Commentary

Commentary: Mental health and public health

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Mental health looms large for those of us concerned with health of populations. As the paper by Steel et al. in this issue shows, based on 175 surveys across 63 countries, we can say that just under 30% of us will have a mental disorder at some time in our lives.¹ Questions have been raised as to whether we should think of this as an epidemic of mental illness, or an overactive psychiatric profession, and the extent to which it is driven by the availability and marketing of pharmaceutical remedies.² Even allowing for debates as to whether misery or distress should receive a medical diagnosis, this represents a great deal of human suffering.

Further, like so much else, mental disorder does not strike randomly, but with greater frequency the lower
people’s socioeconomic position. Concern, then, for public health, and for inequalities in health, require a focus on mental as well as physical ill-health.

Looking in the other direction, those concerned with mental illness should be concerned with public health, particularly if the wish is to prevent ill health, rather than wait for the suffering to occur and then treat. In the UK, the Royal College of Psychiatrists produced a wonderful report, *No Health Without Public Mental Health*, that brought together the evidence on what can be done to prevent mental illness and reduce the population burden. I should declare an interest here. *No Health Without Public Mental Health* (I’ll call it *PMH*) endorsed the recommendations of the Marmot Review, the review of social determinants and health inequalities that I led in England, and published as *Fair Society Healthy Lives*. PMH produced evidence that the six domains of recommendations that I put forward were all relevant to preventing mental illness: early child development, education and life-long learning, employment and working conditions, minimum income for healthy living, healthy and sustainable housing and communities, a social determinants approach to prevention.

This embrace of social determinants of mental health by psychiatrists, the Royal College no less, is a most welcome change. I served on the Acheson review of health inequalities in the 1990s. In response to specific questions, we were told that there was simply no evidence to support recommendations to prevent mental illness and reduce social inequalities. The only recourse was treatment. It is, indeed, important if there are inequalities in access to effective care that they should be remedied. But paying attention to inequalities in care should not be at the expense of addressing issues of prevention.

A good place to start is at the beginning. PMH, as did *Fair Society Healthy Lives*, placed great emphasis on early child development. I pointed above to the lifetime risk of mental illness as being just under 30%. Half of all lifetime diagnoses begin by age 14 years. It means that prevention is crucial. The greater the government spending on social protection—active labour market policies, unemployment benefits, health care—the more the link between unemployment and suicide is broken. Fiscal policy is health policy.

PMH also concludes that other risk factors for poor mental health in adulthood include lower income, debt, violence, stressful life events, inadequate housing and fuel poverty.

All of these were highlighted in *Fair Society Healthy Lives*. Fuel poverty and cold homes may occasion some surprise. But a review that the UCL Institute of Health Equity was commissioned to carry out, showed that there is evidence that growing up in a cold home has an adverse effect on children’s mental and social development. Short of outright abuse, there is good evidence from high-income countries that social and emotional development of children can be adversely affected by the caring environment. The perspective we have taken, building on the Commission on Social Determinants of Health, is to examine the influence on children of parents and other carers, and the context in which parenting takes place. Both parenting and the social influences on parents account for much of the social gradient in social and emotional difficulties of children. The paper in this issue by Baker-Henningham and colleagues shows that such findings extend to low- and middle-income countries. Consistent with looking at both parenting and parents, they show particular benefits for children’s mental health where there is emphasis on ‘child skills including cognition, language, self-regulation and social-emotional competence; training caregivers in the skills required to provide a cognitively stimulating and emotionally supportive environment; and attention to the caregivers’ mental health, motivation and self-efficacy’. There are also demonstrable benefits on parents’, or caregivers’, mental health.

Influences on mental health do not stop with early childhood. Unemployment is bad for mental health and is associated with increased risk of suicide. I have argued that a key consideration for economic policy should be the effect on mental health. There is little doubt that policies of austerity have had a disastrous effect on youth unemployment in Europe. Unemployment rates of 15–24-year-olds are 36% in Portugal, 41% in Italy, 58% in Spain and nearly 60% in Greece. Even allowing for some ‘informal’ employment that inflates these figures, the levels are shockingly high. And they have consequences. Comparisons across Europe show that the higher the rate of unemployment, the higher the suicide level. Government policies can mitigate these effects on suicide. The greater the government spending on social protection—active labour market policies, unemployment benefits, health care—the more the link between unemployment and suicide is broken. Fiscal policy is health policy.

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for the poor is a poor health service; an education sector for the poor represents poor education. For example, in Britain, most of the population have a stake in the National Health Service—a universal service. Were there a special health service for the poor, the middle classes would have less immediate interest in its being of high quality.

That said, people at high risk may indeed need special attention. Hence proportionate universalism—universal programmes and services with effort proportionate to need. Mental illness illustrates the need for proportionate universalism. The paper by van Zoonen and colleagues\textsuperscript{16} shows that targeted interventions in adults can reduce risk of depression. The interventions included interpersonal psychotherapy and cognitive behavioural therapy, both of which appear to be effective in reducing the incidence of depression. Presumably for people to undergo such interventions, they must have been considered at elevated risk. Such targeted interventions should be complementary to the kind of public health approaches touched on above.

There are further reasons to be concerned with mental illness: those with mental illness are disproportionately likely to smoke, to drink and to be at risk of physical disease. Tackling the population burden of mental illness is an important contributor to tackling other non-communicable diseases.

As in other areas of medicine it is easy to be imprecise: to speak of mental health when one means lack of mental illness. I will blithely talk of the health of populations and then go on to use life expectancy as a measure when, of course, life expectancy is simply calculated from mortality rates, and is hardly an indicator of health. Healthy life expectancy, or disability-free life expectancy, get closer. But these are not readily available for international comparisons. So, too, with mental illness. It is highly likely that someone with mental illness does not have positive mental health. But lack of mental illness is not the same as having positive mental health. There has been a welcome movement to bring mental illness in from the cold. We need to recognize quite how important mental health is for population health and to approach prevention and treatment with the same rigour and vigour that we apply to public health more generally.

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**References**


Commentary

Commentary: Improving the mental health and substance use estimates in the Global Burden of Disease study: strengthening the evidence base for public policy

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An understanding of the comparative impact of disease and injury requires the assessment of the mortality and morbidity attributable to each cause. To maximize their usefulness for policy, those causes need to be disaggregated and comprehensive, covering all major diseases and injuries likely to be of relevance for public health programmes and policies. Understanding their comparative importance, and adequately accounting for health loss from morbidity or disability, as well as mortality, requires a common metric such as the disability-adjusted life-year (DALY), a combination of years of life lost prematurely (YLL) and years lived with disability (YLD). DALYs have been widely used in Global Burden of Disease (GBD) studies to measure health loss in populations in a comparable fashion, across time, causes, geography and risk factors.

The first Global Burden of Disease study (GBD 1990) released in 1996 found that neuropsychiatric disorders (a grouping which included mental and substance use disorders as well dementia and other neurological disorders) accounted for more than one-quarter of all years lived with disability (YLD),1 even though some common disorders (e.g. cannabis dependence, generalized anxiety disorder, eating disorders, and most childhood-onset disorders) were not included. Moreover, the study estimated that mental and behavioural disorders accounted for more than 8.5% of the entire global burden of disease in 1990, taking into account both premature mortality and disability, dramatically highlighting in a way not previously shown, the public health impact of this group of relatively neglected disorders.

Global Burden of Disease 2010 study

In 2007, a new global burden of disease study (GBD 2010) was launched. This was a comprehensive re-analysis of burden for 291 causes, 20 age groups, for males and females separately, in 187 countries, across 21 world regions for 1990, 2005 and 2010. The principal findings of the GBD 2010 study suggest that global disease burden has continued to shift from communicable to non-communicable diseases, and from premature death to years lived with disability. The methodology and main findings of the GBD 2010 study have been extensively reported.2–8

In GBD 2010, neurological disorders (including dementia) were modelled separately from mental and substance