Public Mental Health prevention – what works?

A joint event with the Faculty of Public Health and the Royal College of Psychiatrists, 10.5.19

Presentations are [available on the FPH website]

Opening

The day was opened by Dr. Peter Byrne from the Royal College of Psychiatrists (RCOP) and Liam Hughes representing the Faculty of Public Health (FPH). Their hope was that this was the first such combined conference of many in the future. The RCOP is looking increasingly at using public health methods for refining goals, achieving better health for all and preventing disorders. The current state of mental health services with more and more referrals and staff cuts is impossible to maintain.

The Faculty of Public Health's Public Mental Health Special Interest Group strives to put public mental health at the heart of the work of the Faculty of Public Health. The SIG was originally delegated the area of public mental health work but there is a coming together with the general work of the Faculty. The ongoing requirement for working on public mental health is to listen hard, debate, contest and add to the conversation through knowledge and experience.

Thanks were given to Mag Connolly, Jennifer Elder, Executive Assistant to President and CEO, Nikol Krehanova and Marijana Curic both from the Education and training team, Hannah Payne from the membership team and David Parkinson the digital officer who was taking photos and tweeting. Queen Mary University was thanked for giving the venue for free and Christine Grey in particular from the SIG, who was instrumental in getting the conference organized.

Session 1: Health Creation - Lessons from history, vision for the future: **Sir Harry Burns, Professor of Global Public Health, Strathclyde University**

Discussion points:

- If we come at things through social relations, do we need to shift how we treat and think about mental health issues, to shift away from looking at people as individuals and the way we use medical language?
- It is not an either or. Antonovsky believed the sense of coherence was laid down by age 8/9. It has been shown that brain changes from early life are repairable by mindfulness, physical activity and social networking. We can fix problems well into adulthood.
- How do we activate this kind of shared power, working on a policy scale?
- In Scotland the Early Years Collaborative is a coalition of Community Planning Partners - including social services, health, education, police and third sector professionals - committed to ensuring that every baby, child, mother, father and family in Scotland has access to the best supports available. The Early Years Collaborative includes health data but also for example the Scottish Police are contributing data, there is data from social housing so that when a housing officer goes into fix a broken window or kicked in door this also goes into the AI report that will allow us to say these people, whose situation may be known already individually to a teacher or a doctor, this family need this support.

It is about working with front line support to get what matters to people, that is the approach. The idea is to mobile the workers who already have the job to help people fix themselves. It is not about public policy coming first, front line workers will only be committed to a change that they have a say in shaping and then test out themselves and spread what works.

Session 2: Understanding the lifelong impact of Adverse Childhood Experiences: **Dr Lynne McNiven, Public Health Department NHS Ayrshire & Arran and Dr Tamasin Knight, Consultant in Public Health Medicine, NHS Tayside**

Discussion points:

- There should be a box asking drug users about whether they have children, this is actually quite unusual as professionals are concerned that people will worry that social services will take the children away. Overwhelmingly though users did have a child somewhere but few services routinely made the connection between drug use and being a parent. It is important to consider how we address that particular adversity.
- The information sharing part of the Children and Young People act was meant to deal with this issue. Work is going on in adult services to ask whether when someone has substance misuse issues do you recognise that children within the family as having an ACE? In general yes workers do, even though they do not necessarily write it down. But **when you come to look at what support is in place it is very little.**

Session 3: Public Health approaches to alcohol; politics, partners and psychiatrists: **Professor Joe Barry, Trinity College Dublin**

Discussion points:

- Different countries are at very different points in terms of their attitude to drink driving.
- Australia seems to have a very mixed set of attitudes as whilst in some areas of the country there is acceptance of drinking and driving, the most effective intervention on drink driving came from the State of Victoria. There is a public health approach on top of the national culture. Any given country is dictated to by what is normal in the culture and this can be shifted by industry in one direction and by public action in the other.
- Ultimately in Public Health you may be accused of many things. Politicians usually follow rather than lead as they are so sensitive to votes, in Ireland this has been the pattern with serial public opinion surveys and if there is a big opinion shift then the politicians go for it. The alcohol debate in Ireland has gone on for nearly 20 years, as the first random roadside testing legislation was put in place at the end of the 1990s. The alcohol industry messages are very subtle and clever, most advertising is subliminal.
- In Australia there was a time where they had breathalyzers in pubs so people were led to think they could drink and drive. The server liability legislation in Australia did suffer a bit of a backlash and drove alcohol where it is in the UK too with solitary drinking. It always points back to pricing. If any measures around pricing are proposed then the industry will oppose the. It is interesting to consider the example of paracetamol overdoses that cause death by liver failure, it is not possible to buy unlimited amounts and the approach has been to make it a bit harder such that people can build it up but generally they do not do that. So simple things can be quite effective.
- Alcohol exposure in pregnancy messaging is very hard. The evidence is that fewer people are drinking in pregnancy and the public debate on the issues has been having an impact.

Session 4: Public Health and Psychiatry - a meeting of minds? Panel discussion with **Professor John Middleton, President FPH, Professor Wendy Burns, President RCPsych, facilitated by Dr Neha Shah, Specialty Registrar in Public Health and Dr Amabel Dessain, Specialty Registrar in Public Health**

How is it possible to establish more cross specialty working?
Prof. Burns recognized that public mental health has been relatively neglected by psychiatry partly because the specialty has been so busy trying to deliver the core psychiatry services. But this is a mistake and there is general acceptance on the need to address this situation. She spoke about how risk taking behavior for example alcohol abuse, disproportionately affects psychiatry patients and that people with a severe mental illness (SMI) are likely to die 20 years on average earlier. Last year the College signed up to the Equally Well initiative from the Centre for Mental Health in New Zealand that tackles reduced life expectancy, as the College is very committed to working on that.
Prof. Middleton spoke about how the issue of public mental health has been a priority for two previous presidents to the Faculty. Under his presidency the Faculty has set up agreements and memoranda of understanding with the British Association of Mental Health and has an agreement ready to sign with Emergency Medicine on accident prevention. Prof Middleton recognized that public mental health is similar to physical health in terms of not just an absence of disease. A great deal of psychiatry deals with people with severe mental illness but those people have not been well served in terms of their physical health. Public mental health and wellbeing provides an agenda that is new to all of us. The biggest evidence for the science of early interventions for many years has been informed by Marmot and his work on inequality, those things have been known about but the science of neurobiology that gives concrete reasons for why intervening early is becoming clearer as solid science. Prof. Middleton highlighted the need to train people to work with patients and the public and not to impose solutions.

How can we strengthen these areas in our work together taking into account the time and energy it takes?
Prof. Burns spoke about how hard this was given how busy everyone is and that there was a need to sit down together and find ways to do it such that it fits into current practice as there is simply no space for an add on.
Prof Middleton thought that one practice way could be through the Faculty of Public Health with the registrar placement scheme. In the last 3 years 20 registrars have been able to engage in national project work for the Faculty for between 1 and 3 days a week up to a year with an activity supervisor working in the Faculty. They have done work on Brexit and funding and have been working in Chatham House on international relations and violence. The Faculty could very easily devise activities that registrars want to do working with psychiatry, the agenda from the morning sessions provides examples of fertile areas for registrars to work on.

What should we be working on if we want to strengthen public mental health training?
Prof. Burns mentioned that the College is reworking the curriculum at the moment so it is a good time to suggest things. Psychiatry trainees have a day a week for personal development. The best way to get them to become involved is to set up placements and advertise them, there is a whole CPD programme with conferences and e-learning which would be a good place to put things. The best way will be with clear results.
Prof. Middleton gave several examples of places where training opportunities currently exist for example in attachments with Public Health England and local government, he stressed the excellent practice in the defense forces and the learning coming out of those placements. The idea of placements with public health training in acute settings is gathering pace such that we have around 70 public health people in NHS trusts, the chair of the Faculty healthcare

committee works for an acute trust in Nottingham. There is the possibility to make more of those connections.

Discussion points:

- It can be a struggle to combine public health and psychiatry training with people leaving the programme when they cannot make it work. It would be good if trusts had population health in their strategy but even where it is in there, consultants do not get the time to contribute. The question is how to engage at the board level to prioritise population health outcomes.
- Old age psychiatry did not exist at one point and people just started doing it and then the College caught up and the GMC followed them. The trick is to create a movement, find like-minded people and start doing it. That is how old age psychiatry started, there is no harm in engaging the board but get going in the meantime.
- Dual diagnosis is very difficult in practice to get a good service in place. This could be an area where there is a link between public health and psychiatry. It is a contentious area, a bit like the transition to adult services. It requires better collaboration and cooperation as well as planning and commissioning. This is certainly something that any future arrangements between the Faculty and the College could look at.
- There are mutual concerns about addiction services and problems with quality and variation amongst local authorities, this could be an area of work to take forward with LGA and the Association of the Directors of Public Health and inputs from other Colleges including Psychiatry and legal medicine too.

Session 5: Time to listen to the experts: **Dr Peter Byrne, Consultant Liaison Psychiatrist, Royal London Hospital**

Discussion points:

- The voluntary sector is much better at engaging people with messy problems than other services, how can we work better with the voluntary sector for public mental health?
- The public realm is being thinned out so that organisations that have the capacity to be versatile cannot afford to be in the way they used to. Commissioners are being more explicit about what is allowed, we need to allow some things to emerge in the voluntary sector where they will be most effective. It can't just be a single track but they need to have more time to listen to people. The "voluntary sector" as a tern can be unhelpful as it covers such a range. Turning Point as a provider is incredibly innovative and flexible in a way that the NHS isn't. So we need to use providers that have shown a track record of doing things better and they should be part of the team.
- Health trainers are an example, as they were employed from the local communities, the same model has happened with health champions from GP practices. You can underestimate their success. An example is where the aim was to recruit 40 champions for 8 GP practices and there was concern that would be difficult but the GPs asked the community and in one of the poorest areas over 100 people responded the first request. People do want to put something back into their commuinities.

Session 6: Social Prescribing in Tower Hamlets: **Professor Sir Sam Everington, Chair of Tower Hamlets CCG**

Discussion points:

- What is the role of occupational therapists in Bromley by Bow surgery?
- There is a housing officer and a lot of scenarios need housing adaptation. There is a raft of people doing the job of the occupational therapist, there are psychologists in all the practices but they can't see everyone.

- How long as it taken to develop the social prescribing model, given the level of interest there is a need to manage expectations of the model being rolled out. It is quite a slow, organic process.
- In the long term it is about creating an evidence base that competes against biomedicine and is sometimes more effective. There are 1500 voluntary organisations in Tower Hamlets, mostly underused so you are using what is out there to maximise the effect. If you follow people's passions then you can do amazing things. It is about changing the way we think and work as doctors, so you see the person as a whole and focus on what matters to them. It is not about a doctor solving someone's problem but about handing it back to the patient. It may be tempting to just give someone a statin and let them carry on their lifestyle but we have to break the mutual addiction as doctors and patients that we have. The sense that the doctor can solve the problem, in fact the most important thing you can say to a patient is that you do not know, not that you do not care. You do not have to do everything, there is a whole raft of people and the patient who can do it for you.
- It is good to see the emphasis on the physical building and the architectural structure has an effect. How can PHE give guidelines on the construction of new health centres?
- To what degree was the project allowed to fail?
- The atmosphere that was created was one of innovation, with shared vision about fun, friendship and compassion, not fear of failure.
- There is a positive impact where people find something that is meaningful to them but it might be hard for some people who are isolated, how do you find out what is meaningful for them?
- A big part is having choice, the key thing is the conversation and accepting that you might get it wrong but in trying you are on the right path.
- How do you take this prototype to scale when so much of what you describe has been about developing something organically?
- It can be replicated, but it does not happen quickly. It is like bringing up a child, it does not happen overnight. It is important to pay attention to the relationships.

Session 7: The Last Word – questions / suggestions, proposal for future events – collect feedback: facilitated by **Professor Woody Caan, Editor in Chief, Journal of Public Mental Health**

Discussion points:

- Public mental health: Evidence, practice and commissioning; A report by Dr Jonathan Campion, Director for Public Mental Health and Consultant Psychiatrist, South London and Maudsley NHS Foundation Trust.

https://www.rsph.org.uk/uploads/assets/uploaded/abe811ae-df07-4d5e-a6d9b60a3eb333ba.pdf

- It can be hard to ask people what they would really like to try if they have limited life experience, for example drug and alcohol users with few personal resources who had been in and out of prison, when they were asked what they wanted it was bereavement help. But there also needs to be an approach to give tasters of lots of things and see what works. In one LA that was further education, it became the most effective intervention to stopping drug use and reducing mortality. People who could not read or write felt a deep sense of shame that they had not acquired the life skills as children. So you need to find out what they want but also try little bits of lots of things.
- Ideas for sessions next year could be black and ethnic minorities, refugee health. The approach to prevention in different groups. This kind of meeting and conversation may not be happening in the places where the greatest burden exists, so it would be good to see more of a focus on migrant and minority groups in the UK. Some of the members of

the Faculty are in the military and working in situations of war, crisis and refuges. There could be the possibility of an association that looks at refugee health and includes them in the planning of it so we can try to better understand what these colleagues do that is invisible to the Faculty.

- There is some debate on whether we should be identifying ACEs in the first place, these are not determinants, there is the risk of ranking pupils. ACEs are useful as policy makers use them, there is an all parliamentary group just on ACEs, there is interest in children's welfare even if the money does not necessarily follow. There is one ACE that it is possible to do something about which is to support the children of parent's with mental health problems, this is something that can be brought into the practice psychiatry to ask about the child at home, particularly when the mother is sectioned.
- Social prescribing should not become the answer to everything, there is still the need for proper services for people with substance misuse issues for example. What practically can LAS do with very little money, that is the situation that is being faced. The model in Bromley by Bow is not going to happen for most areas in the country but what can be done?
- Discussion on whether a film on mental health would be a good idea for a future conference.
- Subgroups working on mental health e.g. older people, learning disabilities, would like to find each other to network further.
- There is considerable appetite for further conferences on mental health. There is much to be debated and discussed and shared between regions for example Scottish colleagues are further ahead in pursing rights and the law, Welsh colleagues are better at looking at the health of future generations.