with improving schools, creating jobs and reducing crime as an end in itself, rather than a step on the road to happiness?  I am not sure, although I am sure that there is a wide range of views on this - political, social, medical and probably even theological.

But as an academic psychiatrist with a major interest in population approaches, I am not yet convinced that this will do something significant about reducing the burden of morbidity that we deal with – for example disorders ranging from major depression, phobic disorders, OCD, autism, schizophrenia and so on and so forth.  The evidence for this is slender, and largely theoretical, extrapolating from Geoffrey Rose’s lectures when I was doing my epidemiology Masters at the London School of Hygiene rather a long time ago.  He would show how if you reduce the population mean of a particular parameter (for example blood pressure) you would shift the entire curve to the left – in other words reducing the mean also reduces those at the extreme.

So a general improvement in population happiness would hence reduce the numbers of those with severe disorders.  The problem is that there is precious little evidence for this.

Ideally we could do both.  Support what we traditionally do, and what our patients expect from us, whilst at the same time also lending our support to the broader agendas that are now being looked at by all three political parties.  Unfortunately as we all know “there is no more money”.   And my worry is that the money for the experimental interventions, which is what they are, will come from our own budgets.  I have noticed that is often the case – something that is new, buzzy, smart and promises much tends to be more attractive precisely because it is innovative, and will take resources from what is seen as “conventional”.

We need to put our weight behind the new Health and Wellbeing Boards, speak up for mental health (and I genuinely believe we will find a very receptive audience), but also make sure that there is no raiding of our already over stretched mental health budgets for this. That said, it’s fair to say (as the CentreForum report does) that you can come at this from the other direction i.e. that by treating their mental illness patients will inevitably become happier as their suffering is alleviated. And I certainly can’t argue with that.

So if we have to make choices, we should remain on the side of patients, carers and the evidence.  It’s a difficult balancing act, one that confronts all the three main political parties as they prepare their health manifestos. In the meantime, let’s pursue happiness, but equally let’s not expect that happiness alone will deal with the problem of mental disorder.

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