Mental Health 2.0

Mental Health Foundation of New Zealand, 2015

The time is right to transform the way we understand mental health in our communities. Instead of talking about it as a liability that just keeps getting bigger, we need to engage with the positive side of mental health as a way of decreasing risks of developing common mental health problems. The outcomes of more positive and optimal mental health include better social relationships, higher workplace productivity, increased happiness, better physical health, as well as reduced levels of common mental illnesses such as depression, anxiety and addictions. Positive mental health is best increased at a population wide level rather than through expensive individual therapeutic approaches. A huge increase in wellbeing science over the last 10 years shows us the way forward. All we have to do now is act to create the societal will, attitudes and activities to improve our mental health.

Over the last 100 years New Zealand has overall, along with many other countries, experienced large increases in material wealth; social progress; increased life expectancy; advances in technology, levels of physical comfort, personal safety and convenience (Rosling, 2006). There are of course problems in this materially positive picture, with the benefits being shared unequally, particularly for indigenous people and also cultural and ethnic minorities remaining relatively disadvantaged but for most, compared with the lives of our great, great grandparents, we have riches, luxuries, convenience technologies and civic social protections which they could only dream of.

The Organisation for Economic Co-operation and Development's (OECD) Better Life Index (2014) puts New Zealand in the top cluster of countries that are doing very well across a range of social and material indicators. We also score 4th out of 162 countries in the Global Peace Index (Institute for Economics and Peace, 2014), lowest of any country in perceived corruption (Transparency International, 2013), and 7th in The Global Gender Gap Index (World Economic Forum, 2013).

In addition to this, countries like New Zealand, Australia, UK and Canada have seen huge increases in mental illness treatment funding (in New Zealand it has increased over 400% in the last 20 years (Ministry of Health, 2012)), improvements in service philosophies such as involving consumer advocates and a recovery approach, better use of evidence-based therapies and less coercive settings. It's also now more acceptable to talk about mental illness thanks to initiatives such as www.depression.org.nz which is part of the Ministry of Health's National Depression Initiative, and Like Minds Like Mine, www.likeminds.org.nz.

Yet despite this, according to recent national surveys, experience of psychological distress remains high, and our psychological wellbeing is lacklustre (Human Potential Centre, 2013). The 2013 New Zealand Disability Survey estimates 5% of New Zealanders are 'living with long-term limitations in their daily activities as a result of the effects of psychological and/or psychiatric impairments' (Statistics New Zealand, 2014). However the New Zealand Mental Health Survey Te Rau Hinengaro (Oakley-Browne, Wells & Scott (Eds.), 2006) suggests 47% of people will experience a common mental illness in their lifetime related to depression, anxiety or substance addiction. More recently the NZ Health Survey (Ministry of Health, 2013) reported that almost 6% of New Zealanders had experienced high or very high levels of psychological distress in the four weeks preceding that survey. New Zealand also saw a steady increase in antidepressant use with 427,900 people

prescribed anti-depressant medication in 2013, an increase from 348,200 in 2008. (Pharmac, 2014). This paradox between increasing material, social progress and mental health service delivery, and apparently static or declining mental health, is repeated across the world's wealthy nations – and similar trends may be emerging among developing nations (Helliwell, Layard & Sachs (Eds.), 2013). Some medical academics and mental health advocacy agencies have described mental illness at epidemic numbers in Western Countries (Mulder, 2008) and others are talking of entering an 'age of melancholy' (Joyce, Oakley-Browne, Wells, Bushnell, & Hornblow, 1990). Depression is seen by the World Health Organisation (2012) as a hidden burden and a leading cause of disability worldwide. In a large study of 10 wealthy nations, New Zealand was shown to have some of the highest rates of depression (Bromet et al.,2011).

Surely with the increasing and high levels of material and social wellbeing being reflected in the international data, and improvements in the quality of mental health services, our mental health should be improving in similar measure? A possibility to explain this paradox is the competing mental health drivers at play in our society. Much of our social and material progress will have a positive effect on mental health, and build protective and institutional improvements in our wellbeing. However many of the ways we are living in the modern/postmodern world, shifting socio-economic relationships, how we interpret and make sense of our lives and interact with others, and increasing job demands may be hindering our wellbeing, primarily by increasing stress levels. It is a bit like driving a car with a foot each on the brake (trends that erode our mental health) and the accelerator (trends that boost our mental health), with a net effect of minimal forward motion.

To make progress in maximising the processes and relationships that increase mental wellbeing, and minimising those that decrease it, we propose that we need to transform our general approach to mental health as a society – *mental health 2.0*. Despite mental health being in large part a social phenomenon particularly in relation to common mental illnesses such as depression and anxiety (Horwitz & Wakefield, 2012) , we largely respond to it through our health and social support systems only as an individual experience, with solutions to problems lying within a one to one treatment paradigm, mediated between patient and professional. It is time for a much more social and population wide level response to improving mental health as well. Much of this could be done at low cost by using existing social capital, linking with broader social policy and riding the new wave of social entrepreneurship. The recently-developed Perth Mental Health Promotion Charter (Anwar McHenry & Donovan, 2013) provides a useful framework to view mental health as a public-health and whole-population issue as much as a personal-health agenda.

Another widespread and unhelpful understanding of mental health is that it is overwhelmingly negative. So pervasively is the term *mental health* used as a euphemism for mental illness, (e.g. (somebody) has *mental health issues*) it is difficult to comprehend mental health as the positive and essential resource that it is, our ultimate experience for everyday living, good relationships and general wellbeing. An example of the negative bias towards understanding mental health is within the otherwise promising moves in workplaces to put mental health on the agenda as a key human resource issue to be managed. Almost universally the emphasis on mental health at work is as a liability to be reduced rather than a positive resource to be realised, so that mental health becomes a reactive responsibility in the occupational health and safety realm, rather than a positive resource to protect and build. An evidence-based and holistic approach to mental health will of course be dealing with poor mental health in the workplace, but also putting equal effort into preventative measures and creating environments where people can flourish psychologically. Research has firmly established that good mental health is not merely the absence of mental illness, and that increasing

positive mental health is one of the more effective ways to reduce mental illness (Keyes, Dhingra & Simoes, 2010).

There is growing interest and application worldwide in the science of wellbeing and increasing developments in how it can be measured and become public agenda for governments (Helliwell, Layard & Sachs (Eds.), 2013). There is little progress however in making a connection between subjective wellbeing and good mental health. This is despite these two terms referring largely to the same psychological state. We have almost separate universes for policy and science relating to mental healthiness on the one hand, and mental illness on the other. We are therefore missing the opportunity for the potential of increases in mental wellbeing to be a powerful force in reducing the prevalence of common mental illness.

Drawing on public health epidemiological studies, it has been proposed (Huppert, 2009) that a focus on mental health at a population level can affect individual mental health, i.e. the mental health of all of us affects the mental health of each of us. It has been demonstrated through longitudinal studies (Christakis & Fowler, 2009) that behavioural and emotional aspects of health are contagious, even among the so called non-communicable diseases such as depression. As common mental health problems have both behavioural and emotional elements to them this is a significant understanding in how to improve overall mental health in our population. It provides a strong case for promoting psychological wellbeing across the entire population (resilience, emotional literacy and awareness) and not just focussing on psychological problems in individuals. Promoting mental wellbeing as a collective strategy rather than each individual being left to work it out for themselves may be more effective. For instance a dogged individualistic search for increased personally focussed happiness, divorced from empathy for others, can actually result in reduced wellbeing (Ford & Mauss, 2014). Pro-social approaches like giving and volunteering on the other hand are shown to increase psychological wellbeing (Marsh & Suttie, 2010).

Another perspective within a population-wide approach to mental health is that while some people have mental illness at one end of the spectrum and other people are flourishing at the other and enjoying optimal mental health, most of us have moderate mental health. Those with middling mental health are neither flourishing or meeting the criteria for mental illness (Huppert, 2009; Keyes et al, 2010). This group will experience some symptoms of the common mental illnesses from time to time or at an ongoing low level, but not enough to meet the diagnostic criteria for a disorder (Mulder, 2008). Focussing on this group to increase evidence-based behaviours and habits that increase wellbeing will both provide a benefit of greater wellbeing and reduce the risk of individuals in this group sliding into the mental illness category. *Mental health 2.0* is about moving the whole population towards greater mental health – including those with mental illness and not excluding those who are already doing quite well, or those who might be struggling somewhat but are not mentally ill. In other words, most of us will benefit personally from improved mental health.

Recent research suggests that thinking styles have a large part to play in the causes of common mental illness. While people's biological makeup and negative life events can also contribute, a very large study in the UK (Kinderman, Schwannauer, Pontin, Tai & Laks, 2013) suggests negative thinking, such as self blame and unrealistically negative appraisals of life, is the major cause. Unhelpful and negative thinking styles can however be unlearned – as demonstrated by the evidence showing effectiveness of cognitive based therapies (Hofmann, Asnaani, Vonk, Sawyer & Fang, 2012) now available through low cost methods including on-line mediums or mindfulness practices (L'Abate, 2007). Cognitive behavioural therapies show some of the best results for any treatments for common mental disorders (Layard & Clark, 2014).

Numerous studies from behavioural economics and social psychology show that our thinking is not always aligned with good factual appraisals of our life situation that might be in our best long-term interest (Ariely, 2008; Kahneman, 2011; Gilbert, 2007; Dweck, 2006). In simple terms, our brains have developed so that we have two, often competing, ways of viewing the world, one being immediate and relying on very limited data, but finely-honed emotional, intuitive and 'survival' based responses, the second being a more considered and rational appraisal. Another aspect of thinking is that we are notoriously bad at assessing our medium and long term prospects and making the best decisions to reach them. In short, we are often overoptimistic about our longer term prospects, the optimism bias (Sharot, 2011), and overly pessimistic about our immediate ones, the negativity bias (Baumeister, Bratslavsky, Finkenauer & Vohs, 2001).

The implications of this new science on human thought and behaviour for our psychological wellbeing in a modern, advanced economy are that while our physical threats and violence have massively reduced overall since early human history (Pinker, 2012) social and imagined threats have potentially increased through much wider and shallower social networks and pervasive 24 hour graphic depiction of wars, disasters and crime through online media. A number of social forces may be at play that are increasing social opportunities through technology but also social threats simultaneously.

In addition real physical threats in New Zealand do continue to exist at unacceptably high levels from domestic and sexual violence, and child abuse.

Real psychological abuse as well as imagined social threats sensationalised through the media may also be reducing our overall wellbeing.

The old adage 'sticks and stones will break my bones but names will never hurt me' has been overturned with the field of neuroscience showing that the experience of social pain creates similar responses in the brain to physical pain (Lieberman, 2013). Social and emotional pain are key drivers of the causes common mental illnesses and suicide.

Although negative emotions such as fear, anger, disgust and embarrassment are necessary and helpful for everyday living, if we have too many negative emotions in relation to our positive emotions, this can start to erode our mental health (Fredrickson, 2009).

A key threat to our mental wellbeing is too much psychological stress. Although there is limited data in New Zealand, countries which have similar lifestyles to ours are experiencing steady increases in stress (Mental Health Foundation UK, 2012; Australian Psychological Society, 201;, American Psychological Society, 2014). Chronic stress undermines positive mental health and is a risk factor for developing mental illness as well as physical illness (Benson, 2008) [i] This includes workplace stress (Melchior et al, 2007).

There are a number of trends in our current lifestyles and social relationships that could be related to a negative effect on our collective mental health, by increasing anxiety, stress and helplessness, and increasing risk factors for common diagnosable mental disorders including depression, anxiety and addictions. These include:

- Loneliness - potentially an increasing risk in western individualistic societies (Griffin, 2010)
- Increasing debt levels (StepChange Debt Charity, 2014)
- Increasingly unrealistic expectations (created in a hyper-consumerist economy) about what we need to live a good life
- Dislocation from the natural (non-human modified) environment (Suter-Brown, 2014)

- Increasing levels of narcissism in Western culture (Twenge & Campbell, 2009)
- Reduced sleep (Robotham, Chakkalackal & Cyhlarova, 2011)
- Increased sedentary lifestyles; only around half of New Zealand adults are physically active (Mason, et al., 2012)
- Domestic and sexual violence (World Health Organisation, 2012; New Zealand Family Violence Clearinghouse, 2014)
- Children getting a poor start in life (World Health Organisation, 2012)
- Workplace stress from constant change and resulting social threats (Melchior et al, 2007)

With such an apparently dynamic mental health landscape, it is important that everyone needs to be more engaged in thinking about the importance of mental health. We can't take it for granted. There is still much to be done to improve and change the culture of health services for those who need them for their mental health. This topic requires a separate paper, but there is also social policy that can be changed, and there are simple things we can do individually and in groups and whole communities that will increase overall wellbeing and thereby build emotional literacy and psychological resilience, and counteract some of the threats to our wellbeing.

What we need is a wide range of influential champions in our communities, far wider than just health service representatives, that call for better mental health and a push to make it our personal and collective responsibility.

Key areas of intervention in society that evidence suggests would increase mental health across the whole population include:

- Ensuring children get a good start in life
- Supporting communities to be strong and have a level of self determination
- Reduce physical and psychological abuse – particularly towards women and children
- Valuing and promoting diversity of world views, and universal human principles on what it means to be mentally healthy
- Widespread education on how thinking styles can affect mental health, and better mastery over our cognitive processes and self knowledge
- Raising awareness of the health and social damage caused by chronic stress
- Valuing mental health as a key workplace issue
- Socialising evidence-based group and individual wellbeing activities
- Removing the shame and stigma that is associated with experiencing a mental health problem

The Mental Health Foundation of New Zealand takes the following approach to providing leadership in improving mental health at population-wide level:

- We support and argue for social policy that reduces child poverty, reduces domestic and family violence, strengthens families and communities, and reduces social inequalities
- We support and promote efforts to ensure that Māori have at least equitable health outcomes compared with the whole population, and that Māori values relating to *hinengaro* (emotional health) pervade our social and health institutions
- We promote and organise projects, programmes and events that socialise messages and habits leading to mental wellbeing, and better understanding of mental health and where to get help for problems

- As we are relatively small organisation (approximately 30FTE), we tend to work collaboratively and in partnership with organisations to increase efficiency and effectiveness by extending the range of our work.

We do this through government funding for mental health promotion and prevention work, funding agreements with organisations such as the Movember Foundation, and other philanthropic funding and donations. We currently have over 20 workstreams and projects that practically promote better mental wellbeing and these are listed at Appendix 1 (not yet attached).

We think there is a call to action to move beyond talking about the large numbers of people experiencing common mental health problems, and thinking that our only response is more treatment services for this seemingly growing problem. The WHO recognises that 'a number of mental disorders can be prevented and that mental health can be promoted in the health sector and in sectors outside health'. (World Health Organisation, 2012). We believe that we now need a target for reducing mental illness at population-wide level. Common mental illnesses, although they will always be with us, are also preventable through a combination of lifestyle changes, thinking techniques and social policy changes.

Because of the high levels of personal suffering, social and economic damage caused by high rates of mental illness, and low rates of optimal wellbeing, it is surprising that there is no government-led national target to reduce common preventable mental illnesses and increase levels of wellbeing. We therefore propose exploring such a target. Whatever it ends up being, we will need our best creative minds and social innovators on the job to reach this target.

To circumvent problems relating to under-diagnosis of common mental illnesses in the New Zealand population, a relevant target for reduction in mental illness would be aiming for a decrease in high or very high levels of psychological distress as measured bi-annually in the National Health Survey. According to the survey this measure is closely associated with having a diagnosable anxiety or depressive illness. (Ministry of Health, 2013).

A target for increases in wellbeing could be derived from subjective wellbeing indicators now being measured on a regular basis in the New Zealand Household Social Survey and the Sovereign Wellbeing Index – both bi-annual surveys.

Conclusion

There are a number of positive and negative drivers affecting our mental health at a population-wide level. Reducing the negative and reinforcing the positive social trends that affect everyone's mental health is likely to result in a reduction in common mental health problems, but also increase the resource of positive mental health, which in turn will lead to better social and economic outcomes.

Good mental health is our greatest resource in individuals and across communities. We can't take it for granted. Good mental health needs a range of social conditions and personal resources in order to flourish. While there are many new social trends, technologies and economic advances working in favour of mental health and wellbeing; a number of these also have potential unintended negative side effects on mental health. Greater awareness, research about mental health, and how to maximise and protect it throughout life is needed.

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