



**Xplore
Health**
DISCOVER THE LATEST ON HEALTH RESEARCH

- ➔ **Educators' guide
"Rethinking Mental
health"
(Background information)**

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1. Introduction

These teacher guidelines will give you information on the Xplore Health module “Rethinking mental health”. It will first introduce the topic to enable you to prepare your lesson using the different multimedia tools that you will find on the website. The guidelines provide information on the state of the art in this research field and on the ethical, legal and social aspects surrounding this topic.

2. State of the art

2.1. Introduction

Mental health disorders are one of the leading causes of disability worldwide. Schizophrenia, depression, epilepsy, dementia, alcohol dependence and other mental, neurological and substance-use disorders constitute 13% of the global burden of disease, surpassing both cardiovascular disease and cancer. Every seven seconds, someone develops dementia, costing the world up to US\$609 billion in 2009. By 2020, an estimated 1.5 million people will die each year by suicide, and between 15 and 30 million will make attempt. In Europe, brain disorders cost almost 800€ billion a year. Most adult mental health disorders begin in childhood and adolescence and have a multifactorial cause. By the end of adolescence about 30% of young people will meet lifetime criteria for a mental health disorder with 12% having significant impairment. Studies estimate that in developed countries only half of these patients receive mental health care. The clinical presentation of mental disorders in children and adolescents and the response to treatment can differ from adults. However, current classifications of mental disorders lack a clear description of their evolution and patients with the same disorder may have different clinical presentations and they can present different disorders at the same time. Mental health conditions in childhood have a chronic and recurrent course, with substantial continuity into adulthood. They are also predictors of onset of a range of physical disorders and of adverse life course outcomes and have a considerable economic cost for society. Although reduction of global burden of mental illness must begin with an appropriate prevention, recognition and treatment of child and adolescent mental health disorders, there is still a considerable gap between needs and resource availability. Additionally, many questions on the causes, epidemiology and treatment remain unresolved and need further developmental research.

According to the World Health Organization (WHO), mental health disorders are one of the leading causes of disability worldwide. Both retrospective and prospective research has shown that more than 50% of impairing adult mental disorders have their origins early in life. This highlights the importance of gaining understanding of the magnitude, risk factors and progression of child and adolescent mental disorders and of recognizing their differential features from young and older adults mental disorders. It also suggests that reducing the global burden of mental illness must begin with an appropriate diagnosis and treatment of children and adolescents. Nevertheless, despite the widespread recognition of the importance of mental health promotion and prevention in children and adolescents, only about half of children and adolescent with mental conditions receive mental health care in developed nations. The gap between needs and resource availability is even more concerning in low-income and middle-income countries.

2.2. Epidemiology

Recent studies indicate that about one third of young people in developed countries are estimated to meet lifetime criteria for a mental disorder by the end of adolescence. Twelve per cent have a serious psychiatric disorder causing a severe distress or impairment and a drastic impact on the child's ability to function socially, academically and emotionally. There is little sound epidemiological research focusing on the incidence and prevalence of child and adolescence mental health disorders in middle and low-income countries. As a result, difficulties arise when attempting to compare patterns of child and adolescent mental disorders across countries.

Similarly to community studies in adults, anxiety disorders are the most prevalent mental condition in children with a median prevalence rate of all anxiety disorders of 8%, according to a recent review. Next in frequency are behaviour disorders (including attention-deficit/hyperactivity disorder, conduct disorder and oppositional defiant disorder), followed by mood disorders and substance use disorders. Nonetheless, rates can vary when considering specific age, gender or ethnic groups.

There are different peak periods of onset of specific disorders. Most cases of attention-deficit/hyperactivity disorder (ADHD), autism and non-autistic pervasive developmental disorders, separation anxiety, specific phobia and oppositional defiant disorders begin in childhood, whereas social phobia, panic disorder, substance abuse, depression and eating disorders usually start in adolescence.

With regards to gender, most of the childhood-onset disorders have more male than female cases, whereas most adolescent-onset disorders have more female than male cases.

2.3. Burden of mental health disorders in childhood

Mental health disorders in childhood usually have a chronic and recurrent course and create a significant clinical and social burden on the individuals, their families and society. There is substantial continuity of psychopathology into adulthood. For most psychiatric conditions it can take the form of direct persistence of the same problem (homotypic continuity). Sometimes, a different form of psychopathology can follow psychopathology in childhood in adolescence or adult life (heterotypic continuity). A significant heterotypic continuity has been identified for anxiety-depression, anxiety-substance abuse and ADHD-conduct disorders.

WHO World Mental Health analyses show that early-onset mental disorders are also significant predictors of the subsequent onset and persistence of a wide range of physical disorders. This is part of a larger pattern of associations between early-onset mental disorders and a wider array of adverse life course outcomes including reduced educational attainment, early marriage, marital instability, and low occupational and financial status. Furthermore, child and adolescent mental health conditions have a considerable economic cost to a range of services involving not only mental health, but also education, social services and justice system.

2.4. Classification and diagnosis

There are two highly systematized classifications of mental health disorders: the 4th edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV, American Psychiatric Association, 2000) and the 10th revision of the International Classification of Diseases (ICD-10, World Health Organization, 1996). Although they differ in many ways, their overall classifications are very similar and both classify psychopathology into categories.

They were originally developed for adult disorders and subsequently applied to mental disorders in childhood. Therefore, most of the disorders that are common in young people have been defined and described on the basis of their presentation in adults. However, though the great majority of symptoms of child and adolescent mental disorders are the same than in adults, they can be present in different proportions or associations throughout the different age groups, leading to syndromes with different patterns. This is why there is

currently an intense debate among child psychiatrists on how well these definitions and descriptions apply to children. Many experts feel that they lack developmental perspective and therefore fail to account for the particularities of the clinical presentation of mental health disorders in children and adolescents and for the high rates of comorbidity.

2.5. Clinical assessment

Diagnosis can only be made after a careful interview conducted by a psychiatrist with the child or adolescent and the family or carers. In clinical practice, interviews are usually unstructured. The psychiatrist explores the presence of psychopathology and judges if it meets the criteria for the different conditions defined by the diagnostic schemes mentioned before. However, for research purposes it is essential to use systematic standardized approaches. Two different ways of providing standardization to the interviews have been used; one is through the use of a set of structured questions giving rise to “yes” or “no” answers, like the Diagnostic Interview Schedule for Children (DISC) and the Diagnostic Interview for Children and Adolescents (DICA). Another way is to use interviews in which the standardization is achieved by explicit specification of the psychopathological concepts. The Child and Adolescent Psychiatric Assessment (CAPA) and the Autism Diagnostic Interview-Revised (ADI-R) are examples of this approach.

Questionnaires are also routinely used in clinical practice and research. Some can assess a broad range of behavioural and emotional problems, while others have been designed to focus on specific areas of pathology, such as disruptive behavioural disturbances, hyperactivity and attention deficit, anxiety, mood or pervasive developmental disorders. For some questionnaires, parallel versions for parents, teachers and children have been developed, allowing the comparison and combination of information collected from different sources.

Finally, information about family functioning, wider psychosocial influences, educational progress and negative life events is also routinely collected in every assessment.

2.6. Risk factors

With few exceptions, child psychiatric disorders have a multifactorial and complex aetiology. Focus has traditionally been on family factors, what is partly justified since the family provides the child with its genes and an important part of its environment. However, it is

known that not only family, but also other biological, psychological and social factors interact at an individual level and can predispose, precipitate or perpetuate these conditions in a particular child. Risk factors can be linked to the individual (e.g. gender, gestational and perinatal exposures), the family (e.g. psychopathology in parents, marital and family conflict, socioeconomic status) or/and wider environment (e.g. school or peer conflict). Because no single cause can be identified, they are best thought as risk factors that increase the likelihood of a particular disorder, rather than as “causal” factors. Although an extensive body of research has examined risk factors for childhood mental health problems, how risks in different developmental periods work together is largely unknown and need further investigation.

2.7. Treatment

Both psychological and drug treatments have evolved amply in the last decades so nowadays there is a substantial range of interventions with proven effectiveness. In general, best evidence of effectiveness is obtained when a combination of psychological and pharmacological approaches is used, along with family, school or community-based interventions.

Among psychological therapies, Cognitive Behaviour Therapy (CBT) is the one that have provided more evidence of effectiveness in the treatment of different mental health disorders in children and adolescents. It is particularly useful in anxiety, obsessive-compulsive and major depression disorders. Other approaches, like Family Therapy and Interpersonal Therapy bring also proven benefits in mood disorders. Additionally, problem solving strategies and parenting programs are very helpful for managing conduct disorders and ADHD. New therapies like Dialectical Behaviour Therapy and Mindfulness are also increasingly used to treat older adolescents with suicidal ideation and self-harmful behaviours with promising results. Psychoanalytic therapies, which used to be very popular in the mid 20th century, are now rarely used as no sound research has shed light on its effectiveness.

With regards to pharmacological treatments, drugs designed for adults have been frequently used in paediatric population without previous validation in this age group, partly because of limitations in clinical trials and pharmacological research in children and adolescents. However, studies in this population suggest that medications are often less effective in children and adolescents than in adults. This strongly emphasizes the need for carefully

designed studies to develop specific therapeutic strategies for young people and suggests that adult treatment protocols should not be extrapolated to children and adolescents. Nevertheless, some well-designed randomized controlled trials have proven a positive risk benefit ratio for some medications like for example for fluoxetine in the treatment of adolescent depression or for stimulants in ADHD.

2.8. Prevention

Benefits to child mental health have been shown from early non-specific childhood interventions including early stimulation interventions, interventions to improve carer sensitivity and responsiveness, an adequate nutrition and health status and attendance at a high-quality preschool. There are also interventions to prevent specific mental health disorders: School-based preventive interventions involving teacher training and brief behavioural parent training have some evidence for behavioural disorders. Additionally, psychosocial group interventions and structured routines have generally, although inconsistently shown benefits preventing emotional disorders in selected high risk groups.

2.9. Research

The basic principles of research in child and adolescent psychiatry are identical to those in other areas of medicine. However, child and adolescent psychiatry pose special demands and challenges for researchers. Information must be collected from different sources, such as the child, parents, carers, teachers and sometimes siblings and peers. Moreover, the breadth of the field is huge and includes the study of heterogeneous populations, ranging from infants to young adults, which are still evolving. Besides, since psychopathology in young people results from the interplay of biological, psychological and social factors over time, research must take a developmental approach.

Developmental research in child and adolescent psychiatry can be divided into three areas. The first one studies normal and abnormal development, assessing the effect of genetic background and environmental factors. For such purpose, molecular genetics, anatomical and functional neuroimaging and longitudinal research designs are key tools. The second area of developmental research comprises epidemiological prevalence studies. The third involves clinical and health delivery research; the evaluation of new treatments, both neuropsychopharmacological and non-pharmacological, such as psychotherapies and psychosocial interventions are usually achieved through randomised controlled trials. This

area also covers the evaluation of how services should be delivered, the development of clinical outcome measures and the assessment of cost-effectiveness.

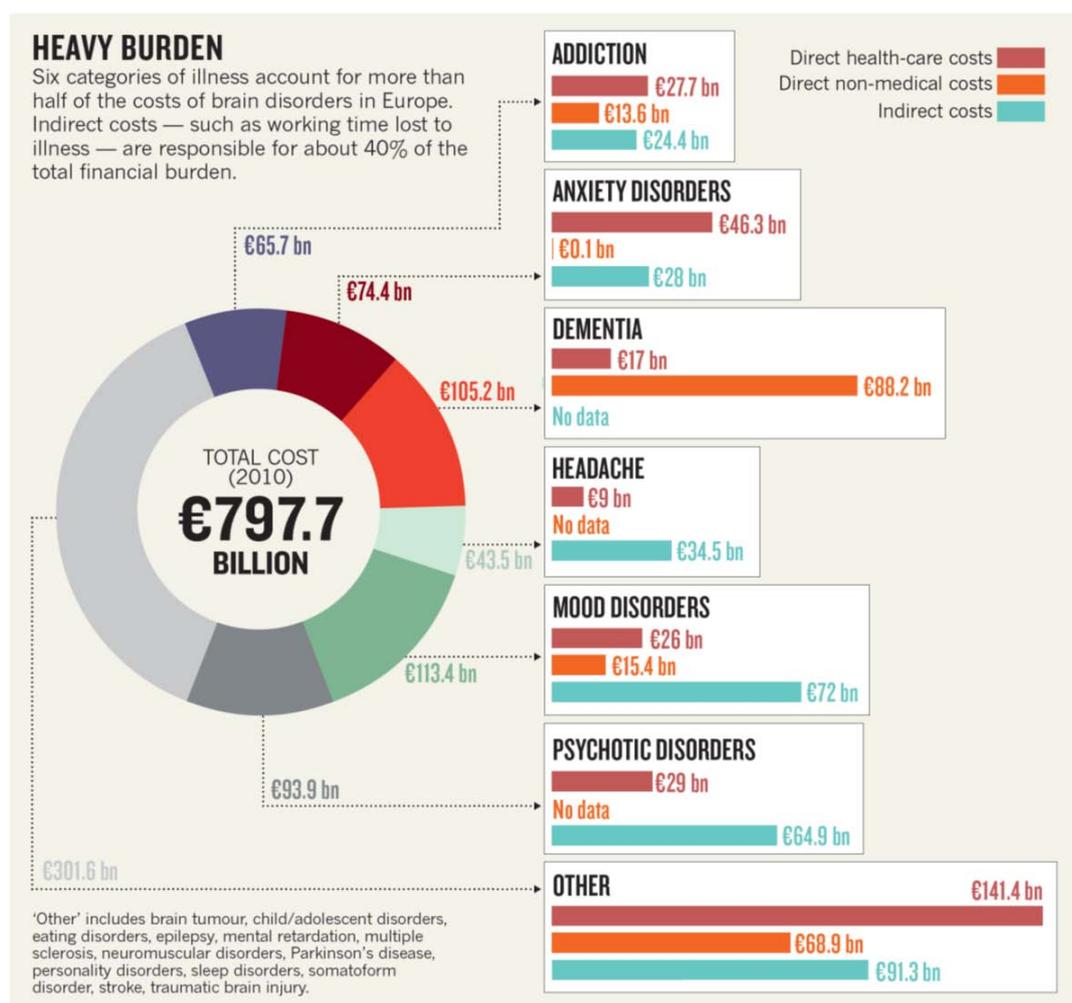
2.10. Health System Cost

Schizophrenia, depression, epilepsy, dementia, alcohol dependence and other mental, neurological and substance-use disorders (MNS) constitute 13% of the global burden of disease (Table 1), surpassing both cardiovascular disease and cancer. Every seven seconds, someone develops dementia, costing the world up to US\$609 billion in 2009. By 2020, an estimated 1.5 million people will die each year by suicide, and between 15 and 30 million will make attempt. The absence of cures, and the dearth of preventive interventions for MNS disorders, in part reflects a limited understanding of the brain and its molecular and cellular mechanism. Where there are effective treatments, they are frequently not available to those in greatest need. In 83% of low-income countries, there are no anti-Parkinsonian treatments in primary care; in 25% there are no anti-epileptic drugs. Unequal distribution of human resources further weakens access: Europe has 200 times as many psychiatrists as in Africa. Across all countries, investment in fundamental research into preventing and treating MNS disorders is disproportionately low relative to the disease burden. In Europe, brain disorders cost almost 800€ billion a year (Figure 1). Mood disorders top the cost estimates, consuming €113.4 billion a year, following closely by dementia, at €105.2 billion. Drugs, visits to doctors and hospitalization- the direct health-care costs- make up 37% of the bill. A further 23% is spent on direct non-medical costs, including informal care, social services and nursing homes. The remainder (40%) is sucked away by indirect costs, such as lost productivity as a result of time off work or early retirement. It is estimated that Europe spent about the same amount on brain research as on cancer research (about €4 billion each), despite the much higher fro brain disorders than for other conditions, in other word there is a clear evidence that greater scientific effort is required to tackle brain disorders, focusing on preventing these disorder in the first place would have the greatest cost benefit.

TABLE 1 | GLOBAL BURDEN OF MENTAL, NEUROLOGICAL AND SUBSTANCE-USE (MNS) DISORDERS*

Rank	Worldwide		High-income countries†		Low- and middle-income countries	
	Cause	DALYs‡ (millions)	Cause	DALYs (millions)	Cause	DALYs (millions)
1	Unipolar depressive disorders	65.5	Unipolar depressive disorders	10.0	Unipolar depressive disorders	55.5
2	Alcohol-use disorders	23.7	Alzheimer's and other dementias	4.4	Alcohol-use disorders	19.5
3	Schizophrenia	16.8	Alcohol-use disorders	4.2	Schizophrenia	15.2
4	Bipolar affective disorder	14.4	Drug-use disorders	1.9	Bipolar affective disorder	12.9
5	Alzheimer's and other dementias	11.2	Schizophrenia	1.6	Epilepsy	7.3
6	Drug-use disorders	8.4	Bipolar affective disorder	1.5	Alzheimer's and other dementias	6.8
7	Epilepsy	7.9	Migraine	1.4	Drug-use disorders	6.5
8	Migraine	7.8	Panic disorder	0.8	Migraine	6.3
9	Panic disorder	7.0	Insomnia (primary)	0.8	Panic disorder	6.2
10	Obsessive-compulsive disorder	5.1	Parkinson's disease	0.7	Obsessive-compulsive disorder	4.5
11	Insomnia (primary)	3.6	Obsessive-compulsive disorder	0.6	Post-traumatic stress disorder	3.0
12	Post-traumatic stress disorder	3.5	Epilepsy	0.5	Insomnia (primary)	2.9
13	Parkinson's disease	1.7	Post-traumatic stress disorder	0.5	Multiple sclerosis	1.2
14	Multiple sclerosis	1.5	Multiple sclerosis	0.3	Parkinson's disease	1.0

Figure 1. Cost of mental health problems in Europe



3. Ethical, Legal and Social Aspects (ELSA)

In this section you will find a number of opinions and incentives for discussion in class on ethical, legal and social aspects (ELSA) related to mental health:

3.1. Introduction

Mental health problems affect as many as one third of us over the course of our lifetimes. The impacts of mental health problems on people's lives and well-being can be very serious: not only the direct impact of the problem itself (be it depression, schizophrenia, alcoholism, or a personality disorder, to name a few examples), but the stigma, lack of understanding or toleration, loss of secure employment, and loss of civil rights which may go along with the problem.

3.2. Classification and diagnosis

One of the biggest difficulties in the field of mental health problems concerns the diagnosis and classification of mental illnesses and disabilities. The main approach is to group psychological phenomena or behavioural traits together, where they commonly occur together, and label this cluster a syndrome or disorder when the person in whom they occur suffers significant distress or dysfunction as a result of these behavioural and psychological traits. However, there are obvious difficulties here.

First of all, the approach depends on accurate, reliable, reproducible identification and description of symptoms, something that may obviously be rather difficult with mental phenomena such as "low mood". Psychologists and psychiatrists seek to overcome this by developing standardised tests and checklists that are tested in large numbers of people who, for some independent reason, we are confident suffer the disorder in question. But this does not help much when we aren't sure whether the disorder we are seeking to define or measure is real or not, or when it may simply be a variant of something else, better defined.

Second, we may have difficulty distinguishing the seriously pathological from the merely atypical or harmlessly abnormal. A standard example is how we distinguish mild depression from grief or sadness or melancholy. A classification of mental health states that is purely "phenomenological" (relying on information about beliefs, emotions, moods) would have difficulty making clear distinctions here. We might try to distinguish sadness from depression on the basis of the intensity or duration of the low mood; but this would be somewhat

arbitrary, and besides, what scale of measurement do we use, and what do we measure? A way around this is to posit a theory that would explain how the phenomena we observe come about, and that explains the differences between sadness and depression.

This theory might be biological, and look for biological correlates of depression, be they in brain structure, or brain chemistry, or evolutionary mal-adaptations, or specific losses of biological function which go beyond the subjective accounts of experiences of the patient (for instance loss of appetite, or exaggerated sex drive, or movement disorder). Or the theory might be historical – sadness is a response to bad news or loss; depression may not be tied to a concrete, recent event. Depression might be a response to a loss of attachment with the mother in early childhood.

This theory-led approach has its own difficulties: for one thing, these theories can be quite hard to test. For another, we may find ourselves confusing correlation and cause. It may be that people with schizophrenia have a characteristic difference in their brains that “normal” people don’t have. But we may need to be very cautious about saying that this different structure causes schizophrenia. It might be an outcome of schizophrenia. Or there might be some underlying cause that explains both this structure and the schizophrenia. Or it may be a mere chance association, not replicated in further research.

Finally, it may well be that because it is relatively difficult to diagnose mental illness psychologically, we start with the physical signs and symptoms: rather than saying – most people with schizophrenia have the following biological traits (though not all do), we say instead – schizophrenia is the disorder where the following biological traits are present. Where they are not present, the disorder (if any) is something else. And where they are present, but the patient is seemingly unaffected or only mildly so, then this is still schizophrenia but of a mild or asymptomatic kind.

This is all quite slippery, and causes a lot of controversy within the mental health professions for three broad reasons. It is awkward and difficult to operate with a set of diagnostic categories which are rather unstable and uncertain, and whenever the standard reference works in psychiatry are revised there is considerable controversy about definitions, classification strategy, and what is included or excluded. A current dispute concerns whether Autism and Asperger’s Syndrome are the same thing, just in different degrees, or different disorders, with some similarities. Some behaviours now considered normal were once

considered psychiatric disorders (homosexuality, for example) and vice versa (some forms of autism and depression, for instance).

There is also a long running dispute between those who consider mental health problems essentially as psychological problems, which should be defined – and treated – in view of the ways they display pathological ways of thinking and feeling, and those who consider them essentially biological problems, which should be defined – and treated – in view of the alterations they involve in physiology and chemistry of the brain.

This difference is both philosophical and pragmatic. At a biological level, changes in mental processes have physical correlates; and there will be genetic, structural and physiological factors at work in any mental illness. So the dispute here is not about the role of physical features in mental illness; but rather about the best ways to conceptualise and treat such illnesses. For instance, in bipolar disorder, the psychological and behavioural features of the illness are central to the patient's experience of the illness, but drug treatment has a better track record than psychological therapies. On the other hand, in depression, although depressive traits are common to both depression and bipolar disorder, cognitive behavioural therapy has a good evidence base, and is often preferred by clinicians (and patients) to drug therapies.

Classificatory disputes cut right across this debate: pragmatists, meanwhile, focus on what works as treatment, and may draw inferences from what works as treatment to what the underlying problem “really” is. How we explain and define mental health problems can have a very significant impact on a person, both in terms of how their problem is recognised and acknowledged (or not), and in terms of how they are treated as a result. At its most crude, when a person is considered to have committed a crime, it makes a big difference to how they are handled by the criminal justice system whether they are considered to be psychologically normal or whether they are considered to be mentally disordered.

In the end, working mental health professionals manage these difficulties through a combination of pragmatism and professional judgement, combining a range of diagnostic strategies, treatment approaches, and theoretical ideas to make the best sense they can of patients' problems and how to help them. Although we have been thinking about madness and mental health for hundreds of years, psychiatrists and psychologists and neuroscientists would all agree that the science of mental health is very young, and will change considerably in the years to come.

3.3. Treatment

Treatment of mental health problems has been revolutionised since the Second World War by the rise of drug therapies. Before that time, although “medical” methods of treatment were tried, there were very few which were successful, or which relied on much more than guesswork. Much of the time, the approach to mental health problems focussed on removing the seriously mentally ill from society and managing their behavioural and psychological problems through confinement, physical restraint, and behavioural management techniques involving rewards and punishments.

Two trends in the first half of the twentieth century showed more promise: the rise of the “talking therapies” developed by Freud and his followers, alongside other psychologically-based therapies based on Watson and Skinner’s behaviourism; and the rise of biologically-based therapies, from insulin coma to electro-convulsive therapy and lobotomy. The drastic form many medical therapies took was usually reserved for the seriously ill, institutionalised patient; whereas the talking cures were more popular in the mildly mentally ill living and working in the community. Nevertheless, both approaches could be found in all mental health settings to a greater or lesser degree, and which approach the psychiatrist took was as much a philosophical choice as one governed by secure scientific theory or evidence-based pragmatism.

The innovative drug therapies of the 1950s for the first time offered the prospect of a carefully designed, patient-specific approach to managing symptoms of mental disorder, and promised to make psychiatry closer to “mainstream” medicine by reconnecting psychiatry to neurology and pharmacology. The successes of “biological psychiatry” in the early years of drug therapy were remarkable, and though drug-therapies are often criticised today, they have made a big difference to many people’s lives by enabling them to live independently, hold down jobs and relationships, and overcome the distress caused by their mental disorders.

Unfortunately, the drug therapies for schizophrenia, bipolar disorder, depression and other conditions are frequently beset by side effects, personality changes, and medical side effects. For this reason, as well as for philosophical and ethical reasons, many patients and some clinicians, reject drug therapies, save as a last resort, preferring psychological therapies. Many psychiatrists in practice combine drug and psychotherapy approaches to

help their patients: where drugs may work, talking to me seems more humane and to reflect the distinctively mental nature of my illness.

3.4. The ethics of treatment

A critical element of the medicine of mental illness is that it is more or less the only branch of medicine, and one of the few areas of private life, where patients may be treated without their consent, and indeed against their will and expressed wishes. All countries have some kind of legislative framework for the compulsory detention of the seriously mentally ill patient, believed to be a serious danger to himself or others; and all countries include in this framework a power to administer treatment to that patient once detained, even where the patient refuses treatment, under certain conditions. Given this, the mentally ill patient who is not formally detained, and is either a “voluntary” patient in a mental hospital (because she referred herself at her own request) or lives in the community, may consider her treatment choices not fully free because there is, in the background, the threat of formal detention and compulsory treatment.

This is especially obvious in cases such as drug addiction, where someone who is addicted to drugs may face a stark choice between being arrested on criminal charges or seeking treatment; and again between voluntary treatment in the community and involuntary treatment in a clinic. In practice, the availability of in-patient care may be very limited, for financial reasons as much as for clinical ones, but the threat of compulsory treatment is often real enough.

Compulsory treatment will normally be imposed where there is a significant risk of serious harm befalling the patient or being caused by the patient to others. But there is a difficult ethical tension between the ordinary medical obligation to treat the patient in their best interests, usually with their autonomous consent, and the special public obligation of protecting the public from the potentially dangerous patient. Very few mental health patients pose any kind of threat to the public (indeed they are at much greater risk of ill treatment by the public than the other way round), but some do, and compulsory treatment in the public interest remains an important part of mental health legislation. Protection of the interests of patients is critically important, and the duties of psychiatrists to act as good doctors, as well as the need to enshrine civil rights protections for the mentally ill, are a consistent theme in the debates about psychiatry and mental health law worldwide. Sadly, the conditions in which

the mentally ill or disabled person may live, in or outside formal care, can be appalling due to abuse, bullying, neglect or poverty.

The ethics of treatment, therefore, are subtle and difficult, at least for the seriously mentally ill patient. For the mildly mentally ill patient who is able to consent to treatment, treatment can offer considerable relief and reinforce their independence and well-being to a considerable extent. Most modern treatment strategies involving working with the patient in partnership. However, the philosophical debates about mental illness and about treatment remain important even in these mild-to-moderate cases, as they strongly influence what patient and psychiatrist (or general practitioner) believe would benefit them, and how they think about the nature of the illness being treated. While many patients welcome the “medicalisation” of mental illness (something that can be treated with a pill is more like an ordinary disease, perhaps), others resent being “drugged” (seeing this as a denial of their humanity or of the real causes of their distress).

Cutting across this debate is the debate about the role of evidence in psychiatric medicine: some popular treatments appear to have little or no evidence to support them (or even some evidence that they may be harmful). Other treatments may be effective, but are beset by side-effects or are disliked by patients. For example, computer-based cognitive behaviour therapy is relatively effective, and much cheaper than counsellor-based cognitive behaviour therapy. But most patients would far rather talk to another person than sit at a computer. Should patient preference, or even philosophical theory, outweigh clear evidence from well-designed controlled clinical trials?

3.5. Social issues

One interesting issue concerning mental illness is how prevalent it is. It seems to be much more common than many people realise (or admit). In part, this is because there is considerable stigma in talking about it, or admitting to suffering from it. This stigma is unfortunate or worse, in that it may prevent people from seeking help, or realising that help is available, and it may provoke unhelpful responses from others – on the one hand, “there’s nothing wrong with you, pull yourself together”, and on the other “oh, you’re mad, keep away from me”. Yet, while acknowledging this, it is also true that the criteria for a diagnosis of a mental illness, and the range of phenomena considered to be, or not be signs of, mental illness, are much wider than in the past.

This is particularly evident in the case of childhood mental illness and mental disability: the diagnosis rate of autism and the development of the category of Attention Deficit Hyperactivity Disorder are both examples of categories which have expanded and become much more numerous than a generation ago. In part this is because of greater diagnostic sensitivity, and because a greater awareness in parents, schools, and the professions of these conditions. Some people think there is a genuine epidemic of these conditions: we diagnose more people with autism purely and simply because there are more autistic people today, and that is something needing a biological explanation. Others think that this is because of better and more reliable diagnosis; and others think it is because we have weakened the criteria for diagnosis. If the last of these is true, why would it be true? One reason is that to get certain kinds of support in the classroom or from the welfare state, a medical diagnosis is essential, so that there is a strong incentive to seek such a diagnosis – especially if the alternative is punishment, low educational attainment, and so on.

Another important issue in mental health concerns the integration of people with mental health problems into society. If mental health problems are gradually being more widely recognised as common, and the stigma attaching to them is diminishing too, then it will be easier, and more widespread, for people with mental health difficulties to live as part of mainstream society. On the other hand, since the early 1980s, people with mental health problems who were living in institutions, or who at one time would have been institutionalised, are now expected to live in society with relatively little support beyond their drug therapy and occasional interactions with social workers and psychiatrists. The moderately mentally ill may really struggle, be socially marginal, live in poverty due to limited welfare benefits and poor employment opportunities, and little possibility of being readmitted to the dramatically reduced number of long-stay mental health beds.

Mental illness and disability are likely to be a major social policy issue in the 21st century, and while society and medicine have made great strides, there is a long way to go before we have a humane and effective policy for helping people with mental health problems recover, flourish, and play a full part in society with their dignity intact.

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