Hong Kong Journal of Mental Health
2013, *39(1),* 55-63

Prevention is Better than Cure - Lessons for Psychiatry *

Professor Dinesh Bhugra
Professor of Mental Health & Cultural Diversity
Institute of Psychiatry, King's College London
President-elect, World Psychiatric Association

It is a great privilege and honour for me to deliver this 6th Annual Gerald Choa Memorial Lecture. This is my sixth visit to Hong Kong in the last ten years and I feel quite at home, though I still cannot find my way around Hong Kong. But I feel at home.

What that says about my psyche, I don't know. Over the years my research interests have moved, but now and again my thinking has been that if I were sitting here with a patient, what would it be like if I were a patient or if any member of my family were a patient, what would be the things we were looking for as services or from other medical health professionals? Over the years and certainly the last four years, I've become very interested in the notion of public mental health. It has been one of the big challenges to us. However, I'm not sure this applies to Hong Kong because looking at your *Hong Kong Journal of Mental Health,* it seems that you're probably way ahead of the U.K.

Talking about a mental health agenda and mental health promotion, I really got shot down by psychiatrists who said that this is not what we are trained to do. My challenge - the question I kept asking them - was why are you a psychiatrist? Why are you treating patients? You're treating patients because you want to get them better? You're treating them because you want to avoid complications and you want to avoid further problems? Isn't that secondary and tertiary prevention? What is the problem in taking one step back? Within the European Psychiatric Association, I did manage to make some suggestions on what a public mental health agenda should be, and what is it that we ought to be looking at and on what is it that we ought to be working together on?

The fascinating thing for me as I go around the world is that there is quite often a sense of feeling that "West knows best". Don't believe it. Not at all. I think we have to learn from each other. You have done some fantastic things in spite of limited resources. In the U.K. time and time again we ask for more and more money without justifying what it is that we are doing with the money. It is a two-way process. Some of us are perfectly attuned to the fact that things are relative, and the tragedy surviving for a long time has been that we assume that every patient responds in the same way. What is exciting is that patients respond in different ways. No two patients are alike. Their needs are not alike. Their necessities are not alike. They deal with their symptoms, their distress, their inner pressure in completely different ways. So I tell health professionals that that is the challenge for us as to how we deliver that.

Mental Illness and Mental Health

We talk a lot about mental illness. We know what mental illness is. We know the diagnostics and we create different strategies.

*Transcript of the presentation at the 6th Dr. Gerald Choa Memorial Lecture of The Mental Health Association of Hong Kong delivered on 6th December 2012.

But how often do we sit down and think, "What is mental health? How do we define mental health?" And we have a definition about absence of ill health. Surely that is not good enough. In the 21st Century we ought to be more sophisticated than that. To my mind mental health is a positive emotion. It's feelings of resilience and feelings of happiness. I'll come back to that because happiness is a very subjective feeling; the things that may make me very happy probably may make you very angry. And vice versa. Health is a state of fitness and ability to deliver a reservoir of personal resources that can be called upon when needed. In fact, personal resources are not in the mind or in the brain or in the body; it is also around us. It can be defined as one level and distant level. One level is how do I fit in with my family, with my kinship, with my peers, with my colleagues? At distant level it is about employment, about culture, about society.

A major challenge of cross-cultures is the definition of the self. "Who am I?" I say that "I am." Am I talking about my body, am I talking about my brain, am I talking about my mind? Every time I go to India, which is quite frequent because my extended family is still there and I see them quite regularly, my identity is not who I am but my identity is son of so and so, the grandson of so and so. Under those circumstances the notion of my self and my health is intricately linked to it. If I do things which cause shame to the family, that is going to cause emotional distress not only to them but also to me. In an egotistical, egocentric society, I can do what I like. It's me.

Part of the tragedy of psychiatry is that we paint all pictures with the same brushes, rather than looking at what are the individual notions of the self. How can we express distress? What is mental health, what is positive mental health? You can argue the notion also that mental health is very culturally influenced. As I said earlier, we can define mental health as a state of complete physical, mental and social well-being, and not merely an absence of disease or infirmity. I think we need to improve on this definition. We need to be able to say what we understand by physical well-being. One of the challenges of providing mental health services is where does mental health fit in? Are we saying that it is a sort of spectrum and at one end of mental health is mental ill health or mental illness? Is it somewhere in the middle? How does that work out?

I'll also focus a bit on determinants of health, because these are key factors which enhance or threaten an individual's or community's health status. We have swathes of information and reams of papers on social determinants of health. Money doesn't always make you happy, but it makes you feel better. In the U.K. Sir Michael Marmot's work has been absolutely splendid in looking at physically ill health, longevity. For those of you who have been in London, or even if you haven't, look at the London Underground map, look at the Central Line. From Liverpool Street if you go east on the Central Line, Sir Michael has shown that for every tube stop you lose one year of your life. You're likely to live one year less than if you are living on Liverpool Street or towards the centre of London. It's as straightforward as that. What we need to do is try to tease out what are the factors within that area? Is it simply quality of life? Is it green spaces? Access to health services? Access to better education?

We need to be looking at factors other than mental health. We need to be looking at health in general. Positive mental health is about well-being. We know of several people who in spite of a number of miseries are still quite contented. This is from the European Psychiatry Association guidelines for mental health promotion. It's about optimism. It's about reliance. It's about capacity to conquer adversity and quality of life in spite of that. One of the major challenges as societies change and in view of globalization, industrialization

and increased urbanization – certainly as I see it in India and in Brazil and in Russia – things are becoming more complicated, this keeping up with the Joneses: they've got a washing machine so I'm going to have three, and they've got one car so I'm going to have two. That stress becomes incredibly important. It applies to the individual's perception, not what 'I' think. What 'I' think for myself in the context of the cultural and value systems in which I live and in addition to the goals and expectations and standards and concerns that I may have. There are challenges in quality of life as quite often these instruments have been developed in the West and there are very different ways of looking at quality of life. We need to be ensuring that whatever measures we use are culturally appropriate and are culturally sensitive.

Types of Prevention

We know that prevention is primary, secondary and tertiary. One sort of spends some time in going through and leafing through the Journal, that you've already beaten me to it in the paper on mental health promotion if you're talking about the three levels. There is a universal level, a selected level for people at risk and then individual level . So you notice it's the whole population, whether it is prevention or health promotion. Everybody needs to know that. Certainly in the U.K. in the past few years there have been various campaigns like Five a Day, you have five fruits and vegetables per day. Tobacco – we haven't gone in the same direction as far as alcohol is concerned, but Scotland is ahead of England because Scotland has introduced minimum pricing for alcohol. There may be nothing to see two years down the line, whether it works or not. The second thing is that when they introduced a ban on public smoking, much before England did, we're now seeing that the number of pulmonary and cardiac diseases are beginning to drop off in Scotland. There's very clear evidence. Interventions targeting particularly specific risk groups who have significant risks because there are children, women, elderly, unemployed, asylum seekers, migrants, lesbian, gay, bisexual, transgender individuals. We need to identify those groups and focus and provide very targeted information, education and interventions. Then there are interventions which are targeted to individuals who are at high risk. I want you to bear this model in mind because each of those will vary across cultures. In the U.K., for example, by 2020, the number of people who are over 65 is going to be massive. It is inevitable that longer people live more of them are likely to develop dementia, so we need to be looking at universal and selected interventions so that people can be in a state of being happy, healthy and prosperous.

Positive Mental Health

There is hedonistic or hedonic well-being, which is feeling good and deriving pleasure and happiness from life, being alive. There is eudemonia, which is doing good is good. I was struck by a piece of work last year and you can go on the Mental Health Foundation website and access it. If you do good things, you feel better about yourself, and it is a good way of managing, coping, being optimistic, doing the right things, obviously leading on to wellness. How do we measure wellness? Is it simply emotions? Some people are very good at hiding their emotions no matter what they are feeling. Some people carry their emotions on their sleeve. So what is it we are looking for? Do we measure well-being by personality? Towards happiness? Towards unhappiness? We don't know. So what is life satisfaction? Am I happy with what I have or am I forever striving for something more and then getting more and more agitated and anxious and angry because I want to get something I cannot? That is straight forward. Then, measuring well-being by virtue. Again, there is an interesting paper in your Journal that I strongly urge you to read. The principles of well-being are about working in service of others. If you are one part of a really big society and don't have the

answers, trying to work with others. Letting go of things and that is where some of the spiritual thinking comes into play. Perhaps you are interested in Buddhist contacts. Are you like a lotus flowering at the point you are in it but you are above it, but you can't be sort of muddied by the mud? As we are aware of who we are and what we are and what our emotions are, what our thinking is, what is it doing to us? Whether we take time out to meditate or do some physical exercise, listening to music or whatever it is, becoming aware of what's going on in our internal world. These principles are related to age, gender, race, education experience and a number of other factors. I think that is critical because one size does not fit all. All that you have at a universal level of interaction and education, but you also need to make sure that it is relative, that people can pick and choose what is going on.

Another point which has been associated with improved educational attainment is creative activity and, it is positively associated with improved physical health and cognition and can produce more benefits. It produces increased social interaction and social participation, reduces risk of mental illness and suicide, reduces criminal behaviour, reduces risk-taking behaviour such as smoking and alcohol and increases releasing of adversity. There is considerable amount of evidence on that.

Keeping mental health promotion at the forefront of mental health services is going to be absolutely vital.

Impact of Poor Mental Health and Mental Illness

I want to show you some evidence of what happens when the population is mentally unhealthy or mentally ill. In the U.K. where mental disorder accounts for nearly a quarter of total disease burden, compared with 16% for cancer and 16% for cardiovascular disease, and yet cardiovascular disease and cancer take more money in terms of resources. We ought to be fighting this very strongly and saying that we don't want to put up with this. People have argued that 1 in 4 will experience mental illness during their lifetime and people have questioned this figure but it depends on how you measure mental illness. But study after study, certainly in the UK and in Europe has shown that at least 1 in 6 adults would experience mental illness lasting a considerable period of time. There was a study recently from Europe, a conservative estimate of 39% of the population had had some kind of mental illness the previous year. I understand that there is a survey going on in Hong Kong, so it will be very interesting to see what the findings are. The message which I want you to take away is every family in the land is going to be affected by mental illness directly or indirectly. So you either know somebody or you have somebody in the family. That has implications because it affects individuals, it affects families, communities, wider society and indirectly affects production, it affects benefits, it affects transport and also other things that we don't think about. We know that mental illness leads to health inequalities and inequalities lead to mental illness, so there is a kind of vicious circle we need to break. Mental illness reduces life expectancy. Some studies in the U.K. and in the U.S.A. have shown that patients with schizophrenia are more likely to die 20 years younger than those who don't have schizophrenia. 20 years – that's a long time. We also know that mental illness has a trans-generational effect, so that if one of the parents has mental illness or a grandparent has, the children will be affected. The child may have a conduct disorder or some kind of psychological problem or whatever, the circle continues.

The economic cost of mental illness in the U.K. is 110 billion pounds a year, which is nearly 8% of the Gross Domestic Product. One third of that is due to lost

productivity. In the single largest cause of costs to the NHS in England in 2007, service costs alone were 22.5 billion pounds. The annual costs of depression are 7.8 billion, anxiety 8.9 billion, schizophrenia 6.7 billion, medically unexplained symptoms 18 billion, and dementia 17 billion. For Scotland total average costs per suicide are 1.3 million and in Ireland 1.5 million.

If we look at medically unexplained symptoms, patients with medically unexplained symptoms get frustrated because they are passed from pillar to post, they are passed from one speciality to another and investigations come back normal. Patients get frustrated and doctors get frustrated.

There is a very interesting project just completed in Birmingham, where they showed that if you have a consultation liaison team 24 hours a day, you can close down 60 beds and you can save several million pounds a year just dealing with medically unexplained symptoms. Per child the cost of mental illness is between 30,000 and 65,000 Euros per year. It also has longer term economic impact across the life span because of the cost of crime.

Doctors in particular have always led on prevention. We have the evidence. It is just a question of making sense of it, working with health economists, saying you're investing one pound and getting eight pounds back.

A Case for Prevention

In addition one of the challenges looking at mental health is that it is not only the mental health professional's business. It is not only even the health care's business. It is everyone's business. It links health services, judicial services, education, social services, you name it. Every ministry needs to be involved in signing up if you are going to get anywhere in public mental health. You need to go beyond health services. You can reduce the burden of mental health disorders. You can produce cost-effective user services as the survey indicated, and you can improve both social functioning and social capital for those who have mental illness. The principles of intervention are a linked function. Who do we need to educate? That is absolutely critical. The most important group that we need to target are the school children. It is about improving social drive and social capital. It is developing healthy habits and healthy life styles, it is increasing education and awareness, being aware of cultural diversity. Again I emphasize that one size does not fit all. We need to direct more school mental health programmes.

We know there are **protective factors.** There are genetic factors, but more important there are issues about maternal care, ante-natal and post-natal, early upbringing, how can we protect children and individuals, early experiences including how children attach themselves to parents and others, good parenting plus personality traits. We know that certain ages are more prone to certain disorders. Women are certainly more prone to certain disorders than men, and yet they are the parents and so they have double stress. We need to look at the way of strengthening their role and general role expectations in society. We know that marriage is good for men but bad for women. So what does that tell us? We need to look at them. There is a considerable amount of data that women who are married are protected compared with those who are divorced or separated. Men do better than women as marriage is protective towards them. Obviously there are social and economic factors that matter. Living in Liverpool Street are you better off? If you are living in Chelsea you are even better off. Obviously that means we have to reduce inequality. The question quite often I am asked when I talk about mental health promotion

and prevention is, "what can we do as mental health professionals in terms of relieving social inequality?" You have to stand up and shout! We may not be able to offer people jobs. We may not be able to offer them better housing, but politicians are frightened of patients. Every time I've gone to see a politician with a patient by my side, I've had a better hearing than if I'd gone alone. I don't know what it is, but they're really scared. If a patient stands up and says that we need this, politicians are more likely to listen to that.

We know that employment and other purposeful activities work. This is why you set up employment opportunities. The work affects our relationships, because that's about who we are. Community factors about social capital and levels of trust and participation help. It's also about self-esteem and altruism and doing good. It's about emotional and social literacy, expressing things, understanding other people's emotions, trying to make sense of that, good physical health is linked to good mental health. For children we know the **risk factors** for mental illness are many. All the available data from the United States shows something like three quarters of mental disorders in adults start from the age of 18. Three quarters! We need to do something about it. We know the risk factors, particularly in children. Abuse – whether it's physical, emotional or sexual or combined together. We know that if mothers-to-be are smoking during pregnancy or drinking heavily, there will be problems with the new born. We know about cannabis use. We know about physical ill health and infections. We know about men under stress. We know about domestic violence and its impact on women's physical and mental health, and children's physical and mental health. We need to stand up and say, "domestic violence is not acceptable". Society has to stand up and respond to men who indulge in domestic violence. We know the importance of mental health in parents is the cause of abuse for children. Income, single parent households, emotional and physical poverty. We should look at the specifically targeted groups. We know that looked after children develop more problems. Children with learning disabilities have more problems. Minorities – ethnic, sexual, whatever – have more problems. If you look at the social context, minorities will always feel got at because the majority is comfortable doing whatever they do. It is not only what is being done to the minorities, and there is considerable evidence from Jim van Os' data which shows that it is the perception. If they perceive that something is being done to them, they are more likely to develop disorders. Over 50% of prisoners in American prisons have disorders. The same is true for other prisons. I don't have the data for Hong Kong but perhaps you know.

What is it that we need to do to make sure that the people who need intervention get it at the right time? Lesbian, gay, bi-sexual, trans-gender groups, high rates of systematic problems, high rates of anxiety and depression consistently. Part of it is being in a minority, part of it is persecution perceived and real. Social inequalities. The poorest neighbourhoods have 17 years less disability-free life expectancy. Health risks are high. We don't know the cause and effect, but inequality gets you to smoke more and drink more, and therefore if you smoke more and drink more, you get into a sort of poverty circle. We know that high income inequality leads to low trust, low social capital, high mortality, high violence and high racism. Among children, 6% of children between the ages of 5 to 16 will have conduct disorder. Now I don't know if these are figures for Hong Kong but you would know. 4% would have emotional disorders and 1% autism. So a total of 11% of children have some kind of problem which leads to poor educational attainment, high risk behaviours, high levels of violence, personality disorders, criminality, substance misuse, self-harm and suicide. There's quite a lot of evidence coming out from the Institute of Parental Health in

King's College that have shown that you can prevent childhood disorders by home visiting, getting home visitors, educating them so that they can identify and intervene early. Home visitors would be visiting families for about a year or 18 months after birth, giving parental advice.

It always surprises me that in order to drive a car, you need a license. But in order to be a parent nobody asks, "What skills do you have?" I'm not for one moment advocating that we should set exams, but what I'm saying is that people's experience with their first born, is different by the time they get to second born, they have some experience and things are different. We need to make sure that families, parents and children don't struggle. I don't have an answer as to what we need to do but as a society we need to be aware of what the needs are and offer them some help. Some parents are quite capable and may tell us to take a flying leap and 'don't come near me', but there are others who are struggling who need help. How do we get them to develop those skills? They need pre-school education and school-based health promotion and interventions to prevent conduct disorders.

Early Intervention

Early intervention can save six times in the long run. I keep telling the politicians this but for politicians this long run is about 18 months. The next election is in five years time but in 18 months time they will start working towards the next election. The only way we can persuade them is to talk about their legacy, what they will leave. It's like planting a tree – you may not be able to sit in its shade, but generations to come will. We know that early intervention will reduce criminal behaviour. It will stop people going into prisons, which will save money in the courts and in the prisons. Each pound spent on parenting intervention for conduct disorder saves eight pounds. Plenty of evidence. Early diagnosis and intervention in depression saved five pounds for every pound spent. Screening for alcohol and intervention in primary care saves 12 pounds for every pound you invest. So it's about early parenting skills, school-based prevention programmes, early treatment of childhood anxiety, early intervention for psychosis, but I also think that it's early intervention for substance misuse, early intervention for personality disorders, early intervention for aggression, and early intervention for borderline personalities.

We know from looking at the other end of the age spectrum that over the age of 65, 5% have dementia, 35% of mental illness effects people over 65, and 25% have depression in the community. We know that physical activity can prevent some forms of dementia, getting people to do exercise, cognitive exercise interventions, filling in things, doing crosswords, social engagements is good for their mental health. We know people who have higher social engagement networks have better cognitions. Treating physical conditions early, preventing onset of hypertension and diabetes, preventing strokes, building strength and resilience.

Suicide prevention is fairly straight-forward. Also one can argue that not every individual who commits suicide has an underlying psychotic disorder. Sometimes it's compulsive, sometimes it's political, sometimes it's economic. In south India, in certain parts, rates of suicide among farmers are huge. About five years ago the rates starting shooting up and the federal government in its infinite wisdom decided that for every suicide, the family would get 100,000 rupees. You can guess what happened. The suicide rates shot up! Because people decided that their family could use the money. The challenge is how to reduce that. In the U.K. in- hospital in-patient suicides have dropped down dramatically by collapsible ligatures on the wards. Making sure that you cannot buy more than 16 tablets of paracetamol is one of the many simple

measures have brought about reduction in the suicide rate, which tragically now is beginning to creep up as a result of the economic downturn.

That brings some very interesting challenges for us. We should be doing more stress reduction and management of stress in the workplace. Interestingly, we at the Royal College managed to get some money from the Financial Services Authority to produce information leaflets on how to cope with depression and the economic downturn and how to cope with stress and depression. Obviously workplace-based health promotion would be one way of reducing stigma as well. Alcohol pricing, again needs a political argument. It will be very interesting to see what happens in Scotland as from this year they have introduced higher per unit pricing. (The case is now in front of European Court so teh process is halted) Education – do we control advertising? Controlled availability of drugs, alcohol, cigarettes? You would have seen earlier this week the Australian government has introduced really horrible packages for cigarettes, with no names, blackened lungs and so on and so forth.

We ought to be looking at reducing unemployment. I'm not a politician, thank goodness, but there is evidence we need to convince them, how do we keep people occupied, how do we intervene when people get into debt, how do we improve housing, heating, green spaces, transport, how do people get from A to B without worrying about not having a car. Social cohesion in communities and group programmes, adult learning, improved neighbourhoods and targeting interventions.

Politicians don't like to hear about problems. They want solutions. Nine times out of ten when I went to see politicians, I went with a very clear message that I think we're going to have this problem in six months time and this is what we ought to be doing. They listen to that. They remember when you get them out of a mess. The other thing that I started doing in the College was having regular sessions on proactive policy changes, that this is what we need to do and this is how we are going to do it.

We know many people have high levels of physical illness and the same people have low levels of mental health. They have high levels of mental health problems. We know that depression is double in people who have diabetes, hypertension, coronary disease, triple in endstage renal failure, COPD. Obviously smoking and alcohol play a role. We need to be looking at working with our public health colleagues, looking at smoking cessation and to control substance misuse, sexual health, obesity, nutrition, exercise.

Psychological Factors

There are other things – psychological factors, such as meaning and purpose, mindfulness, spirituality, learning, leisure activities, creativity, making sure we get some decent sleep. Mindfulness is about increasing awareness, increasing quality of life, increasing self-esteem, increasing optimism and reducing distress. Spiritual needs are, we know, associated with improved well-being, satisfaction and quality of life, associated with recovery, reduced risk of depression. We need to develop a sense of meaning and purpose. What's the meaning of life? What's the purpose? Why are we here? Fostering relationships and social networks, improving social inclusion. Learning and education right across life span. Learning new languages, learning new skills does give us better life satisfaction, does give us better social networks and may increase earning potential and employability.

Meeting with arts improves personal sense of well-being. There is considerable evidence of its effects on community cohesion. Volunteering can increase well-being, giving you structure and making you feel good. Part of doing good does you good. We know a lot of psychiatric disorders lead to relapse. Sleep disorders themselves cause poor social function and poor quality of life. So we need to be co-oping help for a full range of potentially modifiable determinants of health.

Conclusion

Prevention and promotion complement the treatment of mental illness. It does not take away the need for the other. It is not one or the other. We need to look at both. That is the only way we are going to reduce mental illness and promote recovery as well as increasing resilience to wider adversity. We know that significant personal, social and economic savings result from investments. I can show you the evidence. Since most mental illness begins before adulthood, we need to look at early interventions, early education, early mental health, promotions, programmes aimed at schools, working with teachers, working with educational psychologists, working with parents. We need universal efforts and targeted interventions. It's not a one-off thing. It's not, let's do this for the first two weeks in December. The first two weeks in December are going to be important for targeting alcohol but there are other things for which you need sustained periods. People have very short-term memories. You set up a campaign and it disappears as soon as you stop talking about it. So it has to be sustained, regular and ongoing. We need to invest in training both at undergraduate and postgraduate levels, the way we train our doctors, the way we train our nurses, the way we train other health professionals. We need to make sure that they start learning early that prevention is better than cure. We need public will. We need stakeholders. We need the politicians. We need the civil servants. We need the families in the communities with us to do that. As clinicians we need to change the way that we look at mental illness. We need to go beyond what is in front of us. We need to look behind, forward, in each direction to see how we need to invest in mental health promotion and early interventions.

It is for the team, the policy makers, the people who deliver the services, whether it's in the hospitals or in the community being aware. There are things we need to do about mental health, promotion and prevention of mental illness.

I've shown you and I hope you're convinced that the literature evidence is good. Now we need to translate that into making sure that we can reduce the rates of mental illness and the burden that mental illness produces on the society and on the healthcare system.

Suggested Reading :

M Marmot & R.G. Wilkinson 2006
Social Determinants of Health 2nd Ed.
Oxford University Press