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# Public discourse on mental health: a critical view

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Mental health has received much-needed public interest in recent years through public, private/corporate, philanthropic, and professional organizations, usually in the form of public awareness campaigns sponsored by mental health organizations (e.g., Mind; Canadian Mental Health Association), corporations (e.g., Bell Let's Talk), and health care institutions (e.g., Centre for Addiction and Mental Health), and often involving celebrity spokespeople. Presumably, the purpose of these activities is to improve public mental health literacy; to reduce stigma associated with mental illness; and to encourage people to strive for good mental health and well-being, and seek help for mental distress. The increasing rates of mental health problems, with claims of a catastrophic rise associated with presumed effects of the COVID-19 pandemic, have been used to amplify the need to pay attention to mental health. This is implicitly accompanied by well-founded observations that mental health services are inadequate, with access often being severely delayed in most jurisdictions. It is anticipated that such public discourse will encourage greater public spending on mental health and improve services for those in need.

This discourse on mental health, while timely and generally positive, is incomplete. It does not operate with a clear distinction between good mental health, including adjustment to mental distress associated with the many profound challenges people face, and the rather different category of "mental illness" or "mental disorders," especially serious mental illnesses such as major depressive, eating, or psychotic disorders, that require adequate and timely professional care. In addition, there is no discussion about the general failure to improve the poor clinical, social, and work outcomes and the appalling social conditions and quality of life endured by people living with these disorders. The market approach used in the public discourse on mental health may not only be ineffective, but also may lead to unintended negative consequences. We focus on 3 in particular. First, as a consequence of labelling all forms of mental distress as problems of "mental health" and therefore requiring care, public resources for major mental illnesses may be significantly reduced. Second, the mental health profession has neither the resources nor the expertise to address all forms of mental distress. Third, when we make all distress a matter of mental health, we absolve other institutions —

governments in particular — from committing the resources required to alleviate the profound distress associated with many forms of social deprivation. A deeper examination is needed to make the discourse on mental health more meaningful to improve the lives of citizens who suffer from mental illness, while at the same time ensuring promotion and protection of the population's mental well-being. We argue that both generic mental distress and mental illness require serious attention, but that the field of psychiatry cannot be solely responsible for alleviating all of it. Blurring the distinction between mental distress and mental disorder renders all human suffering a form of illness to be treated by clinicians. A great deal of human suffering, however, is often a normal or healthy response to social conditions that can only be addressed by the state and society as a whole.

In this editorial, we identify a few key issues that must be addressed to achieve the desired objectives regarding mental illness, mental well-being, and general distress. First, we examine the meaning of terms used in relation to mental health. For example, does "mental health" in the current discourse include mental illnesses or mental disorders, and if so, are the needs of those with serious mental illness being adequately addressed? Or does the term "mental health" refer only to achieving and maintaining a good sense of well-being? Or is it both? Next, we examine changes in rates of mental health problems in the context of varying definitions, how real and how large such increases are, how society and health systems should respond to such changes, and what implications this has for service delivery for people with varying severity of mental disorders. Finally, we examine the broader implications of the ever-changing boundaries of the definitions of mental health and mental illness for culture and society. We conclude with some recommendations that would help to address the key challenges faced by the field.

## What is meant by mental health, mental illness, and mental disorder, and how does that affect the discourse on increasing rates?

To accurately assess reports of an apparent increase in mental health symptoms and problems, we have to account for how

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much of this is an increase in rates of illness and how much is a general stress response, such as that associated with the pandemic.

Understanding the concepts of disease, illness, and health is a central aim of the philosophy of medicine. According to the standard view, disease is thought to presume the existence of a physiological process of some kind,<sup>1-3</sup> whereas illness tends to refer to the experience associated with disease, such as being in a state of pain.<sup>4</sup> Nonetheless, the concept of disease is contentious because it is not exhausted by empirical judgments about bodily changes; it also depends on value judgments.<sup>5</sup> For example, someone whose memory improved as a result of traumatic brain injury<sup>6</sup> would not be thought to have a disease, despite the presence of a pathological change in brain physiology, because their state was not detrimental to themselves or others.

In contrast to the concept of disease, less attention has been paid to understanding the concept of health. According to the Constitution of the World Health Organization (WHO), health is a state of complete physical, mental, and social well-being, not merely the absence of disease or infirmity.<sup>7</sup> This capacious definition raises a number of questions, not least because the term “well-being” seems less clear than the concept it is supposed to be characterizing. More importantly, according to the WHO definition, everything from physical mobility to meaningful work and decent housing are — somewhat counterintuitively — components of health. Indeed, this conception of health seems to include components that belong to many other categories of human life, including economic, educational, social, and spiritual components. These are not problems to be solved by biomedical research, clinical psychiatry, or psychology. A person without friends may not be living the good life, but that problem does not seem best addressed by a health professional. However we define health, it cannot include everything that might be relevant to living a good life. If health is everything that contributes to a good life, we lose our grip on the concept of health altogether, and an investigation of health and health policy that abolishes the concept it is trying to understand has gone wrong somewhere. In short, illness and well-being are not the opposing ends of a single continuum. They are different, albeit overlapping, concepts.

The concepts of mental illness and mental health raise these issues in a particularly acute way. The WHO definition of mental health emphasizes it is “a state of well-being... a basic human right and crucial to personal, community and socio-economic development.” It also distinguishes it as a state of health and “not mere absence of mental disorder.” The WHO posits that mental health conditions include mental disorders and psychosocial disabilities. While avoiding the use of the word “illness,” the definition clearly distinguishes a state of health and well-being (mental health) in relation to mental abilities and the need for this state to be preserved, as distinct from mental disorders, which require direct intervention. Many other national and regional organizations, such as Mind in the UK and the Canadian Mental Health Association, treat mental health and mental illness as 2 aspects of a single topic.

We do not, of course, want to deny that many features of well-being contribute to illness and health. For example, there is considerable evidence that homelessness is associated with poor physical and mental health,<sup>8-10</sup> and it would be acceptable — indeed, progressive — for a government to provide social housing as a health measure. What we claim, however, is that housing is a good for people beyond it being a contributor to health, and making housing in general a component of health obscures that distinction. When it is the burden of a health system to provide all of the human goods, we are asking more of it than it can possibly deliver, and we are losing sight of the fact that there are many components of well-being that are the responsibility of our society.

In the absence of a definitive understanding of the biological processes that underpin mental illness, unlike physical illness, we cannot rely on physiologic or anatomic pathology to distinguish health from disease; hence it is that much more tempting to think of severe mental illness and perfect mental health as ends of a continuum. Indeed, psychiatry contributes to this thinking in holding as a general theoretical principle that psychiatric symptoms are on a continuum in the population, with more frequent, severe, or distressing symptoms associated with a clinical diagnosis.<sup>11</sup> Nonetheless, we do not believe that mental health or well-being should be thought of as the opposite of mental illness; rather, it is a separate, albeit overlapping, construct. Mental illness should be restricted to states identified by our diagnostic categories, which take into consideration the severity of symptoms, resulting dysfunction, and need for care, notwithstanding problems associated with the diagnostic system. In contrast, mental health or well-being should refer to satisfaction of the wide range of human needs, at least some of which are required for a human being to flourish — safety, autonomy, respect, meaningful work, creativity, friendship, and family. Included among these, of course, is the value of not suffering from mental illness. The latter, but not the others, is the specific responsibility of the field of psychiatry and the mental health system.

### Are rates of mental illness increasing?

Alarm has been raised at the high rate of poor mental health or mental health problems in recent years. In 2017, the British newspaper *Independent* reported that two-thirds of British adults have experienced a mental health problem such as anxiety or depression and that only one-fifth were experiencing high levels of positive mental health based on a survey conducted by the Mental Health Foundation.<sup>12</sup> Similar reports of high rates of mental health problems with an even greater recent increase have been presented in different media in many other western countries without clarifying any differences between the population’s status of mental well-being and rates of mental disorders or mental illness.<sup>13-16</sup>

Academic studies have produced a more ambiguous picture. A study using instruments designed to screen for mental disorders have reported 2- to 3-fold increases in recent years (2017–2020, including the beginning of the pandemic) in symptoms of current mental disorder (anxiety, depression,

and suicidal thoughts) in adults.<sup>17</sup> Another study analyzing trends in lifetime rates of nonsuicidal self-harm among people older than 16 years in England reported a 3-fold increase in rates over a longer period (2000–2014), predating the pandemic.<sup>18</sup> A review of trends in child and adolescent mental health has also reported an increase in diagnosis and treatment of most mental health problems over several decades.<sup>19</sup> The recent increase in rates of suicide among American and British youth is of particular concern.<sup>20</sup> On the other hand, a systematic review and meta-analysis of prevalence studies ( $n = 44$ ) of adults with mental illness (using *International Classification of Diseases* [ICD] or *Diagnostic and Statistical Manual of Mental Disorders* [DSM] diagnoses, symptom scales, and/or distress scales) reported a relatively smaller increase of 18% (95% confidence interval 6%–30%) between 1978 and 2015.<sup>21</sup> A more recent epidemiological study using longitudinal data from a national sample in the Netherlands has reported an increase of 9% in 1-year prevalence of common mental disorders (depression and anxiety disorders) over a period of 12–15 years, with no increase attributable to the COVID-19 pandemic.<sup>22</sup>

While such reported increases precede the pandemic, media reports during the pandemic communicated alarming increases in rates of mental health problems. Such a large increase in rates has been supported by a recent study<sup>23</sup> while more modest increases (9%–10%) in clinically significant psychological distress from prepandemic levels to the first few months of the pandemic period have been reported by others.<sup>24,25</sup> Other longitudinal studies comparing rates from the beginning of the pandemic (and the resulting lockdown) to a few months into the pandemic, have generally showed initially high rates of both mental distress and of mental health disorders (anxiety and depression, primarily), which decreased over time or remained the same.<sup>26–30</sup>

Two recent studies examining the effect of the pandemic on rates of mental health problems in the population have clarified the earlier reports of alarming increases. An online survey of a representative UK cohort of more than 2000 adults, followed from the first month of the pandemic in 2020, reported no significant increase in overall rates of anxiety and depression.<sup>31</sup> Additionally, a large systematic review and meta-analysis of 137 studies comparing data on general mental health, anxiety, and depression symptoms from a year before and during the COVID-19 pandemic found no change in general mental health or anxiety symptoms and only a minimal increase in depression symptoms.<sup>32</sup> Both of these studies reported changes confined mostly to specific populations (e.g., women, parents with children, older adults) and even significant improvement in symptoms of people with pre-existing mental conditions.

While there is considerable variation in the reports of the extent to which rates of mental disorders have increased both before and during the pandemic, the evidence points to a modest increase in rates of mental disorders over several decades, confined mostly to the so-called common disorders (anxiety and depression) and predating the pandemic. Precision in assessing true rates of mental illness is indeed important for preparing an adequate and appropriate response from

society and its systems of care. Equally important may be the transmission of such precise information to the public through the media they consume.

There may be several reasons for the reported increase in rates of mental health problems and for the discrepancy in findings across studies and surveys. The larger increases reported by several studies, not confirmed by more rigorously conducted studies, are very likely related to what is being measured and what measures are used. Most studies that provide high estimates of prevalence report on population-level means for symptoms, psychological distress, or status of mental health, and/or use screening instruments that are not designed to determine prevalence of different disorders for which a definition of a case (e.g., diagnosis, need for care) is required. Differences in sampling strategies (such as using convenience v. purposive samples) further complicate the interpretation of the results from these studies.

## Separating mental health and mental illness

There are 2 major ways through which distinguishing mental health and well-being from mental illness or disorders will ensure that the needs and suffering of those with mental illness, especially in its more severe forms, are not ignored while mental health and well-being are promoted and protected at the population level: ensuring adequate and appropriate interventions, and improving precision for diagnostic categories.

### *Adequate and appropriate interventions*

Differentiating what is needed for maintaining good mental health, reducing risk of mental illness, and caring for those with mental illness are important to ensure that finite resources are used for their intended purposes.

Good mental health is likely to require the absence of a mental illness, and individuals experiencing a sense of well-being are also likely to have minimal or no risk factors (e.g., family history of mental illness or addictions, history of personal trauma, living in deprived social and economic environments). While the absence of risk factors reduces the risk of developing a mental illness, it does not eliminate the risk. Beyond the absence of mental illness, good mental health is likely to require certain social and environmental conditions to prevail and interventions to address social determinants of mental illness to be available. At a societal level, these conditions include economic and cultural equity, safe and green space, adequate and stable housing, opportunities for employment and education, adequate civic engagement, and social inclusion. At an individual level, these conditions include health-promoting activities such as exercise, a healthy diet, productive work, and meaningful social and personal relationships. These conditions and activities form a large part of a primary prevention strategy for reducing the risk of mental illness. However, given the nature of these interventions, they are not feasible to be delivered by a mental health care system alone, which should be tasked primarily with providing high-quality service. Instead, they require multiple levels of social, political, and civic involvement. These cannot be squeezed

out of the limited budgets available to provide mental health services, and must be funded and operated separately at both national and local levels.

For those who carry or are exposed to some risk factors, especially those with emerging symptoms of mental illness of any severity, additional interventions should include improved mental health literacy, and rapid access to services for early identification of emerging symptoms, ranging from anxiety and depression of mild to moderate severity to less common but more severe symptoms such as obsessive–compulsive thoughts and behaviour and psychotic-like experiences.<sup>33,34</sup> The recent concept of staging of mental disorders<sup>35–38</sup> has provided an encouraging line of inquiry and may guide us to design methods to match interventions appropriate for these early stages in the course of development of mental disorders, although such a framework still lacks any empirical data to support it. The important task of distinguishing distress related to an emerging mental disorder from distress that is either situational (e.g., upcoming examination, breakup of a relationship) or related to broader problems (e.g., concerns about the environment, social justice) needs to be addressed by supporting a system of enhanced primary mental health care, as has been established in some jurisdictions for youth (age 12–25 yr).<sup>39–41</sup> Research conducted within these new models of care can also assist in identifying new methods of establishing “caseness” of a presenting problem as an alternative to classification systems such as the *DSM*. This aspect of targeted/secondary prevention requires additional resources within the mental health system as well as participation of and coordination with other systems, both public and private (e.g., education, employment, legal).

Most importantly, those experiencing symptoms of a mental illness that is severe and extensive enough to meet the threshold for a disorder (e.g., anxiety, depressive, obsessive–compulsive, eating, bipolar, mood, and psychotic disorders), either for the first time or with an established history, require specific and timely psychiatric treatment and evidence-based psychosocial interventions within a system that can also address their multiple needs (e.g., housing, work, education, social inclusion, and relationships). The latter interventions, while overlapping to some extent with those that reduce the risk of illness, would also promote their mental well-being more broadly, and require collaboration with other systems outside the system of mental health care.

Engaging the public in discussion of mental health is important, but such discussion must include both mental health and mental illness. Given that public funding for mental health services is finite, even at the best of times, and invariably deficient in addressing the multiple needs of those with major mental disorders, the absence of any discussion of these unmet needs from the recent public discourse on mental health is indefensible. Many public campaigns intending to expose the importance of mental health are unlikely to benefit those with an established or first onset of a major mental disorder; the needs of those individuals remain largely unaddressed. Such campaigns are more likely to touch only those with no, transient, or mild mental health problems and may, in fact, do more harm through neglect of discussion of mental disorders of greater severity.

The recent public awareness campaigns have also generally not been adequately evaluated for their impact, but the public may assume that they constitute a sufficient response to the apparent rise in mental health problems. There is indeed a suggestion that these efforts, well intentioned as they may be, may cause some harm, especially to young people, by an exaggerated emphasis on the reportedly rising rates of putative unidentified mental illness, for which there is relatively limited evidence, as well as by misidentifying social and personal problems as mental health problems.<sup>42</sup> While there has been a small increase in rates of more common disorders such as anxiety and depression, there is no evidence of a large increase in rates of mental disorders in general or of serious mental disorders in particular. The recent increase in the suicide rate among young people is alarming in itself but cannot be assumed to be a direct manifestation of an increase in mental disorders. It more likely reflects larger societal, environmental, political, and economic pressures posing real existential challenges for young people. Investigation of this phenomenon should be broader than a focus on mental illness. The antidotes to such tragic phenomena are unlikely to lie in individual therapies and pharmacological interventions, but more likely require bold responses from society and political institutions. To confuse the distress brought about by social conditions with mental illness is to turn a blind eye to social problems and to ask far too much of psychiatry.

#### *Improving precision for diagnostic categories*

Another equally important concern about differentiating mental health or distress from mental illness is rooted in the ever-widening definition of mental illness<sup>43</sup> and the fuzzy boundaries around what is mental illness and what is not. The *DSM-5*, for example, lists nearly 300 disorders, without providing any supporting evidence for the validity of a majority of these. For major mental disorders (e.g., anxiety, major depressive, bipolar, obsessive–compulsive, eating, emotional dysregulation, and psychotic disorders) there is at least both face validity and some predictive validity, as well as effective treatments and known consequences of inadequate or lack of treatment. Widening the definition of a mental disorder risks emotions and behaviours — adaptations to changing circumstances — being regarded as signs of mental health problems. Such adaptations to normal variations in life circumstances are in fact included in the WHO definition of good mental health. For example, psychological distress is a natural response to circumstances that may be generic at a societal level, consequences of political upheaval, awareness of impending environmental disasters, and shared feelings of existential threat. Labelling these as mental health problems, and therefore implying that they require intervention at the individual level, is not only inappropriate, but also likely to erode reparative measures to improve the process of adaptation (e.g., increasing personal and community/social resilience) and demand for social and political change. Such large-scale social phenomena affect young people in particular. Giving them a mental health label and expecting therapeutic interventions to fix them is not likely to benefit either the individuals affected

or the society where the problem may rest. If anything, categorization as a mental disorder may have many negative consequences, including a false identification of the locus of change and an inappropriate demand of — and unnecessary burden on — mental health services.

## Conclusion

The public discourse on mental health is vital but should be based on the best available evidence and avoid a dramatic media-driven approach. Instead, the focus should be on determining what is required to promote and maintain good mental health in the general population (also as a strategy to reduce the risk of mental illness), and on directing our systemic efforts of service delivery toward improving access and quality of care for those with established, identifiable, or emerging mental disorders. Public discussion should explicitly examine the poor outcomes achieved at present for people with serious mental illness and their social, housing, economic, and personal needs. People living with serious mental illness have been repeatedly left out of every new mental health movement from Mental Hygiene a century ago through the psychoanalytical and, more recently, biological revolutions. None have addressed their real needs: safe, humane, and adequate treatments; housing; employment; and social inclusion. Better-informed and evidence-based public discourse, led by mental health professionals in collaboration with other institutions, is likely to lead to a more appropriate response from public policy-makers and funders. Such discourse may lead to improvement in resources being allocated to managing mental illness as well as promoting good mental health at the population level.

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