

## From the Editor's desk

By Kamaldeep Bhui

### Intelligent investment

Health and mental health are inextricably linked to the wealth of individuals and nations.<sup>1,2</sup> Globalised technologies can strengthen global population health, including mental health, through improving the quality of professional practice, standards of care, and community empowerment, but all need better investment decisions at a global, national and regional level.<sup>2–4</sup> A global recession, natural disasters, wars and conflict actively divert scarce resources and militate against effective investment. How do we nurture a healthy society when poor mental health due to poverty, conflict and work stress, and mental illness-related disabilities and premature mortality continue to flourish, and at the same time humane standards of care are not met?<sup>5,6</sup> Greater demands on services and escalating cost pressures in high- and middle-income countries, and attempts to improve basic coverage in low-income countries, produce multiple narratives of what action is necessary, and these narratives vary between practitioners, policy makers and governments.

To meet these challenges, innovations in service models are as important as new brands of professionalism, and both should be the subject of new research to refine existing interventions and help clinicians make better decisions.<sup>7,8</sup> New and cost-effective interventions that withstand the test of diverse local contexts and wealth are needed, and some are reported in this issue (see Kimberley Dean's Highlights (p. A7)).<sup>9</sup> The Chief Medical Officer's report<sup>10</sup> highlighted the need for intelligent investment given that only 75% of people meeting criteria for a mental disorder diagnosis received any intervention. The World Health Organization 2011 report shows that two-thirds of people with schizophrenia around the world do not receive treatment, although this proportion is larger in lower-income countries.<sup>11</sup> There is a drive to treat more, to create more capacity and of course this will cost more. This narrative is often at odds with alternative views that there is an over-medicalisation of distress, and self-coping and resiliency should be fostered. The globalisation of mental healthcare, driven by high-income countries alone, may risk the international export of inappropriate classifications of disability, mental illness and pharmacotherapies that are more suited to higher-income contexts.<sup>12</sup> There is also some disquiet that we risk treating the 'worried well', or people who do not need specialised mental healthcare, but rather what is needed is a healthier and protective society and professionals who understand local contexts and constructions of distress, and address population mental health by harnessing local beliefs, coping practices, psychosocial social assets and promoting resiliency.<sup>13,14</sup> A survey of 62 305 adults in 23 countries that measured DSM-IV disorders and treatment in the past 12 months suggests that excessive treatment is not as big an issue as under-treatment: 70% of people receiving treatment had a diagnosable 'current or lifetime' mental disorder and 18% had other areas of need, leaving 12% with no clear indication for treatment (see Buffaerts *et al*, pp. 101–109).

In addressing the treatment gap in the UK, we face the same challenges as lower- and middle-income countries and other high-income countries, and we share the need to integrate health and social care, and to better harmonise preventive population-based approaches with more specialist health programmes. This might be best achieved by strengthening the primary care sector with a new cadre of specialist expertise to offer rapid intervention

of high quality, rather than an excessively complex stepped-care model that protects specialist resources but may prevent early intervention and the integration of provision in population-based systems of mental healthcare. The integration of specialist services for both mental and physical disorders, given the co-dependent aetiologies, natural histories and consequences, may be better delivered through specialist care that is organisationally more closely aligned with, if not delivered through, population-based and primary care agencies. Public mental healthcare is already delivered by local government; an unfortunate consequence is that there is less specialist expertise, meaning that the most effective interventions across the biopsychosocial spectrum are not commissioned on the basis of evidence, and that population needs assessments are not cognisant of mental illness and its origins in our biology, culture and the environment (see [http://www.rcpsych.ac.uk/pdf/Bridging\\_the\\_gap\\_summary.pdf](http://www.rcpsych.ac.uk/pdf/Bridging_the_gap_summary.pdf)). As a society, we are still seeing mental illnesses (addictions or common mental disorders) as uniquely socially derived phenomena for action by local government or for self-management, more severe disorders (schizophrenia) for action by mental illness specialists, and premature mortality associated with, for example, schizophrenia as the remit of physicians or interested GPs. Pomarol-Clotet *et al* (pp. 136–144), Walker *et al* (pp. 145–152) and Beck *et al* (pp. 164–165) show the importance of basic scientific clinical research on universal biological substrates of healthy life, cognition and higher functions. Might the findings from these studies inform the development of interventions irrespective of country contexts and culture? At the same time, we dare not ignore contexts and culture. Not only the culture of the patient, but the culture of professional practice and systems of thinking, our cultures of care, and the culture of political action; each is responsible for failures in healthcare.<sup>15</sup>

Martin McShane, NHS England's Director for Long Term Conditions, asserted that parity of esteem means: (a) tackling mental health issues with the same energy and priority as we have tackled physical illness; (b) changing the experience for people who require help with mental health problems; and (c) putting funding, commissioning and training on a par with physical health services (<http://www.england.nhs.uk/2014/05/16/martin-mcshane-8/>). Can this really be achieved without investment? There is some recognition that to achieve parity of esteem principles, in reality, intelligent investment of the order of £500 million a year for at least 10 years is necessary. More importantly we need a new workforce of professionals and a professional training and governance framework that assures the public of competent and confident people working across organisational and professional boundaries, in a confident and competent system of care that enables professionals to achieve the best for patients and the population through a balance of preventive and treatment interventions. These fundamental principles are not so different in high-, middle- and low-income countries, but the level of commitment and resource allocation does create debate about the philosophies of what constitutes healthcare and preventive interventions. These debates raise two critical questions.

First, should specialist models of care and treatment be used to inform population approaches if they are ill-fitting to population and low-income contexts?<sup>16</sup> Specialist models are essential as part of an overall picture and should not be ignored, especially when the evidence base is largely in the specialist realm, but mental health specialists, practitioners and researchers must expand their remit to population paradigms of wellness and illness. Appropriate training and skills are needed, alongside appropriate frameworks for diagnosis and intervention.

Second, to what extent should we intervene in social conditions versus the individual agency and athleticism of the

person to better manage their illness? Or put another way, should we take an Epicurean or Athenian position on preventive, treatment and recovery-oriented interventions?<sup>17</sup>

Evidence-based investment is essential for all contexts and wealth conditions irrespective of philosophies of care. High-income countries, and the UK specifically, continue to see positive investments in mental healthcare (<http://www.england.nhs.uk/2014/10/08/120million-mh/>), and long may intelligent and evidenced-based investment continue (see [http://www.esrc.ac.uk/\\_images/ESRC\\_Evidence\\_Briefing\\_Mental\\_health\\_NHS\\_tcm8-26241.pdf](http://www.esrc.ac.uk/_images/ESRC_Evidence_Briefing_Mental_health_NHS_tcm8-26241.pdf)). Low-income countries surely need just as much if not more investment from their own governments and from the global economy to which all nations contribute.<sup>18</sup> It is in the context of diverse philosophies and cultures of care and wealth conditions that more nuanced evidence is needed to test psychiatric interventions.

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