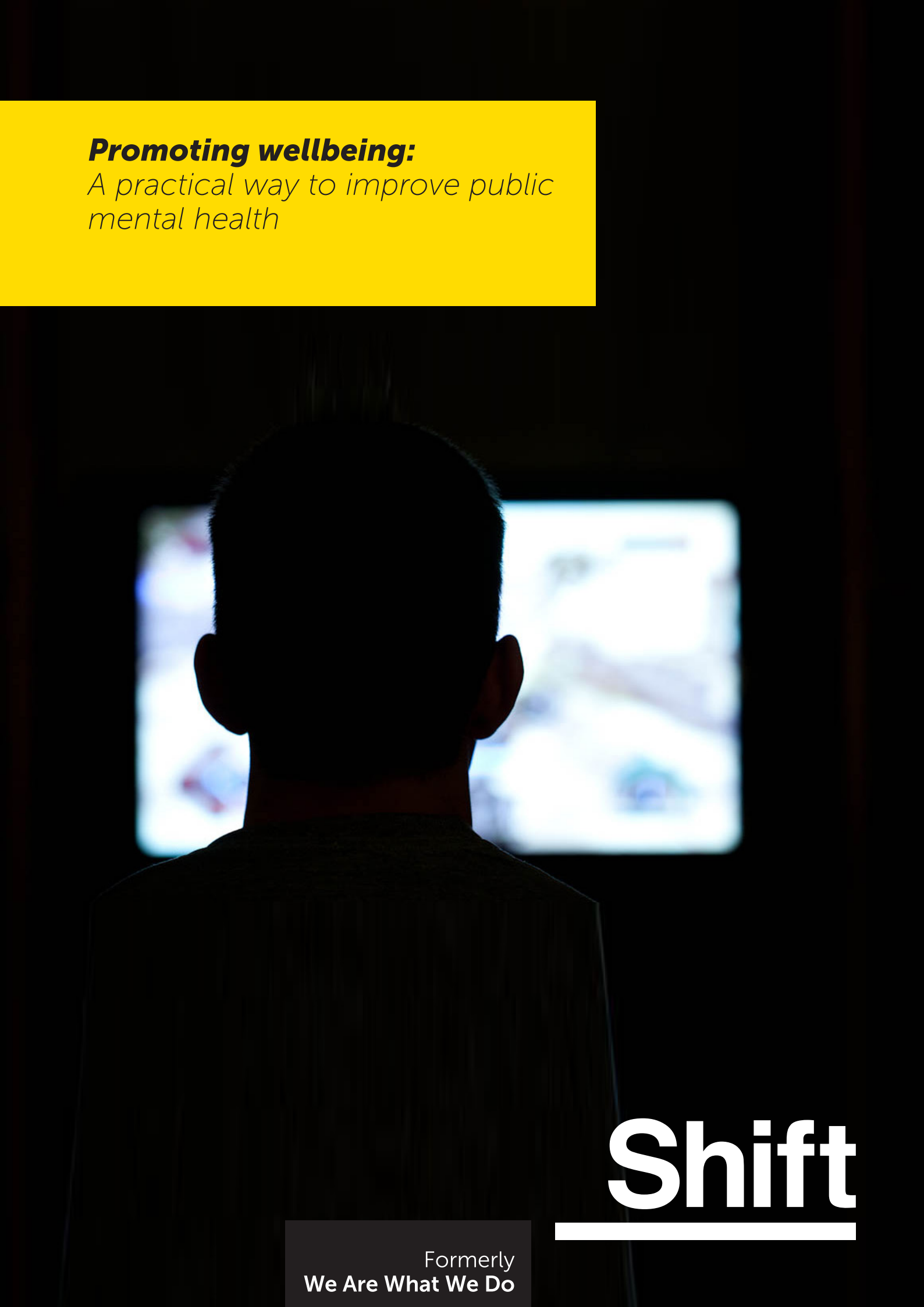
Promoting wellbeing:
A practical way to improve public mental health



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Contents

This document was created by Shift (formerly known as We Are What We Do) as part of the research phase of a product/service development process aimed at improving wellbeing amongst young people in the UK, commissioned by The Nominet Trust.

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Introduction

Mental health is a public health issue with complex causes and serious consequences. This paper gives a brief overview of the scale of the impact of poor mental health on individuals and society. It goes on to explore some of the factors that put some individuals at more risk of developing mental health problems than others, and explain why childhood and adolescence are particularly important times for mental health promotion. It looks at what constitutes wellbeing, and the evidence for believing that promoting positive wellbeing at the population level can reduce the incidence of poor mental health, and well as increasing the number of individuals who experience high levels of wellbeing. Finally, it looks at existing products and services that aim to promote wellbeing.

1. Scale of the problem

Mental health problems represent the largest single source of burden of disease in the UK.[1] This means that mental health problems account for more years of healthy life lost than any other single source of illness.[2] For example, in 2004 mental health disorders (including self-inflicted injury) accounted for 22.8% of the total burden of disease, significantly more than either cardiovascular disease (16.2%) or cancer (15.9%). [3]

Millions affected

Part of the reason that mental health disorders are such a major source of burden of disease in the UK is that a high proportion of the population is affected by poor mental health. The Mental Health Foundation estimates that every year around 1 in 4 people in Britain will experience some form of mental health problem.[4]

Of those who experience mental health problems, only a minority have psychotic symptoms which interfere with a person's perception of reality. The Royal College of Psychiatrists reports that in 2009, only 0.4% of the population had psychosis and a further 5% had symptoms that were clinically significant but below the threshold for the diagnosis of psychosis (sub-threshold psychosis).[5]

The majority of those who experience mental health problems have *"neurotic"* symptoms, which are regarded as extreme forms of natural emotional experiences such as depression, anxiety or panic. These *"neurotic"* symptoms are now frequently called *"common mental disorders"* (CMDs).[6]

The most recent Adult Psychiatric Morbidity Survey, a large household survey which provides data on both treated and untreated mental health disorders, suggested that around 17.5% of the UK population suffers from common mental disorders at any one time, and that a similar proportion have *"symptoms which do not fulfil the full diagnostic criteria for common mental health disorder"*.[7] Generalised Anxiety Disorder (GAD), depressive disorders and mixed anxiety and depression are the most prevalent common mental disorders, affecting 5.8m people in England out of a total of 6.1m people suffering from common mental disorders.[8]

These figures are likely to understate the number of people experiencing common mental disorders. The National Institute for Health and Clinical Excellence (NICE) points out that depression and particularly anxiety often go undiagnosed. Under-recognition is a particular problem for anxiety disorders, and NICE estimates that only a small minority of those who have anxiety disorders ever receive treatment. This is partly due to under-diagnosis by GPs, but may also be driven by patients' reluctance to seek help, due to concern about stigma.[9]

1 Royal College of Psychiatrists (2010) No health without public mental health: The case for action, Position Statement PS4/2010. London: Royal College of Psychiatrists. **2** Burden of disease is measured in Disability Adjusted Life Years (DALYs). According to the World Health Organisation:"One DALY can be thought of as one lost year of"healthy" life. The sum of these DALYs across the population, or the burden of disease, can be thought of as a measurement of the gap between current health status and an ideal health situation where the entire population lives to an advanced age, free of disease and disability" **3** Royal College of Psychiatrists (2010) No health without public mental health: The case for action, Position Statement PS4/2010. London: Royal College of Psychiatrists. **4** Mental Health Foundation (2007) The Fundamental Facts: The latest facts and figures on mental health. London: Mental Health Foundation. **5** Royal College of Psychiatrists (2010) No health without public mental health: The case for action, Position Statement PS4/2010. London: Royal College of Psychiatrists. **6** Mental Health Foundation (2007) The Fundamental Facts: The latest facts and figures on mental health. London: Mental Health Foundation. **7** McManus, S., Meltzer, H, Brugha, T et al (2009) Adult Psychiatric Morbidity in England 2007. Results of a Hosuehold Survey, Health and Social Information Centre, Social Care Statistics. **8** Own calculations based on http://bit.ly/19oY8Ib **9** NICE (2011) Common mental health disorders: Identification and pathways to care, NICE clinical guideline 123. Manchester: NICE

Mental Illness in England (from Royal College of Psychiatrists (2010) No health without public mental health)

- 10% of children and young people have a clinically recognised mental disorder: of 5- to 16-year-olds, 6% have conduct disorder, 18% subthreshold conduct disorder and 4% an emotional disorder
- 17.6% of adults in England have at least one common mental disorder and a similar proportion has symptoms which do not fulfil full diagnostic criteria for common mental disorder
- postnatal depression affects 13% of women following childbirth
- in the past year 0.4% of the population had psychosis and a further 5% subthreshold psychosis
- 5.4% of men and 3.4% of women have a personality disorder; 0.3% of adults have antisocial personality disorder
- 24% of adults have hazardous patterns of drinking, 6% have alcohol dependence, 3% ilegal drugs dependence and 21% tobacco dependence
- 25% of older people have depressive symptoms which require intervention: 11% have minor depression and 2% major depression; the risk of depression increases with age - 40% of those over 85 are affected
- 20-25% of people with dementia have major depression whereas 20-30% have minor or subthreshold depression
- dementia affects 5% of people aged over 65 and 20% of those aged over 80
- in care homes, 40% of residents have depressio, 50–80% demetia and 30% anxiety
- a third of people who care for an older person with dementia have depression

Source: Royal College of Psychiatrists (2010) No health without public mental health: The case for action, Position Statement PS4/2010. London: Royal College of Psychiatrists.

Early Onset

Another factor that explains why mental health is such a significant contributor to the overall burden of disease in the UK is that, in comparison with diseases such a cardiovascular disease and cancer, mental health problems affect people when they are relatively young. 1 in 10 young people aged 5–16 in Great Britain had a clinically diagnosed mental disorder according to a major national study of the mental health of children and young people in 2004.[10] Further, studies by Kim-Cohen et al and Kessler et al find that half of all cases of mental health disorder start by age 14 years and three quarters by age 24 years. [11, 12]

The mental health problems young people experience often persist into adulthood in a related form. For example, young people who experience depression in mid-adolescence (14-16 years old) are more likely to experience major depression and anxiety disorders as adults, even once confounding social, familial and individual factors are taken into account.[13] Similarly, young people with juvenile anxiety disorders are at a higher risk of anxiety disorders and major depression in later life. Again, this link persists even once other contributing social, familial and individual characteristics are taken into account.[14]

Mental health problems in early life also precede the development of different types of mental health problems in later life. For example, conduct disorder and oppositional defiant disorders, characterised by *"a pattern of repeated and persistent misbehaviour"*, precede a wide variety of adult mental health disorders. According to Richardson and Joughin *"approximately 40-50% of children with conduct disorder go on to develop antisocial personality disorder as adults"* but conduct disorder is also linked to other negative outcomes such as substance misuse, mania, schizophrenia, obsessive-compulsive disorder, major depressive disorder and panic disorder in later life.[15]

The early onset of mental health problems means that those affected often experience mental health issues throughout large portions of their lives, including crucial years for social and career development.

10 Green, H., McGinnity, Á., Meltzer, H., Ford, T & Goodman, R. (2004) Mental health of children and young people in Great Britain, 2004: A survey carried out by the Office for National Statistics on behalf of the Department of Health and the Scottish Executive. London: ONS. **11** Kim-Cohen J, Caspi A, Moffitt TE, Harrington H, Milne BJ, Poulton R. (2003) Prior juvenile diagnoses in adults with mental disorder: developmental follow-back of a prospective-longitudinal cohort. Archives of General Psychiatry 60(7):709-17. **12** Kessler, R., Berglund, P., Demler, O., Jin, R., Merikangas, K. & Walters, E. (2005) Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication Archives of General Psychiatry 62(6):593-602. **13** Fergusson DM, Woodward LJ. (2002) Mental health, educational, and social role outcomes of adolescents with depression. Archives of General Psychiatry 59(3):225-31. **14** Fergusson DM, Woodward LJ. (2002) Mental health, educational, and social role outcomes of adolescents with depression. Archives of General Psychiatry 59(3):225-31. **15** Richardson, J & Joughin, C. (2002) Parent Training Programmes for the Management of Young Children with Conduct Disorders: Findings from Research. London: Royal College of Psychiatrists.

Significant impact

The final reason why mental health contributes so much to the overall burden of disease is that it has such a significant impact on the lives of those who it affects. The extent of the impact of mental health problems is often not fully recognised as connections between mental health and other aspects of health and wellbeing are not always apparent and are most easily seen at the population level rather than at the individual level.

The impact of poor mental health begins early. Children and young people who experience mental health problems are more likely to have poor educational achievement, with negative consequences for career development and earnings. They are also at a greater risk of suicide and substance misuse, anti-social behaviour, offending and early pregnancy. Poor mental health in childhood and adolescence is also associated with poor health and social outcomes in adulthood.[16]

Over the life course, people who experience mental illness experience more physical illness, and have a lower life expectancy.[17] Depression in particular is strongly correlated with cardiovascular disease and cancer: mortality from cardiovascular disease is 67% higher in those who are depressed, and mortality from cancer is 50% higher.[18] A large cohort study in Norway showed that depression significantly increased mortality from both cardiovascular disease and also all other causes, even after taking into account health-related behaviours (smoking, alcohol use, and physical activity), physical symptoms and impairments, education and socioeconomic status, and physical measurements such as body mass index, blood pressure and cholesterol.[19]

Individuals who experience mental health problems are more likely to self-harm, and are at a higher risk of suicide. Suicide is the third largest contributor to premature mortality (after heart disease and cancer) in Britain.[20] The Royal College of Psychiatrists reports that *"in some studies, the rate of a diagnosed mental illness of those who have killed themselves has been found to be more than 80%"*, and the rate of suicide amongst those with severe mental illness is 12 times higher than in the general population.[21] Self-harm behaviour is also more common amongst those with a mental disorder.[22] Self-harm and suicide are statistically linked: recent studies suggest that those who self-harm are at an approximately 30-fold greater risk of suicide, compared with the general population.[23]

Mental health problems are associated with lower levels of self-care behaviour, and higher levels of risky health behaviours. Almost half of all tobacco in the UK is consumed by those who have a mental health diagnosis.[24] Smoking significantly increases the risk of many serious diseases, and reduces life expectancy. Mental illness, particularly major depression, increases the risk of obesity.[25] Depression may also affect the way that individuals seek help for health problems, with the consequence that physical illnesses are diagnosed at a more advanced stage than they might otherwise have been, and it may reduce adherence to treatment plans, negatively affecting their health outcomes.[26]

Poor mental health is also associated with alcohol misuse. Rates of alcohol misuse are much higher amongst those with poor mental health. Young people with an emotional or conduct disorder are 2-4 times more likely to drink regularly (more than twice a week).[27] Alcohol consumption may also contribute or worsen mental health problems: high levels of alcohol consumption are *"associated with higher levels of depressive and affective problems, schizophrenia and personality disorders."*[28]

The effects of mental illness spill out far beyond the individual affected. People with mental disorders are more likely to be victims of crime and violence than perpetrators.[29] At the same time, mental illness is an important factor in the problem of crime at the population level. The Sainsburys Centre for Mental Health estimates that *"around 80% of all criminal activity is attributable to people who had conduct problems in childhood and adolescence, including about 30% specifically associated with conduct disorder."*[30] The risk of violent behaviour is significantly increased only for those who misuse alcohol and drugs.[31]

Mental health also has a large impact on work and productivity. While employment can provide a group to belong to, an income and a sense of purpose, work can also be stressful and insecure. Around 11.4 million working days are lost annually in Britain due to work-related stress, anxiety or depression.[32]

For those with mental health problems, it is more difficult to find and remain in productive employment, and mental illness is consequently associated with

16 Royal College of Psychiatrists (2010) No health without public mental health: The case for action, Position Statement PS4/2010. London: Royal College of Psychiatrists. **17** Royal College of Psychiatrists (2010) No health without public mental health: The case for action, Position Statement PS4/2010. London: Royal College of Psychiatrists. **18** Royal College of Psychiatrists (2010) No health without public mental health: The case for action, Position Statement PS4/2010. London: Royal College of Psychiatrists. **19** Mykletun, A., Bjerkeset, O., Dewey, M., Prince, M., Overland, S. & Stewart, R. (2007) Anxiety, Depression, and Cause-Specific Mortality: The HUNT Study Psychosomatic Medicine 69:323–331. **20** Royal College of Psychiatrists (201) Self-harm, suicide and risk: helping people who self-harm. College Report CR158. London: Royal College of Psychiatrists. **21** Royal College of Psychiatrists (201) Self-harm, suicide and risk: helping people who self-harm. College Report CR158. London: Royal College of Psychiatrists. **22** Royal College of Psychiatrists (2010) No health without public mental health: The case for action, Position Statement PS4/2010. London: Royal College of Psychiatrists. **23** Royal College of Psychiatrists (201) Self-harm, suicide and risk: helping people who self-harm. College Report CR158. London: Royal College of Psychiatrists. **24** Royal College of Psychiatrists (2010) No health without public mental health: The case for action, Position Statement PS4/2010. London: Royal College of Psychiatrists. **25** Royal College of Psychiatrists (2010) No health without public mental health: The case for action, Position Statement PS4/2010. London: Royal College of Psychiatrists. **26** Mykletun, A., Bjerkeset, O., Dewey, M., Prince, M., Overland, S. & Stewart, R. (2007) Anxiety, Depression, and Cause-Specific Mortality: The HUNT Study Psychosomatic Medicine 69:323–331. **27** Royal College of Psychiatrists (2010) No health without public mental health: The case for action, Position Statement PS4/2010. London: Royal College of Psychiatrists. **28** Royal College of Psychiatrists (2010) No health without public mental health: The case for action, Position Statement PS4/2010. London: Royal College of Psychiatrists. **29** Royal College of Psychiatrists (2010) No health without public mental health: The case for action, Position Statement PS4/2010. London: Royal College of Psychiatrists **30** Sainsbury Centre for Mental Health (2009) The chance of a lifetime: Preventing early conduct problems and reducing crime. London: Sainsbury Centre for Mental Health. **31** Royal College of Psychiatrists (2010) No health without public mental health: The case for action, Position Statement PS4/2010. London: Royal College of Psychiatrists. **32** Royal College of Psychiatrists (2010) No health without public mental health: The case for action, Position Statement PS4/2010. London: Royal College of Psychiatrists.

an increased likelihood of unemployment. Only 20% of those using specialist mental health services are in paid work or full-time education.[33] The social exclusion and financial challenges experienced by many of those who are unemployed can in turn contribute to poor mental health, leading to a vicious cycle.

Despite national campaigns to raise awareness of the importance of mental health and reduce the stigma attached to mental health diagnoses, discrimination still compounds the impact of mental health problems for many individuals. The Royal Society of Psychiatrists also points out that people with mental health problems experience exclusion along a variety of dimensions (economic, social, political exclusion and also service exclusion), compounding inequality, which is itself a risk factor for poor mental health.

High costs

Because mental health problems start so early, and because they have such significant and wide-ranging consequences for the individuals directly affected and those connected with them, the economic burden of poor mental health is very large indeed. The Royal College of Psychiatrists estimates that the wider costs of mental illness in England are £105.2 bn a year. In 2007, the direct costs of mental health to NHS were £10.4 bn, and the Centre for Mental Health estimated that the combined costs of health and social care, including NHS and local authority services for people with mental health problems, were approximately £21.3 bn in 2009/2010.[34]

There is a particularly strong economic case of early intervention. The economic evaluation of costs to society of mental illness in children and adolescents has produced estimates ranging from £11,030 to £59,130 per child per year.[35] The National CAMHS Support Service points to studies that show that public services could save £100m every year by delivering early intervention services to just 1 in 10 of the young people receiving prison sentences, and that £50m per year could be saved by providing early intervention services for patients with psychosis.[36]

It is clear that mental health is a major public health issue, and its development is heavily influenced by early experiences and shaped by risk factors in early life. What can be done to prevent the development of poor mental health? Understanding what the typical risk factors are for the development of poor mental health is vital, as is identifying protective factors that could help prevent the development of poor mental health.

2. Who is most at risk?

Mental health is a major public health problem, which is widely prevalent, starts early and has a major impact on quality of life. Many of the consequences of poor mental health in fact reinforce poor mental health in a vicious cycle. But what are the factors that predispose people to mental health disorders?

Certain groups of individuals are at higher risk of developing mental health problems. Overall, in the UK women are more likely to have a common mental health disorder than men. A 2007 UK household survey found that nearly 1 in 5 women had a common mental disorder compared with only 1 in 8 men.[37]

The same study found that rates of common mental disorder varied by age. The oldest group in the survey (those aged 75 and over) had the lowest incidence of common mental disorder with only 6.3% of men and 12.2% of women experiencing disorders. Women between 45 and 54 years old had the highest rate: over a quarter (25.2%) of this group met the criteria for at least one CMD. For men, the rate of CMDs peaked between 25 and 54 years old (14.6% of 25–34 year olds, 15.0% of 35–44 year olds, 14.5% of 45–54 year olds).[38]

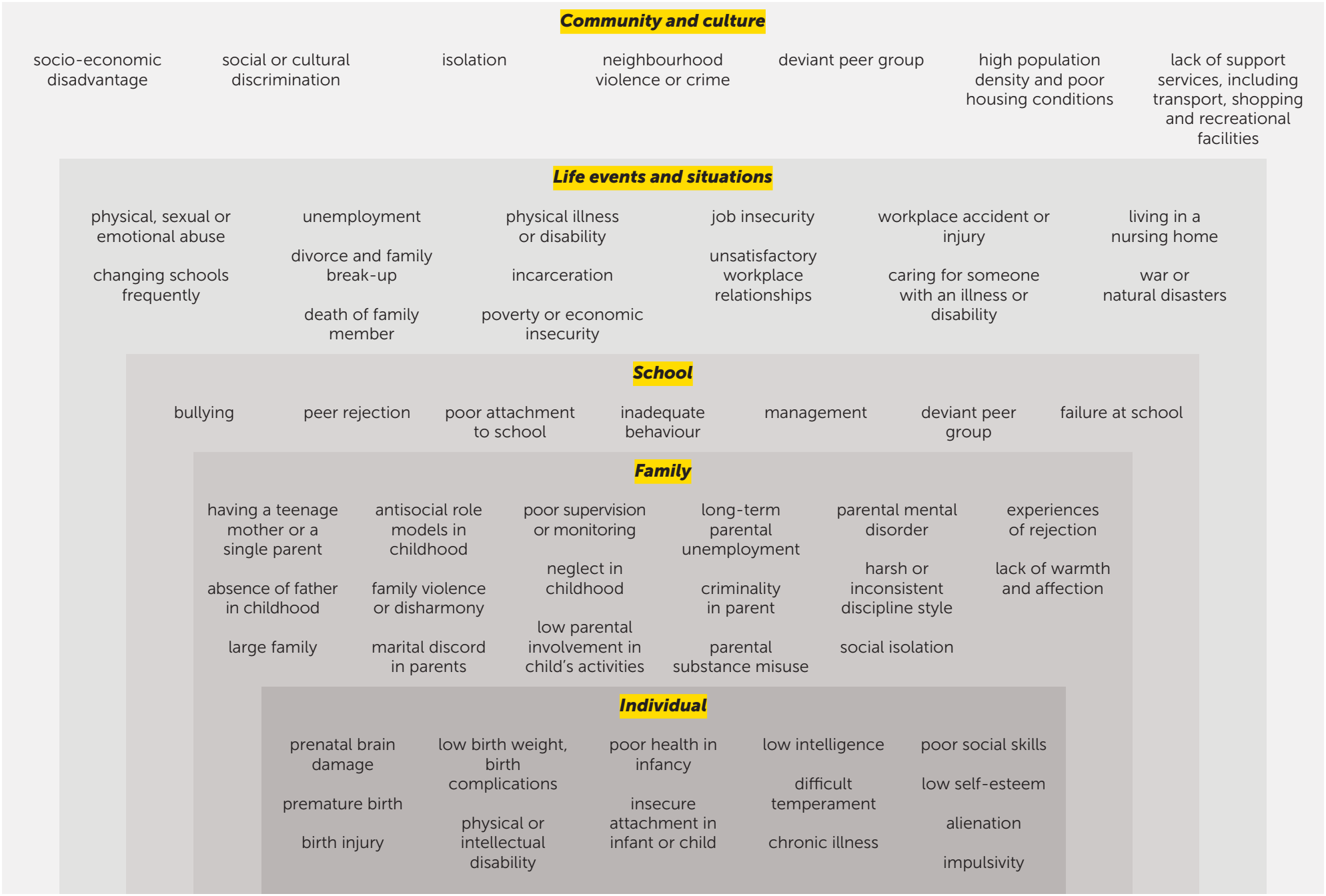
Those living in households with lower levels of income are more likely to experience common mental disorders than those in households with higher levels of income. MacManus et al (2009) found that 23.5% of men in the lowest household income group had a CMD, compared to only 8.8% of those in the highest income households, after adjusting for age.[39]

These statistics summarise the incidence of CMDs for different groups of the adult population. Alongside age, gender and income, there are also a large number of other risk factors which contribute to the development of poor mental health. Because 75% of mental health disorders start in childhood or early adulthood, risk factors for the development of poor mental health early in life are particularly relevant to understanding the factors that put individuals at greater risk.

Risk factors in the development of mental disorders among young people can be identified at the individual level, family level, school level and at the level of community and culture. Some risk factors also relate to specific life events, such as trauma or loss.[40,41] The factors explored below are overall risk factors for the development of mental illness in general – risk factors for particular illnesses will be different.

33 Royal College of Psychiatrists (2010) No health without public mental health: The case for action, Position Statement PS4/2010. London: Royal College of Psychiatrists. **34** Centre for Mental Health (2010) The economic and social costs of mental health problems in 2009/10 London: Centre for Mental Health. **35** Royal College of Psychiatrists (2010) No health without public mental health: The case for action, Position Statement PS4/2010. London: Royal College of Psychiatrists. **36** National CAMHS Support Service (2011) Better mental health outcomes for children and young people: a resource directory for commissioners. London: National CAMHS Support Service (NCSS) **37** McManus, S., Meltzer, Hm Brugha, T et al (2009) Adult Psychiatric Morbidity in England 2007. Results of a Household Survey, Health and Social Information Centre, Social Care Statistics. **38** McManus, S., Meltzer, Hm Brugha, T et al (2009) Adult Psychiatric Morbidity in England 2007. Results of a Household Survey, Health and Social Information Centre, Social Care Statistics. **39** McManus, S., Meltzer, Hm Brugha, T et al (2009) Adult Psychiatric Morbidity in England 2007. Results of a Household Survey, Health and Social Information Centre, Social Care Statistics. **40** Kutz, Z. (2009) The Evidence Base to Guide Development of Tier 4 CAMHS. London: Department of Health **41** Royal College of Psychiatrists (2010) No health without public mental health: The case for action, Position Statement PS4/2010. London: Royal College of Psychiatrists.

Figure 1: Risk factors for developing mental illness



Based on: Children and Mental Health Knowledge Exchange (2007) Best practices guidelines for mental health promotion programs

The following groups are at higher risk than their peers for mental health problems:

Because experiences in childhood and adolescence play such a key role in the development of an individual's mental health, this is a key point for intervention.

Table 1: Impact of risk factors on prevalence of any mental disorder

Risk Factor	Expected prevalence of mental disorder
Looked after children	45%
Children with Special Educational Needs requiring statutory assessment	44%
Child with learning disability	22%
Households with no working parent	20%
Child absent from school more than 11 days in a year	19%
Parental mental illness	18%
5 or more children in household	18%
Lone parent families	16%
Children living in less prosperous / mixed areas	16%
Parents with no educational qualifications	15%

3. Why focus on wellbeing?

Until relatively recently, the de facto approach to addressing mental health has been a combination of treatment for those who are experiencing mental health problems and initiatives addressing risk factors for mental health targeted at groups at high risk of developing mental health problems. Recently, however, there has been recognition that this approach has not been sufficient to reduce *"the prevalence, burden, or early onset of mental disorder"*.[42]

To address the public health issue that mental health poses, major public health bodies and psychological and psychiatric associations increasingly believe that the focus should be on developing and protecting positive mental health or mental wellbeing, as a way of preventing mental health problems. Mental health promotion is now seen as an essential part of public mental health, in addition to initiatives that reduce risk factors for mental health problems, and the provision of treatment.

What is wellbeing?

Good mental health or mental wellbeing is more than the absence of mental illness. The World Health Organisation defines positive mental health as: *"a state of wellbeing in which every individual realises his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community... Health is a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity."*[43] Wellbeing is now widely understood as having two key dimensions.

Feeling good

One dimension of wellbeing relates to individual's subjective experience. Felicia Huppert at the Well-being Institute at Cambridge simply describes this as *"feeling good"*. Others have called it subjective wellbeing or hedonic wellbeing. According to Diener, Suh, Lucas and Smith, subjective well-being has three interrelated components: *"life satisfaction (an overall cognitive sense of satisfaction with one's life), pleasant affect (enjoyable moods and emotions), and unpleasant affect."*[45]

Functioning effectively

Another aspect of wellbeing refers to how effectively an individual is able to function. This is often called psychological wellbeing or eudaimonic wellbeing. An influential model developed by Ryff (2006) suggests that psychological wellbeing is constituted by self-acceptance, positive relations with others, autonomy, environmental mastery, purpose in life and personal growth. Huppert describes these aspects as *"developing one's potential, having some control*

42 Keyes, C., Dhingra, S., Simoes, E. (2010) Change in Level of Positive Mental Health as a Predictor of Future Risk of Mental Illness. American Journal of Public Health, 100(12) **43** World Health Organisation (2013) Mental health: a state of well-being. Downloaded from <http://www.who.int/features/factfiles/mental_health/en/> **44** Huppert, F. (2009) Psychological Well-being: Evidence Regarding its Causes and Consequences. Applied Psychology: Health and Wellbeing 1(2):137-164. **45** Diener, E., Suh, E., Lucas, R. & Smith, H. (1999) Subjective Well-being: Three decades of progress.Psychological Bulletin, Vol 125(2), Mar 1999, 276-302. **46** Huppert, F. (2009) Psychological Well-being: Evidence Regarding its Causes and Consequences. Applied Psychology: Health and Wellbeing 1(2):137-164.

over one's life, having a sense of purpose, including working towards valued goals, and experiencing positive relationships."[46]

Huppert points out that *"sustainable well-being does not require individuals to feel good all the time: the experience of painful emotions is a normal part of life, and being able to manage these negative or painful emotions is essential for long-term well-being. Psychological well-being is, however, compromised when negative emotions are extreme or very long-lasting and interfere with a person's ability to function in his or her daily life."*[47]

Wellbeing is distinct from the absence of mental health problems. There is now a significant amount of evidence that while some of the factors that contribute to mental illness and mental wellbeing are the same, others are not.[48] Keyes, for example, suggests that the findings from many studies which examine the relationship between wellbeing and mental illness support the idea that there are two continuums relevant to mental health: *"one indicating the presence or absence of mental health, the other indicating the presence or absence of mental illness symptoms."*[49] Keyes argues that the two should be understood as separate aspects of mental health.

Mental wellbeing is often represented on a continuum from flourishing to languishing. The concept of flourishing is often used to describe the what mental health development should aim at. Fredrickson and Losada describe flourishing as living *"within an optimal range of human functioning, one that connotes goodness, generativity, growth, and resilience."*[50] The term *"languishing"* is used to describe the other end of the continuum, where individuals experience unhappiness and stagnation but not necessarily mental illness.

Although mental wellbeing tends to improve as mental illness symptoms decrease, this is not always the case.[51] Bolier, Haverman and Bohlmeijer explain that *"people can be free of mental illness and at the same time be unhappy and exhibit a high level of dysfunction in daily life ... . Likewise, people with mental disorders, can be happy by coping well with their illness and enjoy a satisfactory quality of life"*.[52] This perspective has been adopted at the policy level in several countries. For example, the Scottish Government suggest that *"someone can experience signs and symptoms of mental illness and still have good or flourishing mental well being ... just as people with a physical illness or condition can live positively, flourish and have a good sense of wellbeing"*.[53]

Why focus on wellbeing?

Prevents poor mental health

Various studies suggest that good mental well being can act as a buffer for poor mental health. Psychologists who focus on the protective effect of wellbeing on mental health argue that knocks, stressors, traumas and losses are inevitable in life and can have a huge impact on a person's state of mental wellbeing, particularly in relation to CMDs such as anxiety and depression. A core aim of mental health promotion is to help people to build the cognitive and emotional resources that they need in order to *"cope"* not only in times of calm but also in times of trouble, in order that the risk of triggering a CMD is reduced.

Martin Seligman, an early proponent of the idea that psychology should focus on understanding and promoting full human flourishing as well as addressing dysfunction, argued that *"nurturing human strengths such as optimism, courage, future mindedness, honesty and perseverance serve as more efficacious buffers against mental illness as compared to medication or therapy"*.[54]

The view that good mental health protects against mental illness has found empirical support in several studies.

For example, there is evidence that wellbeing protects against the negative effects of stress on mental health. Grant, Guille and Sen (2013) assessed the wellbeing levels of 1621 medical interns directly before they started their internships, an experience recognised to be stressful and a time during which depressive symptoms are known to increase significantly. Those interns who had higher levels of wellbeing at the start of their internships showed a smaller increase in depressive symptoms over the 3 months of the study. [55]

There is also evidence that maintaining good levels of wellbeing is associated with a lower likelihood of developing a mental illness. Keyes et al, in a large 10 year follow-up study, found that individuals that were languishing at both the beginning and the end of the 10 year period were more than 6 times as likely to have a mental illness at the end of the period compared to those who had stayed flourishing at both points. They also found that gains in mental health decreased the likelihood of experiencing a mental illness while losses in mental health increased it. In all, their study provides support for the hypothesis that promoting and protecting good mental health can protect against the development of mental illness.[56]

Reduces the burden of disease

Small improvements in wellbeing could significantly reduce the incidence of mental health disorders in the population.

47 Huppert, F. (2009) Psychological Well-being: Evidence Regarding its Causes and Consequences. Applied Psychology: Health and Wellbeing 1(2):137-164. **48** Huppert, F. (2009) Psychological Well-being: Evidence Regarding its Causes and Consequences. Applied Psychology: Health and Wellbeing 1(2):137-164. **49** Keyes, C., Dhingra, S., Simoes, E. (2010) Change in Level of Positive Mental Health as a Predictor of Future Risk of Mental Illness. American Journal of Public Health, 100(12) **50** Fredrickson, B. & Losada, M. (2005) Positive Affect and the Complex Dynamics of Human Flourishing. The American Psychologist 60(7):678-686. **51** Keyes, C. (2002) The Mental Health Continuum: From Languishing to Flourishing in Life. Journal of Health and Social Behavior, 43(2):207-222. **52** Bolier, L., Haverman, M., Westerhof, G., Riper, H., Smit, F., Bohlmeijer, E. (2013). Positive psychology interventions: a meta-analysis of randomized controlled studies. BMC Public Health, 13: 119. **53** The Scottish Government (2007) Towards a Mentally Flourishing Scotland: The Future of Mental Health Improvement in Scotland 2008-11. Downloaded from: <http://www.scotland.gov.uk/Publications/2007/10/26112853/1> **54** Terjesen, M., Jacofsky, M., Froh, J. & DiGiuseppe, R. (2004) Integrating positive psychology into schools: Implications for practice. Psychology in the Schools, Vol. 41(1), 2004 **55** Grant, F., Guille, C. & Sen, S. (2013) Well-Being and the Risk of Depression under Stress. PLoS One. 8(7): e67395. **56** Keyes, C., Dhingra, S., Simoes, E. (2010) Change in Level of Positive Mental Health as a Predictor of Future Risk of Mental Illness. American Journal of Public Health, 100(12)

Keyes (2002) suggests that although mental illness and mental wellbeing are distinct, there are enough common underlying factors to justify representing mental health as being on a continuum which moves from a full mental health disorder to flourishing at the population level.[57] The stages of Keyes' continuum are flourishing, moderately mentally healthy, languishing, and DSM-III-R major depressive episode. In a given population, the majority of people are languishing or moderately mentally healthy, and only a minority have a clinically diagnosable mental illness or can be said to be flourishing.[58]

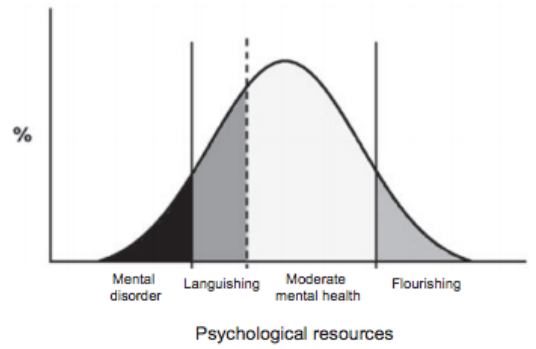


Figure 2: Figure taken from Huppert, F. (2009) Psychological Wellbeing: Evidence regarding its causes and consequences

Evidence from epidemiology suggests that if the key concern is to reduce the number of individuals with clinically significant disorders, rather than focusing on treatment and cure for this group, it may be more effective to target the large proportion of the population with symptoms which are not yet clinically significant (sub-threshold symptoms) or who are free from mental health problems but not flourishing.[59]

The theory is that shifting the overall levels of wellbeing of the population reduces the number of people who are languishing, and more likely to develop mental health disorders, and increases the proportion who are moderately mentally healthy and flourishing, and thus less likely to develop mental health disorders, thereby reducing the overall levels of mental health disorder in the population.

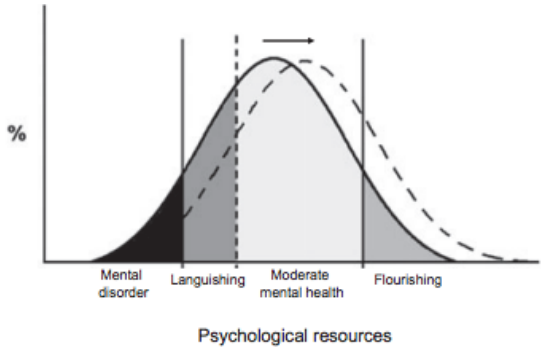


Figure 3: Figure taken from Huppert, F. (2009) Psychological Wellbeing: Evidence regarding its causes and consequences

Empirically, there is evidence of a relationship between average levels of wellbeing in a population and the proportion of individuals experiencing mental health disorders. Felicity Huppert points to a study which compared the average levels of psychological distress and the incidence of clinically significant disorders in a number of population groups that differed in terms of socio-demographic characteristics. The study found across the groups, there was a clear relationship between the percentage of people experiencing a clinically significant common mental disorder and the mean level of symptoms of mental distress. Their model suggested that a small change in the mean scores for mental distress would lead to a relatively large change in the prevalence of common mental disorders in that population. A follow-up study broadly confirmed this finding. Whittington and Huppert found *"a linear relationship between the decrease in the mean symptom score and the decrease in the percentage of people who had clinically significant disorder. For every one point decrease on the symptom scale, the prevalence of disorder dropped by 6%. Moreover, as the mean number of symptoms decreased, a higher percentage of the sample moved into a no-symptom category, which could be described as flourishing."*[60]

This relationship between the prevalence of a disorder and the average levels of underlying symptoms or risk factors in the population is also present for many other common physical and mental disorders, including alcoholism, gambling addiction and hypertension and heart disease.[61] For all of these conditions, *"[i]f the mean number of symptoms in a particular population is low, it turns out that the percentage of people who meet criteria for a common disorder is low; if the mean number of symptoms in a population is high, the percentage of people who meet criteria is high."*[62]

This suggests that in so far as the contributing factors to mental wellbeing and poor mental health are shared, interventions that can achieve a small shift in the overall level of wellbeing of the population could have a disproportionately large effect on the numbers experiencing mental health problems.

In so far as contributing factors are not the same for mental ill health and good mental health, mental health promotion will result in health benefits for the population over and above reduction in ill health, which is a good thing in itself.

Taken together, these facts suggest that efforts to increase the levels of wellbeing in a population may be a more effective way of reducing the incidence of common mental and behavioural problems than focusing on treatment or risk reduction.[63]

57 Keyes, C. (2002) The Mental Health Continuum: From Languishing to Flourishing in Life. Journal of Health and Social Behavior, 43(2):207-222.
58 Keyes, C. (2002) The Mental Health Continuum: From Languishing to Flourishing in Life. Journal of Health and Social Behavior, 43(2):207-222.
59 Huppert, F. (2009) Psychological Well-being: Evidence Regarding its Causes and Consequences. Applied Psychology: Health and Wellbeing 1(2):137-164. **60** Huppert, F.A. (2009), A new approach to reducing disorder and improving well-being, Perspectives on Psychological Science 4(1), 108-111. **61** Huppert, F.A. (2009), A new approach to reducing disorder and improving well-being, Perspectives on Psychological Science 4(1), 108-111.
62 Huppert, F.A. (2009), A new approach to reducing disorder and improving well-being, Perspectives on Psychological Science 4(1), 108-111.

Improves physical health

Wellbeing also has a positive effect on physical health. A large number of cross-sectional and longitudinal studies have shown that positive mental states are associated with better physical health and greater longevity.[64,65] The effect of positive mental states on immunity has also been convincingly demonstrated. Several studies have shown that individuals who have a positive emotional style are less likely to become ill after controlled exposure to a virus,[66] and produce more antibodies in response to vaccination.[67] Studies have also indicated that inducing a positive mental state (through meditation) increases antibody production relative to a control group.[68]

In addition to having a direct impact on health through immune and hormonal responses, individuals with a high level of wellbeing also tend to have healthier lifestyles. They also tend to have stronger and more positive interpersonal relationships, which are known to have a protective effect on health and life expectancy.[69]

How can wellbeing be promoted?

Although genetic, demographic and socioeconomic factors affect wellbeing, studies suggest that these fixed factors and life circumstances together account for only around 60% of the the variation in wellbeing between individuals.[70] The other 40% of the variation in wellbeing is driven by factors that are under individuals' control. In other words intentional activities, including behaviours, cognitions and motivations are also important drivers of psychological wellbeing.[71] Many psychologists now believe that interventions that target behaviours, cognitions and motivations have the potential to improve wellbeing.

Over the last few years, proponents of positive psychology have been looking at what happy people characteristically think and do, examining their habits, behaviours, cognitive patterns (including grateful and optimistic thinking, and prosocial behavior).[72] They have been devising positive activities which replicate these characteristics, and testing out whether practising these activities can increase wellbeing in others. Lyubomirsky defines positive activities as *"simple, intentional, and regular practices meant to mimic the myriad healthy thoughts and behaviors associated with naturally happy people"*.[73] Many positive activities have been shown to effectively increase both subjective wellbeing (positive affect and life satisfaction) and psychological wellbeing (effective functioning). These activities include writing gratitude letters, counting blessings, performing acts of kindness, cultivating strengths, visualising positive future selves and meditating.[74] As Lyubomirsky points out, as well as being effective, all these practices are cheap, brief, and can be done without outside help.[75]

Sin and Lyubormirsky (2009) conducted a meta-review of randomised controlled studies of positive psychology interventions, including mindfulness interventions (which they define as *"treatment methods or intentional activities aimed at cultivating positive feelings, positive behaviors, or positive cognitions"*).[76] Looking at 51 interventions, across 4,266 individuals, they found that these interventions, which prompted people to think gratefully, optimistically or mindfully, did significantly improve wellbeing, and also significantly reduced symptoms of depression.[77] Subsequent meta-reviews have backed up the finding that positive psychology is effective in improving wellbeing and reducing depression. Bolier et al (2013) conducted a similar meta-review of randomised controlled studies investigating the effect of positive psychology interventions, and also found the interventions had a significant, although small, effect on wellbeing and depression, and that the effect on wellbeing persisted even after 3–6 months.[78] Mindfulness interventions were excluded from this study because their effectiveness had already been convincingly demonstrated.

In addition to these reviews, meditation and mindfulness-based therapies have been separately tested and found to be effective in improving mental health and wellbeing both in individuals with diagnosed mental problems, and also in those without.[79,80,81] Professor Mark Williams from the University of Oxford Department of Psychiatry has called the evidence for their effectiveness *"incontrovertible"*.[82]

63 Huppert, F. (2009) Psychological Well-being: Evidence Regarding its Causes and Consequences. Applied Psychology: Health and Wellbeing 1(2):137-164. **64** Bolier, L., Haverman, M., Westerhof, G., Riper, H., Smit, F., Bohlmeijer, E. (2013). Positive psychology interventions: a meta-analysis of randomized controlled studies. BMC Public Health, 13: 119 **65** Huppert, F. (2009) Psychological Well-being: Evidence Regarding its Causes and Consequences. Applied Psychology: Health and Wellbeing 1(2):137-164. **66** Cohen, S., Alper, C. Doyle, W., Treanor, J. & Turner, R. (2006) Positive Emotional Style Predicts Resistance to Illness After Experimental Exposure to Rhinovirus or Influenza A Virus. Psychosomatic Medicine 68(6):809-15. **67** http://www.ncbi.nlm.nih.gov/pmc/articles/PMC196942/ **68** See Huppert, F. (2009) Psychological Well-being: Evidence Regarding its Causes and Consequences. Applied Psychology: Health and Wellbeing 1(2):137-164. **69** Huppert, F. (2009) Psychological Well-being: Evidence Regarding its Causes and Consequences. Applied Psychology: Health and Wellbeing 1(2):137-164. **70** Boehm, J. K., & Lyubomirsky, S. (2011). The promise of sustainable happiness. In S. Lopez & C. Snyder (Ed.), Handbook of positive psychology (2nd ed.). Oxford: Oxford University Press. **71** Lyubomirsky, S., Schkade, D. & Sheldon, K. (2005) Pursuing Happiness: The Architecture of Sustainable Change Review of General Psychology 9(2)111–131. **72** Lyubomirsky, S. (2001). Why are some people happier than others? The role of cognitive and motivational processes in well-being. American Psychologist, 56: 239-249. **73** Lyubomirsky, S., & Layous, K. (2013) How do simple positive activities increase well-being? Current Directions in Psychological Science, 22(1):57-62. **74** Lyubomirsky, S., & Layous, K. (2013) How do simple positive activities increase well-being? Current Directions in Psychological Science, 22(1):57-62. **75** Lyubomirsky, S., & Layous, K. (2013) How do simple positive activities increase well-being? Current Directions in Psychological Science, 22(1):57-62. **76** Sin, N. L., & Lyubomirsky, S. (2009) Enhancing well-being and alleviating depressive symptoms with positive psychology interventions: A practice-friendly meta-analysis. Journal of Clinical Psychology: In Session, 65:467-487. **77** Sin, N. L., & Lyubomirsky, S. (2009) Enhancing well-being and alleviating depressive symptoms with positive psychology interventions: A practice-friendly meta-analysis. Journal of Clinical Psychology: In Session, 65:467-487. **78** Bolier, L., Haverman, M., Westerhof, G., Riper, H., Smit, F., Bohlmeijer, E. (2013) Positive psychology interventions: a meta-analysis of randomized controlled studies. BMC Public Health 13: 119. **79** Hofmann, S., Sawyer, A. et al (2010) The Effect of Mindfulness-Based Therapy on Anxiety and Depression: A Meta-Analytic Review, Journal of consulting and clinical psychology 87(2):169-183. **80** Halliwell, E (nd) Mindfulness Report. London: Mental Health Foundation. **81** Khoury, B., Lecomte, Y. et al (2013) Mindfulness-based therapy: A comprehensive meta-analysis. Clinical Psychology Review 33:763–771. **82** Halliwell, E (nd) Mindfulness Report. London: Mental Health Foundation.

Conclusion

There is a clear case to be made for public health interventions to focus on promoting wellbeing as a preventative measure, and not addressing wellbeing interventions only to those with diagnosable symptoms of mental distress. There is also good evidence that wellbeing can be improved through positive psychology interventions, mindfulness and meditation. Young people are a particularly important target for these types of wellbeing interventions, as improvements to mental health in childhood and adolescence can have a large positive effect over the life course.

This raises the challenge of reaching large numbers of young people without specific mental health conditions, and encouraging them to engage in activities that promote mental wellbeing.