

## Editorial

Public mental health:  
an interdisciplinary subject?†

Sarah L. Stewart-Brown

**Summary**

The Chief Medical Officer's report for 2013 was the first of its kind to highlight the public's mental rather than physical health and thus represents a very important landmark for public health in the UK. Written primarily from the perspective of psychiatrists, the report has created confusion in public health circles by failing to adequately address the public health perspective. David Foreman's editorial in this issue, calling as it does for more training in public health for psychiatrists, is therefore very welcome and timely.

**Declaration of interest**

The author is Chair of the Faculty of Public Health's Mental Health Committee and an expert advisor to Public Health England on mental health and well-being.

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Publication, in the autumn of last year, of the Chief Medical Officer's (CMO's) Report for 2013 *Public Mental Health Priorities: Investing in the Evidence*<sup>1</sup> makes David Foreman's editorial<sup>2</sup> in this issue very timely. He calls for psychiatric training to encompass more of the knowledge and skills of public health so that psychiatrists can better collaborate with public health colleagues and enable public mental health interventions to be effectively delivered. Such a training, he suggests, would need to encompass greater understanding of health intelligence and informatics, health economics and prevention science. He lists knowledge of mental health impact assessment and logical framework matrix (or logic modelling) as approaches that would enable psychiatrists to engage more easily. Training in evaluation and generation of evidence, he suggests, needs to extend beyond the classic randomised controlled trial (RCT) approach and allow for delivery in non-healthcare settings, detection of small effect sizes, use of proxy outcomes and successful implementation – now a science in its own right.

### Psychiatrists' perspectives on public mental health

The CMO endorses the value of this new area of practice and the biopsychosocial model that underpins it, and recommends in Chapter 1 that commissioners in local authorities, health and well-being boards and clinical commissioning groups should commission for mental health promotion, mental illness prevention and treatment and rehabilitation.<sup>1</sup> This very comprehensive 300 page report is co-authored by a large number of UK authorities in psychiatry, but interestingly and relevant from the point of view of Foreman's editorial, the lack of contribution from experts in public health (with one exception) is notable. So this is a report written mainly by psychiatrists for public health practitioners and policy makers. The wealth of

†See pp. 189–191, this issue.

information, succinctly summarised will be of great benefit in bringing public health professionals, as a whole, up to speed on the psychiatrist's perspective on public mental health. And this is to be welcomed because many of those practising in public health have ignored mental health for much too long.

However, there is no doubt that a public health perspective would have enhanced the report and the lack of it has resulted in some unbalanced recommendations. Chapter 3 on neuroscience and mental illness, for example, provides a very readable update on the advances in basic science that have contributed to our understanding of the mechanisms underpinning psychiatric disease. This chapter describes the potential for neuroimaging to detect patients at high risk of developing psychotic disorders, an attractive suggestion on the face of it, but at the same time one that would call for consideration of the principles of effective screening programmes.<sup>3</sup> To date screening has proved difficult to apply successfully in mental health and this is to be expected from the nature of psychiatric disease. Because symptoms of the latter are continuously distributed in the population, leaving no obvious cut-point between illness and health, it is unlikely that screening programmes could ever meet the essential criteria for effectiveness. There is no reason to suppose that improved technology could get around this fundamental issue.

### Interventions to prevent psychopathology

Chapter 5, a fascinating read on the rapidly evolving science of developmental psychopathology, describes epigenetic studies showing the profound interaction of nature and nurture and even the intergenerational transmission of these epigenetic phenomena, all things that would have been considered impossible for most of the 20th century. It covers the central role of environmental factors in establishing the sensitivity of the stress response and thus life course resilience, and shows how these may operate through methylation of glucocorticoid receptor genes. And it puts the 'attachment' relationship – the parent (or carer's) sensitivity to the infant and child's experience – as central to these environmental influences. The discovery of epigenetic phenomena has had an important impact on thinking in public health because that which was previously thought to be genetic is now known to be amenable to intervention. The relevance of this chapter to public mental health therefore lies in the fact that it is possible to

intervene to prevent psychopathology. But this chapter, and indeed the rest of the report, is remarkably devoid of information on the large body of research on programmes to support healthy parent–infant relationships and parenting more generally, and thus prevent psychopathology.<sup>4</sup> This research epitomises all the issues and challenges that arise in trying to apply the medical model RCT approach to complex intervention evaluation, but it has still managed to demonstrate a sufficient number of programmes to be effective for us to know this can be done. Public health professionals would have discussed this evidence base and offered information on what needs to be done to enable these interventions and programmes to be rolled out effectively at local level.

### Promoting mental well-being

Chapter 2 contains the most controversial aspects of the CMO's report and concludes with the recommendation that commissioners in local authorities, health and well-being boards and clinical commissioning groups should not 'commission well-being interventions as there is insufficient evidence to support this'.<sup>1</sup> Public health professionals would have pointed out that the report only attempts to review and discuss evidence relating to mental health outcomes. As much of the justification for well-being interventions rests in the prevention of unhealthy lifestyles and physical diseases this recommendation cannot be justified.

The argument which is presented, relates only to the potential for well-being initiatives to have an impact on mental illness prevalence and rests on three suppositions that do not stand up under public health scrutiny.

The first supposition that the definition of mental well-being is still debated especially its relationship to psychiatric illness and its measurement is not secure. New concepts need to be debated and researched before opinions converge. This healthy process is well documented in the literature<sup>5</sup> as is also the coming together of the understanding that mental well-being is characterised by variation in affect – the hedonic perspective, and functioning – the eudaimonic perspective ('feeling good and functioning well'). In this way it relates to mental illness that is characterised by problems in both aspects of living (feeling bad and functioning poorly). Public health research and development is very often based on proxy measures, and decision-making depends on a consistent story arising from studies using different methodologies and measures. The fact that different measures are giving similar answers strengthens rather than reduces the quality of evidence.

The second supposition is that the central hypothesis of the Foresight report<sup>6</sup> – namely that well-being interventions can prevent mental illness by shifting the curve – is unproved. Geoffrey Rose proposed that for health problems assessed by measures that are continuously distributed in the population, the population mean was closely related to the proportion of the population with scores indicating illness.<sup>7</sup> He showed that where this was true, a small shift in the population mean could achieve a large impact on the prevalence of the health problem, potentially greater than that achieved by treatment of those with the problem. This argument has been used to lobby for reduced salt levels in processed foods and increased taxation on alcohol. The veracity of the proposal has been demonstrated with regard to common mental disorders in both adult and child populations.<sup>8,9</sup> It is simply a matter of maths that if a measure is continuously distributed, and if you shift the mean without changing the shape or variance of the distribution, you will have an impact on the prevalence of the health problem. Exactly how

much will depend on the shape of the distribution, which may vary with the measure employed, and how much it is possible to shift the curve. The only other question that needs to be answered then is 'is it possible to change the population mean?' The answer to this question can be found in studies of interventions in normal or universal populations and it is 'yes'. These studies include the evidence that underpins National Institute for Health and Care Excellence (NICE) guidelines on the promotion of mental health in primary school children,<sup>10,11</sup> studies of some parenting programmes,<sup>4,12,13</sup> and interventions like mindfulness that have proved valuable in general population as well as clinical groups.<sup>14</sup> The latter include doctors,<sup>15</sup> something perhaps of interest with regard to Chapter 10 of the CMO's report, which addresses the mental health of the medical profession.

Finally, the report suggests that 'evaluations of well-being interventions are not sound'. This is undoubtedly true, as it is true for every subject in the public health and medical field, for some studies of well-being interventions. But is it curious to critique in detail one evaluation and ignore the trials and evaluations of mental health promotion interventions that are sound. Even allowing for all the issues that make RCTs so very challenging in this area, a significant positive RCT evidence base relating to key mental health promotion interventions (in parenting;<sup>4,12,13</sup> schools;<sup>8–10</sup> communities<sup>16</sup> and workplaces<sup>15</sup>) has accumulated and been extensively reviewed.

### Conclusions

There is so much of value to public mental health in this report,<sup>1</sup> that I thoroughly recommend colleagues in both public health and psychiatry find the time to read it. I also recommend that next year the CMO produces a report that does justice to the public health end of public mental health and the ever expanding evidence base for commissioning for mental well-being. But if that is not to be, enhancing public health training in psychiatry and mental health training in public health will hopefully create the mutual respect between the two disciplines on which this important interdisciplinary field can thrive.

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poems  
by  
doctors

## Shrink

Tricia Henry

She who would never leave the house without looking neat,  
who I never saw in her utility underwear,  
was taken into care wearing a slip in the winter street.  
She was shoeless and asking for me door-to-door.

Respite. Six-week evaluation. I packed for her  
for the short stay, rummaging through pants and bras.  
Clothes neatly folded, colour-coded, drawer-to-drawer.  
One small case was all. She asked me, "How long for?"

She stood diminished in a Home with a sea view.  
Shrivelled inches in height, fragile as glass.  
Her things were marked indelibly. We did it new  
every week; her clothes shrank in the wash.

Clothes that didn't shrink she didn't recognise as hers,  
the labels even less since they used her real name.  
Six weeks, then three months, she changed gears.  
I adjusted with her but didn't know who she became.

When she went to a locked ward she stopped asking for me.  
She let her mind contract. Time for me to clear  
her home of all her household icons. By degrees  
her character was bleached, she began to disappear.

I found hung up among her "special dresses" (all dry-cleaned  
and ready to wear) his trilby hat and sheepskin fur.  
That smell that never leaves a coat, of smoke, of body,  
after-shave. Suddenly I, too, felt he was there.

And I pictured her recalling winters when he'd worn  
that coat, needing the texture of it to re-invent  
him, to keep her grounded and in the right dimension.  
I held its full length against me, warm, redolent.

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