Public Mental Health prevention – what works?
Comments and reflections from Liam Hughes (FPH Mental Health S.I.G.).

On 10th May, a joint conference was held by the Faculty for Public Health and the Royal College of Psychiatrists. It was result of hard work by many people, and it marked a shared understanding that both communities of evidence and practice could learn from each other, and that neither could stand alone. Individual, family and community mental health are closely intertwined, and the perspectives of both psychiatry and public health (with other disciplines and fields of enquiry) are needed to make sense of mental health in society. The event provided an opportunity for participants to consider how public health and psychiatry can learn from one another. It illustrated points of convergence and encouraged discussion and reflection on how collaboration can strengthen preventative interventions.

There is more than a grain of truth in the caricature that in the past psychiatry has focused more on individual diagnosis and treatment to the neglect of prevention and the social context of positive mental health, and that public health has focused more on understanding the evidence about physical ill health and it`s prevention to the neglect of mental health and illness, and their relationship with physical illness. This is not the whole story, of course, and the picture has changed considerably in recent times, not least because of the growth of social psychiatry and the social neurosciences, the emerging evidence about the impact of mental health on physical health across the life-course (and vice-versa), and the national policy initiative to promote “parity of esteem” .

The two professions are in the process of reframing their concerns, and developing a much richer picture of mental wellbeing, mental distress and mental illness. The conference presenters illustrated the emerging commonality of interests across the professions, and the drive to put a social dimension into the bio/psych/social approach.

Dr Peter Byrne introduced the event and encouraged learning and debate. Sir Harry Burns (now from Strathclyde University) discussed health creation. He argued for a salutogenic approach, rooted in ideas about positive mental health and the importance of social relationships. He showed how the wider social, economic and environmental context shaped social relationships and influenced individual mental health. He unpacked features of Scottish public policy which were intended to reinforce community and individual resilience, e.g., the Early Years Collaborative which ranged beyond medicine, psychiatry and social work to embrace other local authority services (especially housing), the police and third sector professionals.

One key learning point that I picked up was that whilst a decent family income was a prerequisite for good mental health, it was not sufficient by itself to help people fix their existing mental health problems. Networks of community support were essential, and professional needed to work with individuals and families as far as possible on their own terms to help them become more resilient and improve their wellbeing.

I was struck by the irony that whilst public policies in England were moving in the right direction, austerity had hollowed out many of the key community networks and services that could have underpinned their delivery. Children`s Centres, Youthwork Services, CAB sessions and Housing Support have all been hit as local councils have struggled to manage within their budgets. There was a marked difference of approach in Scotland.

I also reflected on the convergence across academic disciplines. The work on child development, adverse childhood events, parental stress and attachment reinforced the interconnections between, e.g., family income, work and nutrition, housing conditions, the availability of play spaces and environmental amenities. Family poverty is connected to the development of childrens` brains, and their development into adult life.

The next section, presented by Dr Lynne Mc Niven and Dr Tamasin Knight, looked at the lifelong impact of adverse childhood experiences, and it reinforced that Scotland was different. This presentation underlined the critical importance of good parenting, positive attachments and the development of a child`s social identity. Lynne and Tamasin referenced the DVD from DartmouthFilms: “Resilience: the biology of stress and the science of hope” as a good introduction to the field, as well as other Scottish training on psychological trauma. There was also reference to the place of early childhood policies in the Scottish Programme for Government 2018/19, and the Knowledge and Skills Framework from NHS Education for Scotland. The Scottish policy landscape seemed to me to be much more coherent and more hopeful.

Professor Joe Barry (Trinity College, Dublin) discussed public health approaches to alcohol, using the Irish experience. He focused on the interplay between alcohol policy, commercial lobbying and public health evidence. The strength of the postwar drinking culture had been toned down as millennials reduced their alcohol consumption despite an increase amongst older people. It had taken some time for legislation to emerge, and the commercial interests had put up powerful roadblocks. However, the amount of evidence built up and lobbying was persistent, leading to the Public Health Alcohol Bill, covering minimum unit pricing, structural separation of alcohol sales, restrictions on advertising and labelling.

Professor Wendy Burn and Professor John Middleton were interviewed by registrars, and they supported greater contact between trainees in psychiatry and public health. They agreed that there was an opening for this in the emphasis on promotion and prevention in national policy. I was impressed by the incisiveness of the questions put to them, as well as the degree of convergence in their replies. Public health is embracing public mental health, and psychiatry is learning from population-based approaches. There remains the practical question of how to arrange mutual learning within the formal training programmes.

This session was followed by three brief illustrations of the variety of work being undertaken. Dr Mike Mc Hugh, the lead consultant for public mental health in Leicestershire, described the work of the local public health team and its partners, and the importance of keeping positive (and keeping going) despite austerity.

Chris Neild gave an example of the work being done in Sheffield using an asset-based approach, and reinforced the importance of improvement rooted in community life and community development. This raised for me the value of the core concepts of social identity and social influence in community mental health.
I spoke briefly about the role of the local council, through (1) the work of ward councilors and cabinets in responding to local issues, (2) the role of councils in leading partnerships like the Health and Wellbeing Boards, and (3) their position as large-scale employers with a responsibility to promote good mental health in the workplace. Most councillors are acutely aware of the paradox that they have taken on an active responsibility for public mental health promotion just as the resources have reduced, but both Chris and Mike demonstrated how much could still be achieved in partnership with local people and other agencies.

This theme was taken up by Dr Sam Everington, a GP who has been at the heart of the radical work to engage patients in Bromley-by-Bow and promote social prescribing across Tower Hamlets. It was heartening to hear about the reshaping of relationships between clinicians and patients, and the approach to teamwork in the practice. Co-design and co-production clearly have real traction in this practice.

The final section, led by Woody Caan, challenged participants to think about what mattered most in public health and psychiatry. Participants made suggestions about the content of the next joint event:

- Refugees and mental health
- A longer session on ACEs
- Child sexual abuse
- Children of parents with mental health issues
- School mental health
- Older people and loneliness
- Handling austerity
- Mental health first aid
- Community approaches to crisis
- The armed forces and refugees

Finally, both Presidents agreed to reflect on what should be done next, and the FPH Mental Health Sig confirmed it would look at next steps along with Peter Byrne and other colleagues from the RCPsychiatry

Overall, I was impressed by two key points:

1.Participants were engaged and enthusiastic about working together.

2.There was momentum, which suggested to me that we should aim to hold another session in October or thereabouts.