EDITORIAL

No health without mental health: a role for the Cochrane Collaboration

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'No health without mental health'. Several years old now, this World Health Organization (WHO) proposition has been endorsed and adopted by a number of prominent individuals and organizations – among them the United Nations Secretary-General Ban Ki-moon, the World Federation of Mental Health (WFMH), the Pan American Health Organisation, the European Council of Ministers, Mental Health Europe, and the UK Royal College of Psychiatrists. The statement acknowledges the targets and indicators that have been agreed as part of the United Nations Development Programme Millennium Development Goals, and highlights the central importance of tackling both physical and mental health in achieving them.

Sunday 10 October sees the celebration of World Mental Health Day 2010. Established by the WFMH in 1992, the Day raises public awareness about mental health issues. It aims to promote open discussion of mental disorders, and investments in prevention and treatment services. Mental disorders, including schizophrenia, depression, and disorders associated with drug and alcohol abuse occur in all cultures and at all stages of life. They are frequently associated with poverty, marginalisation, social disadvantage, wars and other major disasters, and are the most prominent causes of deliberate self-harm, the 10–20 million suicide attempts, and the 1 million completed suicides every year worldwide[1]. Mental disorders can also be risk factors for, or consequences of, many other physical health problems. Depression alone is one of the leading causes of disability across the world, affecting an estimated 121 million people worldwide[2][3]. In the year 2000, depression was already the fourth leading contributor to the global burden of disease in terms of 'disability adjusted life years'; it is projected to become the second leading contributor by the year 2020 (second only to heart disease) – indeed it has already reached second place in the age category 15–44 years [4] and is expected to reach first place by 2030 [2].

Each year, World Mental Health Day highlights a specific theme. This year the Day focuses on the bi-directional relationship between mental illnesses and chronic physical illnesses, highlighting the need for high-quality evidence to support the delivery of safe, effective interventions that are provided through properly integrated services that meet the complex needs of people with mental and physical illness. Systematic reviews already published in *The Cochrane Database of Systematic Reviews* underscore the importance of mental health in a number of significant and chronic physical illnesses. This issue sees the launch of a Special Collection to coincide with this year's World Mental Health Day theme. The collection brings together reviews of trials that focus specifically on the treatment of depression and anxiety in people with other physical diagnoses. In addition to these, many other reviews in *The Cochrane Database of Systematic Reviews* acknowledge the importance of mental health in people with physical illness and summarise the effects of treatment on mental health as secondary outcomes. Although not complete, this portfolio of reviews is growing steadily and provides an excellent basis for treatment decisions for patients with complex needs.

Since physical and mental illnesses are often associated with common risk factors, it is difficult to disentangle the relationship between the two. For example, behaviours associated with depression (such as obesity, smoking, excessive alcohol consumption and sedentary lifestyle) are also risk factors for chronic physical illness. Chronic physical illnesses can result in reduced ability to exercise, increased isolation, poorer quality of life, job loss, financial insecurity, increased worry, family strain, maladaptive health behaviours (including increased alcohol consumption) and brain changes [5]. Each of these factors, separately and in combination, can increase the risk of depression which, in turn, can intensify the experience of physical symptoms, increase functional impairment, impede adherence to treatment, impact on health service use and costs, worsen overall prognosis, and shorten life-expectancy. The result is a vicious cycle of poor physical and mental health and poor functioning [6]. The fact that depression and anxiety in the physically ill may go undetected and untreated merely stresses the importance of developing integrated services [7][8].

Overall, depression occurs in about 20% of people with a chronic physical health problem and is around 2 to 3 times more common in people with a chronic physical health problem than in people who have good physical health [6]. Four chronic physical illnesses (cardiovascular, diabetes, cancer and respiratory illnesses) are responsible for 60% of the world's [3] deaths. Depression and anxiety are strongly associated with all of them, and the impact is considerable. For example, in people with diabetes, the prevalence of depression is about 9% and depressive symptoms affect about one in four people, both of which are associated with poorer glycaemic control, diabetes complications, increased health expenditure, and increased risk of death [9][10][11].

Similarly, many cancers are associated with high rates of depression, including oropharyngeal (22%–57%), pancreatic (33%–50%), breast (1.5%–46%), lung (11%–44%), colon (13%–25%), gynaecological (12%–23%), and lymphoma (8%–19%) [12]; and, overall, mental health problems appear to be associated with an increased death rate from cancer [13].

Despite their impact, mental health problems remain a low priority in most countries. Last month the WHO released a report entitled *Mental Health and Development: Targeting people with mental health conditions as a vulnerable group* [14]. The report makes the case for the integration of mental health in global development efforts, identifying roles for multiple stakeholders, including academic and research institutions, non-governmental organizations and global partnerships, and noting that unless the needs of people with mental illness are met, it will not be possible to achieve the targets of the Millennium Development Goals by 2015. The roles identified for academic and research institutions in improving development outcomes include generating and synthesising policy-relevant research findings, building capacity among policy-makers, planners and service providers to conduct and interpret research at local, national and international levels, and fostering international links to facilitate the sharing of country experiences, knowledge, and best practices.

The Cochrane Collaboration seems uniquely well placed to respond to these recommendations as well as those of other multilateral agencies. The Collaboration's international network of researchers, healthcare providers and consumers, as well as established links with policy-makers in many different countries, continues to facilitate capacity-building efforts and information sharing. Encompassing five mental health Review Groups (Dementia and Cognitive Improvement; Depression, Anxiety and Neurosis; Developmental, Psychosocial and Learning Problems; Drugs and Alcohol; and Schizophrenia) and covering the full spectrum of physical health problems, as well as the organisation of care, the Collaboration comprises the infrastructure and expertise to generate and disseminate syntheses of mental health research evidence that target the problems of greatest importance. Ultimately, mental disorders need to be a central feature of a wider health development agenda if it is to achieve its goals.

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Declarations of interest

The author has completed the Unified Competing Interest form at www.icmje.org/coi_disclosure.pdf (available upon request) and declares (1) no receipt of payment or support in kind for any aspect of the article; (2) no financial relationships with any entities that have an interest related to the submitted work; (3) that the authors/spouse/partner/children have no financial relationships with entities that have an interest in the content of the article; and (4) that there are no other relationships or activities that could be perceived as having influenced, or that giving the appearance of potentially influencing, what was written in the submitted work.

References

1. WHO. The World Health Report: 2001: Mental Health: New understanding, new hope. Geneva: World Health Organization, 2001. http://www.who.int/whr/2001/en/whr01_en.pdf (accessed 5 October 2010).

2. WHO. The Global Burden of Disease: 2004 update. Geneva: World Health Organization, 2004. http://www.who.int/healthinfo/global_burden_disease/GBD_report_2004update_full.pdf (accessed 5 October 2010).

3. WFMH. Mental Health and Chronic Physical Illnesses. The need for continued and integrated care. World Federation for Mental Health: Woodbridge, VA, USA, 2010. http://www.wfmh.org/2010DOCS/WMHDAY2010.pdf (accessed 5 October 2010).

4. WHO (2008). Projections of mortality and burden of disease, 2004–2030. http://www.who.int/healthinfo/global_burden_disease/projections/en/index.html (accessed 5 October, 2010).

5. RCP/AMRC. No Health Without Mental Health: The supporting evidence. London: Royal College of Psychiatrists and Academy of Medical Royal Colleges. http://www.rcpsych.ac.uk/pdf/No%20Health%20-%20%20the%20evidence_%20revised%20May%2010.pdf (accessed 5 October, 2010).

6. NICE. Depression in Adults with a Chronic Physical Health Problem. Treatment and management. NICE Clinical Guideline 91. London: National Institute for Health and Clinical Excellence, 2009. http://guidance.nice.org.uk/CG91/NICEGuidance/pdf/English (accessed 5 October, 2010).

7. Goldberg D, Huxley P. Common Mental Disorders. London: Routledge, 1992.

8. Chew-Graham CA, Hogg T. Patients with chronic physical illness and co-existing and co-existing psychological morbidity: GPs' views on their role in detection and management. *Primary Care Psychiatry* 2002;8:35–9.

9. Lustman PJ, Anderson RJ, Freedland KE, de Grool MK, Carney RM. Depression and poor glycaemic control: a meta-analytic review of the literature. *Diabetes Care* 2000;23:934–42.

10. Katon WJ, Rutter C, Simon G, Lin E, Ludman E, Ciechanowski P *et al*. The association of co-morbid depression with mortality in patients with type 2 diabetes. *Diabetes Care* 2005;28(11):2668–72.

11. Ismail K, Winkley K, Stahl D, Chalder T, Edmonds M. A cohort study of people with diabetes and their first foot ulcer. The role of depression on mortality. *Diabetes Care* 2007;30:1473–9.

12. Massie MJ. Prevalence of depression in patients with cancer. *Journal of the National Cancer Institute Monographs* 2004;32:57–71.

13. Harris E, Barraclough B. Excess mortality of mental disorder. *British Journal of Psychiatry* 1998;173:11–53.

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14. Funk M, Drew N, Freeman M, Faydi E. Mental health and development: targeting people with mental health conditions as a vulnerable group. Geneva: World Health Organization, 2010 http://whqlibdoc.who.int/publications/2010/9789241563949_eng.pdf (accessed 5 October, 2010).

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