



# Faculty of Public Health

of the Royal Colleges of Physicians of the United Kingdom

Working to improve the public's health

## UK Faculty of Public Health (FPH) response to New Horizons: Towards a shared vision for mental health consultation

The UK Faculty of Public Health (FPH) is the leading professional body for public health specialists in the UK. It aims to advance the health of the population through three key areas of work: health promotion, health protection and healthcare improvement. In addition to maintaining professional and educational standards for specialists in public health, FPH advocates on key public health issues and provides practical information and guidance for public health professionals.

### General comments

In general the approach outlined in New Horizons significantly sets the agenda for mental health over the next 10 years. The focus on public mental health and the building of positive mental health and not merely the reduction of risk factors and the treatment of disease is welcome. However, a more explicit public mental health framework (reflecting the life course) may have given readers a more concrete understanding of its components. The emphasis on paternal mental health and its effect on children is very welcome. Many of these areas are new or redefined and making progress on them will be a significant challenge without robust leadership or evidence base in a time of public service spending restraint.

### 1. What do you think are the three most important changes for mental health and mental health care in the next 10 years? And why?

Mental health will be affected by changes in society. An aging population, economic recession or insecurity, climate change and increasing globalisation will have impacts on mental health and dementia. The impacts of such change will be reduced with greater resilience of individuals, communities and populations.

There is an increasing need to recognise and implement a more holistic approach to health combining approaches to both physical and mental health, integrating mental health interventions into general health and social care services and integrating physical health interventions into mental health. This should lead to improved physical health of mental health service users and improved mental health of physical health service users. This will also require changes in training of health professionals, which ensures training in brief intervention for mental health disorders are a core component and requires an acknowledgement that treating common mental health problems is part of the role. Not only health professionals but other professionals require basic

training about mental health e.g. teachers and others who work with children and young people who have a big role in prevention and early intervention

There is a need to recognise and embed the psychological needs of individuals, communities and populations in wider social policy. Mental health and flourishing is intrinsically related to and interacts with material needs. Better measures other than GDP are required to measure societal 'progress'; there are strong arguments for suggesting that wellbeing would be a better measure (see Richard Layard's work).

**2. Do you support the twin themes of public mental health/prevention and mental health service development? Please explain your views giving examples if possible.**

Yes. There is ample evidence for the impact of macro-level interventions on mental health including nutrition, housing, education, economic security, strengthening community networks, violence and abuse, perceptions of safety and fear of crime, and reducing the misuse of harmful substances (tobacco, alcohol and illicit drugs). These prevention approaches though need to be based on systematic assessments of public mental health need.

Mental health services have improved over the last 10 years but there is still more to do. Service users still experience inequalities in access to services and time is needed to embed the proposed changes from *High Quality Care for All*. User involvement (including LINKs) needs additional time to ensure coproduction is embedded fully. The largest cause of health inequality in those with mental illness is their increased levels of smoking, and system change to facilitate better rates of cessation is required in this area.

**3. Are the guiding values described in section 1 the right ones? Please explain your view giving examples, if possible.**

Yes, although differences in power are not mentioned, yet are integral to discussions about rights and social justice.

There is a worrying lack in this context of discussion of the importance of relationships to personal mental wellbeing. Most of this section focuses on the importance of informal carers to people who are ill. Generally while claims are made that promoting the wellbeing of the population is as important as treating mental illness, most of the discussion focuses on treatment services.

**4. What should the Government do to promote more personalised services for people with mental health problems and their families? It would be helpful to hear about both what works in your area, and, if appropriate, what does not and could be done in the future.**

There is a need to consider the effectiveness of personal budgets in mental health. The government should ensure that there is robust evaluation of any policy to promote the use of personalised budgets for people with mental health problems. A more explicit use of a psycho-social recovery model (as opposed to a medical-treatment model) may help.

A particular area of need is support for parenting in families where parents have a mental illness. This approach has the potential to interrupt the non-genetic component of the familial transmission of mental illness and radically influence the prevalence of mental illness in the next generation. Parenting and resilience programmes need to be available to families and young people. Freedom to use personalised budgets to support families and build mental health resilience would be forward thinking.

**5. In your view, which are the most important areas in mental health services where value for money could be improved? And how should that be done? If possible, please indicate examples of the current costs of services and areas where potential savings might exist.**

- Improving Access to Psychological Therapies (IAPT). There are a number of models for delivering this including both high-intensity, low-volume and low-intensity high-volume systems. Clinical outcomes in service models are comparative although the costs of a low-intensity high-volume system are less (Clark and Layard et al, 2009, "Improving Access to Psychological Therapy: Initial Evaluation of Two UK Demonstration Sites").
- Treatment costs for common mental health disorders including depression could be substantially reduced if diet, exercise and nutritional supplements were used in place of newer antidepressants. NICE guidance is awaited on this.
- Decommissioning of packages of care that are either not evidence-based or not effective in improving health outcomes. Encouraging or incentivising if necessary.
- Shared care approaches between primary and secondary care so patients do not have to stay under MH services professional care long term if stabilised or well.
- Investing in early intervention services. Good evidence exists that such services particularly for psychosis improve outcomes, reduce admissions and are more cost effective than as usual services.
- Improved rates of smoking cessation by better access to smoking cessation services would improve physical health of those with mental illness and also often allows significant reduction in doses of medication. Smoking is the largest single cause of increased mortality

and increased inequality in this group. NICE highlight smoking cessation as a very cost effective intervention.

**6. Which areas can you identify where innovative technology can help people with mental health problems, and their families? It would be particularly helpful to hear about what works well in your area and what could be done in the future.**

- Free to use websites including Computerised Cognitive Behavioural Therapy (CBT) should be compared to those that require a license. Such websites would highlight ways to improve wellbeing.
- Web based parenting programmes are effective for general population use.
- Use of Telemedicine, especially in early stages of dementia/ Alzheimer's.

**7. In your view, where are the current gaps on research evidence supporting the development of New Horizons?**

There are still gaps in the evidence base for public mental health and there is a need for adequately powered longitudinal studies, studies on the cost-effectiveness of interventions and multi-modal evaluations of complex interventions that have interrelated outcomes including mental and physical health e.g. Green Gyms.

The current evidence base relating to the interpretative psychotherapies is inadequate and excessively framed in models concerned with illnesses and their cure rather than enabling people to develop their sense of who they are and how they can more effectively relate to other people. Further development is needed of the evidence base on why these therapies have more potential for enhancing positive mental wellbeing than models using a simple illness paradigm.

There needs to be further work done on the benefits of unpaid work, volunteering and caring as work can appear to be the only valid use of time.

Qualitative studies are needed of who are the most effective local champions of mental health promotion, and what resources they feel would assist them.

**8. How can we support local leadership in building mental well-being and mental health care services? Please explain your view giving examples where possible.**

Leaders require sufficient information on which to base future decisions. A strong evidence base is essential as is support to deliver improvements within existing resources. Different levels of summary of such information needs to be available for different levels of leadership/ commissioning.

Leadership for mental well-being needs to be appropriately assigned and links closely to the Local Authorities' power of well-being.

Alongside local council and PCT management, leadership for many of the developments envisaged will need local champions, possibly from among voluntary sector organisations, local politicians, or other community activists. These local champions, particularly local authority councillors need to be helped with tangible evidence about the state of mental wellbeing in their local communities.

Specifically there needs to be explicit and regularly collected survey data about personal mental wellbeing. The Scottish Government's example of including the Warwick-Edinburgh Mental Well-being Scale (WEMWBS) instrument into the Scottish Health Survey is an excellent lead. FPH are pleased to see that this was included in the Health Survey of England (HSE), and recommend that it should also be incorporated into the Annual Population Survey or the 2010 round of the Local Authority Place Survey.

A large range of data types currently provide evidence about mental health and mental health care. At present there is no single organisation adequately resourced to collate and disseminate these to local authorities, PCTs and others who could make use of their evidential value in local developments. The suggestion that the Government is considering establishing a National Mental Health Observatory for this purpose is very welcome and FPH would strongly support this. This approach has been implemented recently in the Children's services and Obesity Areas, and appears to be about to be followed for learning disabilities following the government's response to the Sir Jonathan Michael report. In this context it would represent a very practical way in which the Government help Local Authorities better understand the nature of the task they should be addressing.

For local politicians, evidence specifically relating to their electoral wards is the most cogent and valuable. The government could address this by asking the Neighbourhood Statistics Unit at ONS to explore urgently ways to develop small area data about mental wellbeing.

## **9. How can we promote joint working between local authorities, the NHS and others to make New Horizons effective in your area?**

There is a need for community and population level indicators of well-being which could form part of National Indicator sets and therefore be incorporated into joint strategies and plans including the Local Area Agreements (Huppert et al, 2008 "Measuring Well-being Across Europe: Description of the ESS Well-being Module and Preliminary Findings")

Improved mental health may be a by-product of improvements in place and these initiatives should continue. However these initiatives need cross government sign up and implementation. Literature needs to be provided in

language Local Authorities understand, demonstrating why the New Horizons strategy is key to reducing health inequalities in priority areas. Potentially this could be achieved via joint commissioning and pooled budgets. Also more explicit links between mental health of children and families and the safeguarding agenda could be made.

**10. What do you think are the most important steps the Government can take to reduce inequalities that affect our mental health? And why?**

Mental Well-being Impact Assessments could form a key part of inequalities impact assessments on any new policy e.g. housing, transport and the built environment which would reinforce progress toward the triple bottom line.

To support the findings of the Marmot review as the determinants of mental health inequalities are similar to the determinants of health inequalities. This highlights that ill-health increases proportionally to the level of exclusion, and poverty and that therefore reducing inequality will reduce such determinants and therefore improve mental health. Investment in children and families is crucial.

**11. How best can we improve a) the transition from child and adolescent mental health services to adult services and b) the interface between services for younger and older adults? What works well in your area? And what does not?**

Encourage services to be provided for 16-25 year olds. Services will take ownership of those in transition rather than seeing their role as “babysitters” until the child can access adult services or adult services. Potentially, the cut off between adult and child and adolescent services needs to be later, as in Australia, where it is 25 years. Since majority of mental illness starts before adulthood, there is great opportunity to prevent a proportion of adult mental illness by effectively addressing such illness and early which requires continuity of care. Specialised services with for instance psychosis show better effectiveness and reduced costs although require effective joined up working.

**12. In your view, what more should the Government do to combat stigma?**

It is important to be clear that stigma is a manifestation of lack of mental wellbeing. Societies with a high level of mental wellbeing would be marked by acceptance of different and support for the vulnerable. One key action in stigma reduction is therefore the promotion of mental wellbeing at population level.

Therefore there is a need to increase social inclusion. Approaches could include improved health literacy in the general population, targeted campaigns for front-line professionals and schools, tackle labour market discrimination, improve access to services including the roll out of personal budgets, give more control to mental health service users and enforce anti-discrimination legislation.

Promote the view that mental health problems can be treated and resolved. Work with the media to improve reporting of mental health issues, enforce responsible reporting guidelines of suicide and homicides by those with mental health problems.