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Depression and Public Health Law: Ethics, Governance, and the Socio-Political Determinants of Health and Well-being

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Introduction: Taking a Public Health Approach

Parts I and II of this book have explained the impacts of depression both on people with that condition and on those who care for them, and looked at the nature of different forms of depression. With a view to building on those understandings, and incorporating concerns about ethical (see also Part III of this volume), legal, and other action-guiding reasons, this chapter brings a public health perspective. It aims to demonstrate the strong arguments in favour of framing and approaching depression as a public health question, and also to highlight some of the key legal, regulatory, and practical matters that are entailed in doing so.

A defining feature of taking a public health approach is that it looks to effect positive health changes through methods of socially-coordinated, population-level intervention.[1] With public mental health, as with public health more generally, such changes may be effected at various levels. Some public health interventions are implemented universally (e.g. treatment of a public water supply and maintenance of its provision), some target selected groups (e.g. school food policies to improve child health), while some respond directly to indicated cases (e.g. individual interventions following a screening programme).[2] It should be emphasised, furthermore, that public health approaches may be said to apply to a broader span of persons than do clinical interventions. This is because, as indicated, public health agendas do not simply respond to people who find themselves in ill health, or even at high risk of ill health. Rather, a signal feature is that such agendas aim to prevent or mitigate the incidence[3] of ill health in the first place (often by targeting large, low-risk populations), to promote good health, and (perhaps more controversially[4]) to promote broader concepts of *well-being*.

In the following sections, I explain what it means to take a public health law approach to depression, and in so doing address two sets of questions that should be seen as pervading the analysis in this chapter (and potentially, if at times only implicitly, in other chapters too). First there are questions of *why* we would wish to take a public health approach. And second, there are

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[1] Marcel Verweij and Angus Dawson, 'The meaning of "public" in "public health"' in Angus Dawson and Marcel Verweij (eds), *Ethics, Prevention, and Public Health* (Oxford: Oxford University Press 2007).

[2] See Faculty of Public Health and Mental Health Foundation, *Better Mental Health for All: A public health approach to mental health improvement*, (2016, London: FPH & MHF), available to download at www.fph.org.uk/uploads/Better%20Mental%20Health%20For%20All%20FINAL%20low%20res.pdf (last accessed 17th July, 2016), p. 32 for further detail on these "three tiers of intervention".

[3] An important aspect of a public health perspective derives from epidemiological study, and the distinction that may be drawn between studying an individual *case* of disease as contrasted with the *incidence* of disease within a population: for analysis and explanation see Geoffrey Rose, "Sick Individuals and Sick Populations," *International Journal of Epidemiology* (1985) 14:1, 32-38.

[4] There are various questions raised by public health approaches speaking to well-being. These cannot be addressed in significant depth in this chapter, but see further John Coggon, *What Makes Health Public?* (Cambridge: Cambridge University Press, 2012), especially chapters 1, 8, and 11. For a highly critical perspective, see Petr Skrabanek, *The Death of Humane Medicine and the Rise of Coercive Healthism*, (St Edmundsbury Press: Bury St Edmunds, 1994).

questions of *how* we go about it. These questions intertwine, but broadly speaking we might say that the first set of questions is *conceptual* and *normative*, while the second set is *practical*. In coming to a full answer to them, we require understandings of which actors are at play, within what frameworks of law and ethics, and with what powers and constraints. On that basis, we arrive at answers to what I have elsewhere labelled the philosophical (or academic's) question—what makes health public?—and the political (or activist's) question—how can health be made public?[5]

The chapter is structured as follows. The next section presents and expands on a dominant understanding of public health. The analysis then moves to a broad characterisation of public health law, and with that an explanation of certain of the practicalities of taking a public health approach. This in particular requires an understanding that the concept of law here incorporates not just 'hard' legal measures and powers, but also 'softer' modes of governance.[6] The chapter then builds on these points to explain how a strong combination of rationales suggests that depression is apt to be framed and addressed as a matter for public health law.

Public Health, Mental Health, and Well-being

Public health, in different instances, denotes or refers to a great range of very distinct things. These include a social mission to improve health, governmental responsibility for health, a profession or professional approach, and the health status of a population.[7] For the purposes of the current chapter, I will work with an understanding of public health that incorporates these ideas, and has developed by reference to the canonical definition advanced in 1920 by Charles-Edward Winslow. Winslow wrote that:

> Public health is the science and the art of preventing disease, prolonging life, and promoting physical health and efficiency through organized community efforts for the sanitation of the environment, the control of community infections, the education of the individual in principles of personal hygiene, the organization of medical and nursing service for the early diagnosis and preventive treatment of disease, and the development of the social machinery which will ensure to every individual in the community a standard of living adequate for the maintenance of health.[8]

Winslow's characterisation has great breadth to it. It is not confined, for example, to environmental hazards, notifiable diseases, or medicine and health care, but rather includes these things whilst also extending much further, across all sorts of different means of avoiding ill, and promoting good, health in an organised society. The definition finds clear resonance in contemporary definitions of public health law,[9] in framings of global health,[10] and importantly in

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[5] John Coggon, "Global Health, Law, and Ethics: Fragmented Sovereignty and the Limits of Universal Theory," in Michael Freeman, Sarah Hawkes, and Belinda Bennett (eds) *Law and Global Health*, (Oxford: Oxford University Press, 2014), p. 370.

[6] See further John Coggon and Lawrence Gostin, "Beyond medicine, patients and the law: Policy and governance in 21st century health law," in Catherine Stanton, Sarah Devaney, Anne-Maree Farrell, and Alexandra Mullock (eds), *Pioneering Healthcare Law: Essays in Honour of Margaret Brazier*, (Abingdon: Routledge, 2015).

[7] For a more comprehensive overview and explanation, see Coggon, *What Makes Health Public?*, above n. 4, chapter 3.

[8] Charles-Edward Winslow, 'The Untilled Fields of Public Health' (1920) 51 (1306) *Science* 23, 30.

[9] See Lawrence Gostin and Lindsay Wiley, *Public Health Law: Power, Duty, Restraint* (3rd edn), (Oakland, CA: University of California Press, 2016), p. 4. See also the analysis in the next section, which reflects on the definition of public health law found in John Coggon, Keith Syrett, and A.M. Viens, *Public Health Law: Ethics, Governance, and Regulation* (Abingdon: Routledge, 2017).

[10] See Solomon R Benatar and Ross Upshur, "What is Global Health?" in Solomon R Benatar and Gillian Brock (eds.), *Global Health and Global Health Ethics*, (Cambridge: Cambridge University Press, 2011), p. 14.

how key public health actors understand public health. The UK's Faculty of Public Health (FPH), for example, states that public health is: "The science and art of promoting and protecting health and well-being, preventing ill-health and prolonging life through the organised efforts of society."[11]

Striking to contemporary readers of Winslow's definition will be its focus on "promoting *physical* health", to the apparent exclusion of mental health. It should therefore be stressed that current definitions and their interpretation also incorporate mental health (and if adopting the World Health Organization's famous concept of health, furthermore entail a social component[12]). Indeed, FPH and the Mental Health Foundation (MHF) have said that "mental health and physical health are fully integrated and codependent",[13] and that "[m]ental and social wellbeing are inextricably linked".[14] Accordingly, the understanding of public health considered in this chapter should be taken of itself to include mental health.

Philosophers Marcel Verweij and Angus Dawson have emphasised two points of commonality amongst definitions that are derivative of Winslow's. First, these definitions demand a focus on *populations*. Second, they entail a need to look to methods of *social coordination*, as seen in the texts quoted directly above where they refer to "organized community efforts" or "the organised efforts of society."[15] In order to consider the idea of depression as a public health issue, we therefore do well to ask *whether* and *why* we should look at this condition at a population level (i.e. as opposed simply to responding to individual cases, as they present themselves, through remedial, clinical interventions). Doing so leads to an evaluation of *how* to approach depression at that level and the merits of this. Prior to making such analysis, I will first outline the concept of public health law, and indicate at a general level the legal framework within which a public health approach would be effected.

Public Health Law: Multi-layered, Multi-Sectoral, and Many Modes of Governance

Having addressed the question of what public health is, and how states of mental health and well-being fit within it, this section explains what it means to speak of public health *law*. This will allow us to understand the regulatory context of depression considered as a public health issue. As already seen, matters regarding *social coordination* are intrinsic to public health activity. It is therefore more or less inevitable that law, and other modes of governance, are of relevance. In other words, in the context of (say) clinical medicine it may not seem fanciful to suggest that practice exists in a legal vacuum, and instead is governed purely by (say) expert medical norms or the demands of patients (though, to be clear, I would dispute the plausibility of such position[16]). But certainly in the context of public health practice, means of intervention require the tools of law and regulation.[17]

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[11] Faculty of Public Health, <www.fph.org.uk/about_us> last accessed 5 April 2016. FPH is a Faculty of the Royal Colleges of Physicians of London, Edinburgh, and Glasgow. Details of its role, functions, and mission can be found at the website cited in this footnote.

[12] See United Nations, Preamble to the Constitution of the World Health Organization, entered into force 7 April 1948, 14 UNTS 185, and n. 4 above.

[13] FPH and MHF, *Better Mental Health for All*, above n. 2, p. 12.

[14] *Ibid*., p. 10.

[15] Verweij and Dawson, "The Meaning of 'Public' in 'Public Health'," above n. 1.

[16] John Coggon, "Mental Capacity Law, Autonomy, and Best Interests: An Argument for Conceptual and Practical Clarity in the Court of Protection," *Medical Law Review* (forthcoming); John Coggon, "Comments and Reflections on 'proper medical treatment': A case for coherent inconsistency," in Sara Fovargue and Alexendra Mullock (eds), *The Legitimacy of Medical Treatment: What Role for the Medical Exception*, (Abingdon: Routledge, 2015).

[17] Coggon, Syrett, and Viens, *Public Health Law*, above n. 9.

Public health law can be distinguished from the narrower fields of medical law and health care law,[18] and there now exists an impressive range of rationales for understanding the field in different ways.[19] For the purposes of this chapter, consider the following definition:

> Public health law is a field of study and practice that concerns those aspects of law, policy, and regulation that advance or place constraints upon the protection and promotion of health (howsoever understood) within, between, and across populations.[20]

If we briefly unpack this, a few points might be noted. First, the field is characterised both as an academic area of study and an area of practice. It thus invites critical insights and analysis, but also looks to practice, policy-making, and implementation. Second, it looks beyond 'hard law'. Whilst an important component of legal studies aims to identify and delimit the concept of law itself,[21] public health lawyers need to understand modes of governance found in laws themselves, in rules and regulations generated given legally conferred powers, and in wider modes of 'social coordination' that have no direct link to law or even sometimes governmental decision-makers.[22] Third, there is a need to focus on how law and governance help advance public health agendas (e.g. through empowering a governmental authority to implement particular policies) *and* how laws might constrain public health agendas (e.g. by limiting the authority of a public body, or prioritising individual rights over general public health benefits).[23] Fourth, the definition is open to including a variety of definitions of health, and certainly is not limited (say) to biomedical or medicalised models.[24] Finally, reflective of the discussion above, it incorporates a focus on populations.

Who, then, are the key actors within public health law? The answer to this question will depend in part on the specific context under discussion. Within an English law setting, they will naturally include Parliament and the courts. The Health and Social Care Act 2012 also designates important governmental roles. Section 11 creates a duty on the Secretary of State to *protect* public health, while section 12 creates a duty both for the Secretary of State and local authorities to *promote* public health improvement. These respective duties can be understood as applying to the different points on the continuum described above in FPH's concepts of health and well-being (see next section). In implementation of the Act, furthermore, Public Health England has been instituted as an executive, Department of Health-sponsored agency to advise central government and support local authorities, with an overall aim to "protect and improve the nation's health and wellbeing, and reduce inequalities."[25]

Public health law cannot,[26] however, focus just on explicitly designated governmental public health powers and responsibilities—even the very broad ones found in sections 11 and 12 of the

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[18] Coggon, *What Makes Health Public?*, above n. 4, chapter 5.
[19] Coggon, Syrett, and Viens, *Public Health Law*, above n. 9, chapter 4.
[20] *Ibid.*.
[21] *Cf* e.g. HLA Hart, *The Concept of Law*, 2nd edn, (Oxford: Oxford University Press, 1997); John Finnis, *Natural Law and Natural Rights*, (Oxford: Oxford University Press, 1980).
[22] See also Belinda Bennett, Lawrence Gostin, Roger Magnusson, and Robyn Martin, 'Health governance: law, regulation and policy' (2009) 123 *Public Health* 207.
[23] See also Gostin and Wiley, *Public Health Law*, above n. 9, chapter 1.
[24] As such, in the context of mental health, it does not give rise to the problems identified in Andreas Vilhelmsson, Tommy Svensson, and Anna Meeuwisse, "Mental Ill Health, Public Health and Medicalization," *Public Health Ethics* (2011) 4:3, 207-217.
[25] See https://www.gov.uk/government/organisations/public-health-england/about (accessed 23/07/2016).
[26] Though contrast Mark Rothstein, "Rethinking the meaning of public health," *Journal of Law, Medicine and Ethics* (2002) 30, 144-149.

Health and Social Care Act.[27] First of all, there are vital roles *across sectors* to account for health: for example, in school, environmental, and business law and policy. Private actors, such as employers and producers of consumable products, furthermore, have been formally assigned public health responsibilities. And there are roles in matters such as public education, advocacy, professional training, the development of knowledge and understanding, which are assumed by bodies such as FPH, and organisations such as Universities, the King's Fund, and the Nuffield Council on Bioethics.

Public Mental Health Law and Depression

Why might we consider depression to be a question that is apt for a public health framing? Having spelled out the general features of public health approaches, let us begin here by considering the broad idea of public mental health. First of all, it should be noted that whilst I have stressed that contemporary understandings of public health speak to mental as well as physical health, mental health has generally been treated governmentally and socially as a low(er) priority[28] (or, more damningly, but perhaps more accurately, may just be said to have been neglected). This problem is not limited to public health activity, and its recognition has led to the *Parity of Esteem* agenda, which aims to ensure that physical and mental health are treated as being of equal importance: i.e., recent years have seen a range of actors advocating for better mental health policy, including with the adoption of public health approaches.[29] In recognition of the failures to achieve parity of esteem in the context of public health, FPH and MHF recently joined together to produce a significant (and we might hope influential) report, to which I have already referred, entitled: *Better Mental Health for All: A public health approach to mental health improvement*.[30]

Of course, were parity of esteem realised, it would not be necessary to speak of public *mental* health—or at least it would be no more necessary to emphasise mental than physical public health. Indeed, as indicated above, it is argued that mental health is intertwined with, rather than ultimately separable from, physical health. So neglect of mental health, conceptually speaking, is a neglect of physical health. However, the FPH and MHF report responds to the reality that, at the level of policy priorities, concern for mental health does not enjoy the same standing as does attention to physical health. Equally, the links between (what we may continue to describe as) mental and physical health are not always evident to policy-makers. The report therefore provides, examines, and justifies a very useful concept of public mental health, advocates for its importance, and explains how it might be advanced as a practical agenda.

FPH and MHF advance the following definition:

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[27] Note that public health governmental responsibilities vary in the different nations of the UK, and also that within England the Health and Social Care Act 2012 is not the only statutory source of explicitly designated public health law.

[28] See Department of Health, *Closing the Gap: Priorities for essential change in mental health*, (London: HMSO, 2014).

[29] See e.g. NHS England's *Valuing mental health equally with physical health or "Parity of Esteem*, available at https://www.england.nhs.uk/mentalhealth/parity/ (last accessed 21/07/16). See also Royal College of Psychiatrists, *Whole-person care: from rhetoric to reality—Achieving parity between mental and physical health*, (London, 2013), available at http://www.rcpsych.ac.uk/pdf/OP88.pdf (last accessed 21/07/16). Specifically on approaches relevant to a discussion of public health, see pages 55-71 of this report. See also Department of Health, *No Health without Mental Health: Delivering better mental health outcomes for people of all ages*, (London: HMSO, 2011); Chris Naylor, Preety Das, Shilpa Ross, Matthew Honeyman, James Thompson, Helen Gilburt, *Bringing together physical and mental health: A new frontier for integrated care*, (London: The King's Fund, 2016).

[30] FPH and MHF, *Better Mental Health for All*, above n. 2.

> *Public mental health* is a term that has been coined to underline the need to emphasise the neglected element of mental health in public health practice. It spans promotion, prevention, effective treatment, care and recovery. It is built on the same principles as all areas of public health.[31]

The report in turn explains that:

> The term *mental health* is used to describe a spectrum from mental health problems, conditions, illnesses and disorders through to mental wellbeing or positive mental health.[32]

As FPH and MHF note, there is not a consensus view that mental health should be treated as a singular idea that spans a spectrum from poor mental health (i.e. matters such as diagnosed psychiatric conditions, including depression) at one end, to positive mental states (feeling good and functioning well) at the other end.[33] However, whilst acknowledging that some analysts would separate these different things conceptually, the report explains that from an *epidemiological* perspective it makes sense to consider a single continuum from negative to positive. This is because of the distinct nature of a population approach: rather than emanate from a concern for a single individual's condition, such as depression, which may vary over time, the public health approach looks to the environment and its general impact on the incidence of (ill) health and well-being.[34]

It is clear, then, that we *can* think of public mental health, and that depression could therefore have a place within that. But *should* we push for this? Various answers might be given to say that we should do, and are well evaluated in light too of discussions of ethics in Part III of this book. It ought to be recognised, though, that whilst some of the bases for 'making mental health public' are found in ethical reasons, alternative rationales are also importantly advanced. At least loosely, we might break the overall rationales to be considered here into three: moral reasons, viewed through a political philosophy lens both at individual persons and society as a whole; non-moral (e.g. prudential) reasons viewed from the perspective of individual persons; and finally, instrumental (e.g. economic) reasons viewed from the perspective of societal efficiency.

First, then, consider ethical arguments. By conceiving of *public* health, we invoke a framing from *political* philosophy. That is to say, we are not merely concerned with abstract, interpersonal morality; rather, we are concerned about the rights and obligations that we possess as members of a shared political community, and the overall justice (or otherwise) of that political community.[35] Whilst there is not space here to develop and defend a particular ethical position,[36] ethical arguments in this context generally may be seen as obtaining by reference to individual *citizens*, and to *society* as a whole. In regard to the individual citizen, we can see that prevention or improvement of bad mental health, and the protection and promotion of mental well-being, confer a good that may be argued to be morally due. Such an argument has to be made, of course, and I do not claim to do so here. I do, however, note that protagonists representing a great mix of fundamental ethical positions find routes to such a position. Consider, for example, theories based on benefit and harm (e.g. Millian liberalism[37]), or on the state's responsibility to

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[31] *Ibid*., p. 9.
[32] *Ibid*..
[33] *Ibid*., pp 9-10.
[34] *Ibid*., p. 9. See also Rose, "Sick Individuals and Sick Populations," above n. 3.
[35] See further Coggon, *What Makes Health Public?*, above n. 4, Part II.
[36] For a presentation of my preferred approach, see *ibid*., Part III.
[37] See e.g. *ibid*..

protect the safety of the people (e.g. Hobbesian theory[38]), or on freedom to flourish as a member of a community (e.g. civic republicanism/communitarianism[39]), or on the capacity to flourish as a person (e.g. capabilities[40]), or on 'relational' accounts of ethics (e.g. relational feminist bioethics[41]). These all suggest, in different ways, that there are reasons that health and well-being (including mental health and well-being) are of special moral importance to persons, and thus give rise to at least presumptions of political protections and entitlements. Regarding forms of depression, there are straightforward ways in accordance with these different theories to argue that depression is (in a morally relevant way) a harmful condition, or a condition that diminishes persons' capacity to flourish. Accordingly, within framings relevant to public health ethics we can identify depression as a matter of importance.

Within the context of political morality, such individually-based positions need to be considered furthermore alongside reference to society as a whole, and the ways in which we are intertwined as members of political community. Again, we find a great range of positions on this, but there are crucial questions to ask about (mental) health and social justice. Specifically, are there ethical reasons to be concerned about the *distribution* of health?[42] If we can identify specific groups within society who systematically suffer worse health outcomes by virtue of the ways that society is organised, does this offend against moral concerns for justice? Once more, answers, and their underpinning rationales, will vary. Political libertarians may agree that health is morally important, but nevertheless say there is no moral right to support—indeed there is a moral duty not to allow—the redistribution of resources simply to (try to) improve the lot of people who are at relative disadvantage.[43] However, a great range of theorists with alternative theoretical commitments would disagree. Social epidemiology has shown that socio-economic disadvantage is directly linked with higher morbidity and earlier mortality: in other words, health status and outcomes can be shown to be socially determined.[44] Many justice theorists thus look to politics, and argue that political morality demands that societal structures be reformed to improve health equity by lessening the existence of systemic, social disadvantage.[45] As Verweij and Dawson explain, a population-level concern may not aim simply to heighten the overall aggregate level of health; it may also morally judge a society by reference to the distribution.[46] Thus further ethical arguments still might support the taking of public health approach if we find that depression is a condition that disproportionately affects particular disadvantaged groups.

Therefore, both at the individual and societal levels, arguments within public health ethics support measures to prevent and limit ill health, and promote good health and well-being

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[38] See e.g. John Harris, *How to be Good: The Possibility of Moral Enhancement*, (Oxford: Oxford University Press, 2016), chapter 11.
[39] See e.g. Bruce Jennings, "Public Health and Civic Republicanism," in Dawson and Verweij (eds), *Ethics, Prevention, and Public Health*, above n. 1.
[40] See e.g. Madison Powers and Ruth Faden, *Social Justice: The Moral Foundations of Public Health and Health Policy*, (Oxford: Oxford University Press, 2006); Jennifer Prah Ruger, *Health and Social Justice*, (New York: Oxford University Press, 2010).
[41] See e.g. François Baylis, Nuala Kenny, and Susan Sherwin, "A relational account of public health ethics," *Public Health Ethics* (2008) 1:3, 196-209.
[42] This should not be taken to imply that health itself is a 'good' that can redistributed: see Richard Ashcroft, "Ethics and Global Health Inequalities," in John Coggon and Swati Gola (eds), *Global Health and International Community: Ethical, Political and Regulatory Challenges*, (London: Bloomsbury, 2013). Rather, it is about the social environment and structures, their impact on outcomes (including health), and the possibility and potential imperatives to reform them.
[43] Richard Epstein, "In defense of the 'old' public health," *Brooklyn Law Review* (2004) 69:4, 1421-1470.
[44] Michael Marmot, *Status Syndrome: How your social standing directly affects your health and life expectancy*, (London: Bloomsbury, 2004); Michael Marmot, *The Health Gap: The Challenge of an Unequal World*, (London: Bloomsbury, 2015).
[45] For a very clear argument in support of this, see Sridhar Venkatapuram, "Global Justice and the Social Determinants of Health," *Ethics and International Affairs* (2010) 24, 119-130.
[46] Verweij and Dawson, "The meaning of 'public' in public health," above n. 15.

generally. These may, furthermore, be straightforwardly addressed to depression. We can, that means, find a wide range of positions within political philosophy that support the view that depression—and other mental health and well-being issues—are well considered and approached from within a public health framework. However, even if some sort of ethical consensus were reached, it is a matter of political reality that individual persons require motivations beyond moral argument, and policy-makers will be concerned by competing interests, practical possibility, social acceptability, and economic constraints.[47] I thus conclude this section with reference to non-moral reasons for individuals and policy-makers to approach depression within a public health framing.

We do well to recall at this stage the distinctive approaches entailed by public health as it is presented in this chapter: i.e., it focuses on prevention and mitigation of ill health, and promotion of good health and well-being. From a prudential perspective, individuals have reason to wish to live in a system that attends to their mental health and well-being through a public health approach. Whilst depression has a very high prevalence,[48] many cases in practice go unrecognised and untreated.[49] And perhaps more compellingly, depression is a condition that presents significant incidences of comorbidity.[50] In other words, above it was seen that at a general level there are reasons to question a conceptual divorce of physical and mental health. In regard to depression specifically, there is clear scientific evidence that public health approaches to preventing and limiting the condition from arising have much wider health benefits for individuals: our health broadly is well served if we live in a system that does not neglect our mental health. And of course simply regarding depression, it is better for the individual, where possible, not to suffer the condition in the first place, rather than to suffer it and then receive treatment.

Such considerations are relevant too from a societal perspective. The FPH and MHF report, in line with others cited in this chapter, notes the significant benefits—including economic benefits—if a public health approach is taken to mental health and well-being:

> There is strong evidence that investment in the protection and promotion of mental wellbeing, including early intervention and prevention, improves quality of life, life expectancy, educational achievement, productivity and economic outcomes, and reduces violence, antisocial behaviour and crime.[51]

Martin Knapp, David McDaid, and Michael Parsonage coordinated the production of a detailed economic analysis that overall provides a case in favour of instituting mental health promotion and prevention policies.[52] The report examines many areas of interest within mental health (subject to limitations given the availability of data, explained in the report). Regarding three

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[47] Problems of practical complexity and the potential gaps between theory and reality are sometimes, and considerably, underestimated in bioethical analysis, but require serious attention: see James Wilson, "Towards a Normative Framework for Public Health Ethics and Policy," *Public Health Ethics* (2009) 2:2, 184-194. I have argued elsewhere that public health ethics needs to incorporate concerns of real politics if it is going to effect change: Coggon, *What Makes Heath Public?*, above n. 4, chapter 7.

[48] Gavin Andrews, Richie Poulton, and Ingmar Skoog, "Lifetime risk of depression: restricted to a minority or waiting for most?" *British Journal of Psychiatry* (2005) 187, 495-6.

[49] Paolo Cassano and Maurizio Fava, "Depression and public health: An overview," *Journal of Psychosomatic Research* (2002) 53, 849-857. The authors of this paper are based in the US, but their explanations for this phenomenon are applicable in the UK.

[50] As explained in *ibid.*, and as can be seen to underpin concerns expressed in expert reports cited in this chapter.

[51] FPH and MHF, *Better Mental Health for All*, above n. 2, p. 14.

[52] Martin Knapp, David McDaid, and Michael Parsonage (eds), *Mental Health Promotion and Prevention: The Economic Case*, (London: Department of Health, 2011), available at www.lse.ac.uk/businessAndConsultancy/LSEEnterprise/pdf/PSSRUfeb2011.pdf (last accessed 23/07/16).

areas of intervention linked specifically to depressive conditions, it makes the following findings:[53]

- *Post-natal depression*: interventions led by health visitors make significant improvements to mothers' quality of life, and increase the productivity of mothers returning to work, though within a one-year period do not lead to a net reduction in financial terms.[54]
- *Workplace screening for depression and anxiety disorders*: interventions of screening, followed as appropriate by preventive measures, led to a net economic benefit for the health system and business.[55]
- *Collaborative care for depression in individuals with Type II diabetes*: interventions of 'collaborative care' suggest cost-effectiveness after two years, but high implementation expenditures mean economic costs are high in the short term.[56]

Within a wider context of there being significant economic and other societal benefits to implementing public mental health strategies, there are benefits to be found in implementing measures relating to depression. This is most pronounced in the report by reference to the workplace screening programme. In addition to the positive ethical reasons and prudential benefits from the individual's perspective, a public health approach has strong ethical and other value from a societal perspective.

In short conclusion to this section, a successful public health approach to depression of course aims through the provision of good quality services to support people who are suffering, or because of underlying, diagnosable morbidity, at high risk of suffering from forms of depression. But beyond this, it means taking more general, and even completely general approaches to avoid the occurrence, and mitigate the incidence, of depression in the first place. There are powerful conceptual and ethical reasons to bring a public health approach to depression, and these are significantly underscored by various alternative sources of practical reasoning. This requires a focus across the lifecourse, with careful attention to the effect of the environment on health.[57] As we have seen, high profile governmental and expert bodies are advocating for better attention to mental health. These include the Department of Health, FPH, MFH, the Royal College of Psychiatrists, and the King's Fund. Crucially, in each case we find explicit, evidence-based calls for incorporation of public health approaches.

Conclusions: Depression as a Public Health Law Priority

This chapter has sought to explain what it means to take a public health approach, considered in the context of the field of public health law, and applied to depression. We have seen that there have been recent efforts from various actors to increase the priority that is afforded to questions of mental health. Should these be successful, it is clearly the case that part of their realisation can and should entail a commitment to advancing public health measures to help prevent, and lessen the harms caused by, depression. As has been argued, there are strong principled reasons for following this course, which are bolstered too by reference to the significant individual and societal benefits that would be achieved.

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[53] The bullet points here present my summaries of the respective sections named in italics. The report presents relevant data and fuller, clearer accounts of the findings.
[54] *Ibid*., pp. 4-5 (analysis by Annette Bauer, Martin Knapp, and David McDaid).
[55] *Ibid*., pp. 20-21 (analysis by David McDaid, Derek King, and Michael Parsonage).
[56] *Ibid*., pp. 31-32 (analysis by Derek King, Iris Molosankwe, and David McDaid).
[57] FPH and MHF, *Better Mental Health for All*, above n. 2.

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