RC PSYCH
ROYAL COLLEGE OF PSYCHIATRISTS

Public Mental Health
Implementation Centre

Public mental health implementation

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Summary

Mental disorders account for at least 18% of global and 21% of UK disease burden. This is due to a combination of high prevalence, early onset during the life course, and a broad range of associated impacts. Effective interventions exist to prevent onset of mental disorders, treat mental disorders, prevent associated impacts, and promote mental wellbeing and resilience.

However, only a minority of people with a mental disorder in the UK receive treatment, and far fewer receive interventions to prevent associated impacts. Furthermore, there is negligible provision of interventions to prevent mental disorders or promote mental wellbeing and resilience. The implementation gap is even greater in low- and -middle-income countries and results in population-scale preventable suffering, broad impacts and associated economic costs. The gap breaches the right to health, reflects lack of parity and has further widened with the COVID-19 pandemic.

The implementation gap can be addressed sustainably through a public mental health approach. The Public Mental Health Implementation Centre (PMHIC) of the Royal College of Psychiatrists was established in 2021 to work in partnership with relevant bodies to support improved implementation of evidence-based public mental health interventions, both nationally and internationally. This will support sustainable and equitable reduction of disease burden from mental disorders and promotion of population mental wellbeing and resilience.

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Glossary

Mental disorders: These include common mental disorders (depressive and anxiety disorders), bipolar disorder, psychotic disorder including schizophrenia, eating disorder, personality disorder, substance use disorders, dementia, intellectual disabilities, and neurodevelopmental disorders including autism.

Mental wellbeing: Different conceptualisations of wellbeing include affective wellbeing, which refers to present state satisfaction, pleasure and mood, and evaluative wellbeing, which refers to global, longer-term aspects including meaning and development[1]. Resilience (below) is also related to mental wellbeing.

Primary-level interventions: These address risk factors to prevent mental disorders from arising and promote protective factors associated with mental wellbeing and resilience. This includes the full range of determinants such as socioeconomic inequalities and structural racism.

Protective factors: These are attributes (including genetic, demographic, socioeconomic, environmental, social and educational) that support mental health and wellbeing, and so protect against the likelihood of poor mental health and wellbeing. Protective factors are crucial to resilience (below).

Resilience: A process of positive adaptation in response to life events. Considered to be a dynamic process influenced by individual, family, school and community factors, as well as wider support structures and systems, which can be important to mitigate impacts of adversity and promote mental wellbeing[2,3].

Secondary-level interventions: These involve early intervention for mental disorders and poor mental wellbeing to minimise impact.

Subthreshold symptoms: Conditions with symptoms not meeting full diagnostic criteria for mental disorders.

Tertiary-level interventions: Interventions for people with established mental disorders and/or poor mental wellbeing to promote recovery, prevent associated inequalities and minimise disability.

1. What is public mental health?

Public mental health:

a. involves a population-based approach that seeks to improve the level and distribution of mental ill-health and mental wellbeing in society.

b. supports improved implementation of public mental health interventions at primary, secondary and tertiary levels.

c. includes more targeted approaches to prevent widening of inequalities for groups at increased risk of mental disorder, poor mental wellbeing and/or reduced access to interventions. Such targeted approaches are supported by, for example, being culturally appropriate.

d. promotes coordinated and intersectoral approaches between providers of different types of intervention, including social, educational, workplace, health, economic and policy.

e. involves people with experience of mental disorders and their carers, communities, providers, commissioners, policymakers and industry (public, non-profit and for-profit institutions) in the development and implementation of evidence-based interventions.

2. The role of the Public Mental Health Implementation Centre

The role of the PMHIC is to support improved implementation of evidence-based public mental health interventions both nationally and internationally in the following ways:

a. Support collaboration and leadership on public mental health with a broad range of stakeholders (see list of stakeholders and partners).

b. Promote public mental health as an intrinsic part of psychiatry, and support College members in developing their public mental health knowledge and skills through training[4], evidence briefings, publications and conference presentations.

c. Work with other professional groups to integrate public mental health training into their teaching programmes: for example, in nursing, medical schools, medical specialties, general practice and public health training.

d. Provide high-quality evidence, advice and recommendations about public mental health to government, and other policy-making bodies at local, national and international levels.

e. Support mental health needs assessment at the national level to estimate the size, impact and cost of the implementation gap of effective public mental health interventions. This work will take into account issues such as COVID-19 and includes:
    - highlighting the most suitable options to address the gap, associated economic benefits and ways to improve scale coverage
    - facilitating transparent agreement about acceptable levels of coverage of different public mental health interventions taking account the right to health, the impact and cost of implementation failure, and the UN Sustainable Development Goal target of universal coverage by 2030.
    - supporting the translation of needs assessment into improved implementation across populations.

f. Support identification of public mental health research priorities, including implementation research.

3. Why is a public mental health approach important?

National and global burden of mental disorders

Mental disorders account for 18% of global and 21% of UK disease burden measured by years lived with disability[5], although even this underestimates the true burden by at least a third[6]. The associated annual economic cost is at least £118 billion to the UK economy equivalent to 5% of GDP[7]. By 2030, the global annual cost is projected to exceed US$6 trillion[8]. The burden of mental disorders is so large because of: (a) the high prevalence of mental disorders, (b) the early onset of lifetime mental disorders, (c) the broad range of impacts associated with mental disorders, and (d) the low coverage of public mental health interventions. Subthreshold mental disorders are also common and associated with poor outcomes, including impaired functioning, increased health service use and increased risk of developing a mental disorder, as well as physical health and psychiatric comorbidity[9–11].

The impact of the COVID-19 pandemic

The COVID-19 pandemic has placed considerable strain on mental health and services[12], highlighting the lack of mental health preparedness during emergencies and the urgent need for public mental health interventions to address and prevent mental disorders according to population need[13].

Reasons for the impact of mental disorders

a) Prevalence of mental disorders

Approximately 50% of the population experience a mental disorder during their lifetime[14] while almost a quarter of the population experience at least one mental disorder each year[15].

b) Early age of onset of mental disorders

Mental disorders can affect individuals across the lifespan, from preschool to old age[16,17]. However, approximately 50% of mental disorders emerge by age 14, and 75% of mental disorders emerge by age 24 years[14,18], making childhood and adolescence the most important stage of the life course for early treatment and prevention. The mental health of children and adolescents has been disproportionately affected by COVID-19, with a 50% increased prevalence in England[17,19,20].

c) Impact of mental disorders

Mental disorders result in broad impacts across health, educational, occupational and social outcomes. Since the majority of lifetime mental disorders arise before adulthood, many impacts of mental disorders occur during childhood and adolescence but also extend into adulthood[21–23]. Childhood mental disorders are associated with a three-fold increased risk for adult mental disorders[24–26]. Health impacts of mental disorder include increased health-risk behaviours[17], such as self-harm, physical inactivity, obesity and tobacco, alcohol and drug use[21].

Smoking is the single largest cause of preventable death and occurs at much higher rate in those with a mental disorder compared with the general population[27,28]. A combination of greater levels of risk behaviours, risk factors for chronic disease[29] and disparities in access to physical health care[30] drive poor physical health and premature mortality among those with a mental disorder[31]. There is high comorbidity between mental disorders, physical illness and substance use[15,17,32].

Mortality and mental disorders

The life expectancy of individuals with different mental disorders is reduced on average by between 7 and 25 years[21,33]. The largest proportion of reduced life expectancy is due to associated physical illness[33,34], with an estimated 60% of excess mortality being avoidable in those with schizophrenia and bipolar disorder[35]. The majority of people who die by suicide have a pre-existing mental disorder[36–38]. Drug and alcohol use disorders are also associated with significantly reduced life expectancy[39,40]. In 2020, there were 4,561 deaths related to drug poisoning in England and Wales[41] and 1,339 drug-related deaths in Scotland[42,43], which are the highest since records began. People with mental disorder also experience higher rates of COVID-19 infection and associated mortality[44–46].

Case study: Minimum unit pricing of alcohol in Scotland

Evaluation of minimum unit pricing (MUP) - Alcohol - Health topics - Public Health Scotland

Minimum unit pricing (MUP) of alcohol is an effective way of reducing alcohol consumption[47]. In May 2018, Scotland became the first country in the European Union to introduce MUP for alcohol, set at 50p per unit of alcohol sold. MUP targets low-cost products, which tend to be consumed by drinkers who are at greatest risk of harm.

The introduction of MUP in Scotland has resulted in a sustained decrease in the purchase of alcohol. In 2020, compared with English households, Scottish households had a purchase decrease of 7g of alcohol per adult per day when an alcohol purchase was made[48].

Ongoing research will evaluate the impact of MUP on health and social harms, including the impact on people who are alcohol dependent and accessing services as well as the impact on hospital admissions and deaths.

Wales also introduced a MUP of 50p per unit of alcohol sold in March 2020.

Broader impacts of mental disorders include poorer educational, occupational, economic and social outcomes. Mental disorders among children and young people is associated with truancy, exclusion and drop out from school[17,26,49,50], antisocial behaviour and offending[21]. In England, truancy from school was 10

times more common in 11–16-year-olds with a mental disorder compared to those without mental disorder[17] while, in Wales, absenteeism from school was between 2 and 5.5 times more likely among children and adolescents with diagnosed neurodevelopmental disorder, a mental disorder and recorded self-harms[51]. Mental disorders in adulthood are associated with presenteeism, absenteeism and victimisation in work[52], reduced social functioning and poorer social relationships[17], crime[21], as well as experience of violence both as victims and perpetrators[53,54]. Individuals with a mental disorder are more likely to experience reduced quality of life[15], as well as discrimination and stigma[55,56]

4. Determinants of mental disorders

A range of social, economic, biological and genetic factors are associated with increased risk of mental disorder[21,57–62]. These include:

- sociodemographic factors
- family structure and dynamics
- child adversity, experience of trauma and violence
- physical illness and frailty
- health-risk behaviours
- employment conditions
- housing and neighbourhood factors such as crime[63]
- economic conditions
- government policies and legislation[21,64].

Many key determinants of mental health are outside the realm of mental health practitioners and services, but are important targets for public mental health interventions.

These factors interact and operate at individual, family, community and structural level[64], and account for the unequal distribution of mental disorders and poor mental wellbeing across the population. They also cluster in particular groups of people, rendering them at much higher risk of developing a mental disorder[21].

The overall population impact of a risk factor depends on both the size of impact at individual level and the proportion of population affected. Risk factors with large population impact that can be successfully addressed through evidence-based interventions are important prevention opportunities. Given that most lifetime mental disorders arise before adulthood, such factors are particularly significant during pregnancy, childhood and adolescence.

The impact of socioeconomic inequalities, childhood adversity and conflict

Socioeconomic inequalities underlie several other factors[21,65], and are further exacerbated by onset of mental disorder. For instance, socioeconomically disadvantaged children are 2–3 times more likely to develop mental disorder[66,67], and 31% of children in the UK were living in poverty in 2019/20[68]. Suicide rates in Scotland in people from the most deprived 10% of the population (decile) were four times greater than in the least deprived decile in 2021[69].

Similarly, child adversity, including maltreatment, abuse and bullying[21,70], accounts for 30% of adult mental disorder[71], with half of children globally experiencing emotional, physical or sexual violence each year[72]. Other overarching factors include environmental factors such as pandemics[13,73], climate change[74,75] and disasters[76], as well as conflict and humanitarian emergencies[22,77]. The Troubles in Northern Ireland, encompassing over 30 years of conflict, have impacted on mental health[78,79], where higher rates of post-traumatic stress disorder as well as anxiety, mood and impulse-control disorders among individuals exposed to conflict have been recorded[80].

5. Mental wellbeing, protective factors and resilience

Although several definitions exist, recognised constituents of mental wellbeing include satisfaction, relationships, engagement, pleasure, meaning and achievement[1].

Benefits of mental wellbeing

Health benefits of mental wellbeing include reduction and prevention of mental disorders, suicide, health-risk behaviour, healthcare utilisation and mortality[21]. Broader impacts include improved educational and employment outcomes, reduced burnout, improved social relationships and networks, and reduced antisocial behaviour, crime and violence.

Relationship between mental wellbeing and mental disorders

Mental disorders and wellbeing can be seen as two related yet distinct spectra, so that mental wellbeing is associated with reduced risk of mental disorders, while mental disorders are associated with increased risk of poor mental wellbeing. For instance, people with a mental disorder are 5–30 times more likely to have lower mental wellbeing levels compared with those without a mental disorder[15].

Protective factors

Protective factors promote mental wellbeing and include genetic, demographic, socioeconomic and parental factors, personality traits, educational attainment, physical health, employment, social relationships, living environment and access to green space, adequate sleep, participation in leisure activities, culture and the arts as well as helping others, and having meaning, gratitude, self-compassion, autonomy and values[21].

Case study: Early child development in Greater Manchester

Health Equity in England: The Marmot Review 10 Years On - The Health Foundation

In the past decade, significant effort has been made by schools and children's services in Greater Manchester to improve school readiness (an established marker of early child development and wellbeing). In Greater Manchester, the percentage of children achieving a good level of development increased from 47.3% in 2013 to 68.2% in 2018/19, showing a faster rate of improvement than England as a whole[81].

Particular programmes included developing an Early Years Workforce Academy to support workforce development and collaboration among early years practitioners, the I-THRIVE programme to promote children's and young people's wellbeing, and delivery of evidence-based parenting and child development programmes, such as the Solihull Approach and Incredible Years. Furthermore, Early Years Pathways were implemented at scale to support speech, language and communication, parental and infant mental health, physical development, and social, emotional and behavioural needs.

Resilience

Resilience is also important, to mitigate the impacts of adversity and to promote mental wellbeing[2,82]. Resilience is considered to be a dynamic process influenced by individual, family, school and community factors[3]. Cognitive skills, emotion regulation, family and peer support, relationship with caregivers, academic engagement, supportive school environment, spirituality, and neighbourhood cohesion appear to be associated with more resilient outcomes[3,83].

To promote resilience, it is important to increase the efficacy of existing systems and support structures to provide trauma-informed care to those who are affected by adversity. However, there is a need to reduce adversity at individual and community levels, and not only focus on promoting resilience to deal with greater adversity.

6. Higher-risk groups

Some groups of people are at several-fold increased risk of a mental disorder and poor mental wellbeing[21,84,85]. Such groups require proportionately more targeted treatment, prevention and promotion, to prevent widening of inequalities. Examples of groups at increased risk of a mental disorder include marginalised groups (outlined below), people with physical health conditions and young women. Many people will belong to more than one group.

Marginalised groups

Examples of marginalised groups who are at greater risk of mental disorder and poor mental wellbeing include:

- looked-after and adopted children[86]
- people with intellectual disability and neurodevelopmental disorder[87]
- people who are homeless[88,89]
- people who are unemployed or on low incomes[15]
- people in contact with the criminal justice system[90]
- refugees and asylum seekers[91]
- particular ethnic groups[15,92,93]
- gypsy, Roma and traveller populations[94]
- people who identify as LGBTQ+[95,96].

Underlying societal causes of mental health disparities among different marginalised groups include experience of discrimination, uncertain employment and financial insecurity, housing and food insecurity, and experience of other forms of adversity and stress, such as violence and trauma[92,97–106]. These groups may also find it harder to access support and have poorer outcomes when they do access support.

People with chronic physical health conditions

People with chronic physical health conditions, such as cancer, asthma, COPD, irritable bowel syndrome, heart disease, diabetes or musculoskeletal problems, are at increased risk of developing mental disorder[107–109] and report lower levels of wellbeing[15,110]. People with comorbid depression and physical illness tend to have more severe symptoms of both, and increased use of mental health services[111], as well as worse physical health outcomes[109].

Women

Young women have also been identified as a higher-risk group with increasingly poor mental health outcomes[15,17,20]. The gap between young men and young women's mental health appears to have increased over recent years, with 16–24 year old women in 2014 being three times more likely than men to experience a common mental disorder[15]. Rates of self-harm among young women have tripled between 2000 and 2014[12]. Several factors may account for this increase[112], including gender-based violence, harassment, and experience of trauma[113,114].

7. Public mental health interventions

A range of effective public mental health interventions exist to prevent mental disorders from arising, treat established mental disorders and prevent associated impacts, and promote mental wellbeing and resilience[21]. Table 1Table 1 sets out public mental health interventions at primary, secondary and tertiary levels.

Primary level interventions address risk factors to prevent mental disorder from arising and promote protective factors associated with resilience and mental wellbeing. Secondary level involves early intervention for mental disorder and poor mental wellbeing to minimize impact. Tertiary level interventions are for those with established mental disorder and/or poor mental wellbeing to promote recovery, prevent associated inequalities, and minimise disability.

Many effective public mental health interventions also have cost–benefit evaluations, highlighting economic returns even in the short term[21]. Public mental health interventions need to target higher-risk groups, to prevent the widening of inequalities. Such targeted approaches are supported by being accessible and culturally appropriate.

Public mental health interventions are provided by a range of providers including primary care, secondary mental health care, local government/public health, social care, voluntary sector, third sector, schools/preschools, employers, housing, criminal justice, carers and others. This highlights the importance of coordination between providers.

Table 1: Examples of public mental health interventions at primary, secondary and tertiary levels[21,22]

	Prevention of mental disorders and associated impacts	**Promotion of wellbeing**
Primary-level interventions	• Addressing socioeconomic inequalities: Including poverty, fuel poverty, food insecurity, debt, financial capability, and more active labour market and welfare programmes[115,116] • Parental interventions: Addressing risk factors during pregnancy (alcohol/tobacco/drug use, prematurity, low birth weight), parental mental disorders, parenting interventions and poor infant/parent attachment • Preschool and school-based programmes: Including social and emotional learning programmes, academic support and life-skills training • Childhood adversity prevention: Through parenting programmes,	• Starting wellbeing, including parenting programmes, promotion of infant parent attachment • Developing well, including preschool and school-based interventions • Living well, including physical activity, housing interventions, social

	school-based interventions, prevention of domestic violence, and early intervention to address adversity • Health-risk behaviour reduction: Including smoking, alcohol/drug use, physical inactivity, screen time and insufficient sleep • Prevention of alcohol-related harm: Through action on price, availability, marketing, licensing, screening and brief interventions • Physical illness prevention and treatment • Insomnia prevention • Employment-related stress and mental disorder prevention • Prevention of social isolation, especially among older adults • Prevention of particular mental disorders • Dementia prevention: Through childhood education, physical activity, social engagement, smoking cessation, limiting alcohol use, prevention of air pollution and head trauma, addressing insomnia and hearing loss, and management of hypertension, hearing loss, depression, diabetes and obesity • Suicide prevention • Prevention and mitigation of climate change, air pollution, flooding and pandemics • Conflict and humanitarian emergency mitigation	interaction, neighbourhood intervention, access to green space, arts and creativity, and other interventions including mindfulness • Working well, including increased employee control and rights, training, online interventions, and mindfulness • Ageing well, including psychosocial interventions, cognitive activities, reminiscence, addressing hearing loss and physical activity
Secondary-level interventions	• Early identification and treatment of mental disorders and subthreshold mental disorders • Addressing associated health-risk behaviours: Including tobacco, alcohol and drug use, poor nutrition and diet, physical inactivity, poor dental health and sexual risk behaviours • Prevention, monitoring and optimisation of treatment for physical health conditions in people with a mental disorder	• Early intervention for people with recent reduction in mental wellbeing, with primary interventions, outlined above

	• Interventions to address the socioeconomic impact of mental disorders, such as poverty, debt, unemployment and homelessness • Targeted approaches to suicide prevention in those with a mental disorder: Including through treatment optimisation, reducing access to lethal means, and responsible media reporting • Prevention of violence and abuse • Interventions to reduce stigma and discrimination, both for general population and those with a mental disorder	
Tertiary-level interventions	• Prevention of relapse through evidence-based treatment • Interventions to address health-risk behaviours, including smoking/alcohol/drug use, poor diet and physical inactivity • Prevention of premature death: Prevention, early detection, treatment and monitoring of physical illness in individuals with a mental disorder. Smoking is the single largest cause of preventable death, so people with a mental disorder who smoke require targeted smoking cessation and reduction • Prioritisation of COVID-19 vaccination for people with a mental disorder, given their increased risk of infection and associated mortality • Tailoring of self-management components of treatment • Suicide prevention: Optimisation of treatment and coverage, reducing access to lethal means and responsible reporting	• Mental wellbeing can be promoted through psychosocial interventions, social skills training, physical activity promotion, supported employment and skills-based training, supported housing, positive psychology interventions, arts, music, mindfulness, and yoga

8. The implementation gap of public mental health interventions

Despite the existence of effective, evidence-based public mental health interventions, only a minority of people with a mental disorder in the UK receive treatment[17,27], with far less treatment coverage in low-and middle-income countries[117]. There is even less coverage for interventions that prevent associated impacts of mental disorders, prevent mental disorders, or promote mental wellbeing and resilience[21].

Inequalities in access to interventions

The proportion of people receiving treatment also varies by type of mental disorder, ranging from 81% for psychotic disorder,41% for bipolar disorder, 37% for common mental disorders, 29% for dependence on drugs other than cannabis, 27% for personality disorder, 24% for eating disorders, 6% for alcohol dependence, 6% for cannabis dependence and to 4% for autism spectrum disorder[15]. Factors associated with accessing treatment for common mental disorders include being female, white British and in midlife[15]. Socioeconomic inequalities in people who receive treatment are less evident and more mixed with employed people with common mental disorders less likely to receive treatment than those who were economically inactive[15]. However, people with common mental disorder living in lower income households were more likely to have an unmet treatment request than those living in higher income households.

Causes of the implementation gap

Causes of the public mental health implementation gap are important to identify in order to address the gap[21,22]. They include insufficient knowledge of the current level of provision and unmet need, insufficient transparency about policy decision regarding acceptable levels of coverage of interventions, insufficient public mental health knowledge and training, and insufficient use of evidence in population health programmes or policies.

Specific causes of the treatment gap include lack of staff, skills and training, low demand for treatment due to poor mental health literacy and perceived need among the general population, stigma and discrimination associated with mental health treatment, and treatment not meeting minimal standards[21,22].

Underlying these causes is a lack of resources: despite accounting for at least 21% of UK disease burden[5], mental health (including learning disability and dementia) was allocated only 9.9% of total NHS England expenditure in 2020/21 compared to 11.1% in 2018/19[118–120]. Furthermore, only 2% of total expenditure on public health by local authorities in England was allocated to public mental health in 2020/21[121]. Although not directly comparable, there appears to be variation in expenditure across the four nations: spending on mental health accounted for 5.9% of the overall health budget in Northern Ireland in 2018/19 (excluding learning disabilities and old age psychiatry)[122,123], 13.4% of expenditure by NHS Wales in 2019/20 (including learning disabilities)[124] and 10.6% of expenditure by NHS Scotland in 2019/20 (including learning disabilities)[125].

Case study: NEST in Wales

The NEST Framework - NHS Wales Health Collaborative

The NEST Framework for child and adolescent mental health services has been developed in Wales to increase access to advice, support and treatment for children and young people utilising a 'whole system' approach. It aims to make expertise and advice quicker to access, and to facilitate transference of knowledge to the wider public, especially to parents and adults working closely with infants, children and adolescents. The NEST framework aims to take a 'no wrong door' approach so that families can access timely support in a way that is right for them.

The NEST framework has been developed with young people, parents, carers and professionals, including teachers, social workers, nurses, doctors, therapists and youth workers. NEST is also linked with services for adults, and with housing, police, ambulance, sports and leisure services, as well as policy makers in Welsh Government, regional partnership boards and health boards across Wales.

9. Public mental health policy development and associated work

In the UK, various documents and policies have supported the development of public mental health policy including:

- No Health Without Public Mental Health (Royal College of Psychiatrists, 2010)[126]
- Confident Communities, Brighter Futures (HM Government, 2010)[127]
- No Health Without Mental Health Implementation Framework (HM Government, 2012)[128]
- Mental Health Strategy, Scotland (The Scottish Government, 2017)[129]
- Mental Health Strategy 2021–2031, Northern Ireland (Department of Health, Northern Ireland, 2021)[122].

At a global level, organisations have emphasised the need for commitment to public mental health strategies:

- WHO's Mental Health Action Plan 2013–2020 highlighted the need to promote mental wellbeing, prevent and treat mental disorders and prevent associated outcomes; provide comprehensive, integrated, and responsive mental health and social care services in community-based settings; and strengthen information systems[85].

- The United Nations Sustainable Development Goals committed to the treatment and prevention of non-communicable disease, including mental disorders, as well as promotion of mental wellbeing[130]. This includes a target of universal coverage for the treatment and prevention of mental disorders, and promotion of mental wellbeing, by 2030.

- The World Psychiatric Association made public mental health a key part of its 2021–2023 Action Plan. This included raising awareness, recognising the value and increasing acceptance and prioritisation of public mental health in national health policies; conducting and supporting national assessments of unmet need and required actions to inform policy development and implementation; public mental health training; integrated approaches to disease management and prevention through engagement with primary and general health systems[131].

Previous work undertaken by the Royal College of Psychiatrists relating to public mental health includes:

- Providing expert knowledge and advice on matters relating to welfare reform since the introduction of Employment Support Allowance in 2008, in line with concerns about the impact of these changes on people with mental disorders and learning disabilities. The College has produced published guidance for clinicians to support mental health professionals writing reports for PIP (Personal Independence Payment) claims[132], and has published research evidencing relative disadvantages in accessing welfare payments for people with psychiatric conditions compared with physical health conditions[133].

- Contributing to the establishment of the Violence Reduction Unit in 2005 in Scotland; the unit took a public health approach to reduce knife carrying among young men outside the home. A sustained fall in homicide rate has since been observed, from 26.3 per million in 2005 to 10.65 per million in 2015–2016[134].
- The Fair Deal campaign; a 3-year campaign to tackle inequalities in mental health that included a call for more funding of research into mental disorders, better access to services, better inpatient care, better provision for recovery and rehabilitation, an end to discrimination and stigma, more engagement with users and carers, and better access to psychological therapies[135].
- Choose Psychiatry; an ongoing campaign that has helped to increase the proportion of psychiatry training positions being filled by doctors from 67.3% in 2017 to 99.4% in 2020[136].
- An ongoing commitment to tackle inequalities and racism across mental health services and in the mental health workforce. The National Collaborating Centre for Mental Health (NCCMH) within the College developed the Advancing Mental Health Equality resource, and in 2021, the College published an Equality Action Plan to address inequalities and discrimination that can lead to mental health problems. The College published a clear position statement on racism and mental health in 2018, which highlights the impact of structural and institutional racism on mental health.

10. Opportunities to address the public mental health implementation gap

Public mental health practice involves undertaking national and local mental health needs assessments, identifying ways to improve the implementation of public mental health interventions by various sectors (including for higher-risk groups), and estimating the impact and associated economic benefits resulting from improved coverage[21,22,137].

This information can be used to inform public mental health strategies and policy development of different sectors, transparent agreement between stakeholders about minimum acceptable levels of coverage for different interventions, required resources for implementation of agreed intervention coverage and coordination between providers of different public mental health interventions. A public mental health approach supports the operationalisation of implementation through coordinated planning, as well as evaluation of intervention coverage and outcomes, including for higher-risk groups.

Other opportunities to improve implementation of public mental health interventions include:

- coordinated leadership and advocacy for resources
- public mental health training
- improving population knowledge about mental health
- setting-based and integrated approaches
- digital technology
- maximising existing resources
- use of existing legislation and adopting a rights approach
- implementation research.

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Stakeholders and partners: current and potential

These are organisations and groups of people doing important work in public mental health. The PMHIC aims to collaborate with them and complement their work in the future. See also the affiliations of the PMHIC Advisory Board members.

- College members and trainees across all UK nations and worldwide
- Faculties at the College
- Patients and carers
- Other medical Royal Colleges:
    - Royal College of General Practitioners
    - Royal College of Nursing
    - Royal College of Physicians
- Health organisations:
    - British Psychological Society
    - Department of Health and Social Care
    - NHS Benchmarking
    - NHS Digital
    - NHS England/Improvement
- Public health organisations:
    - Association of Directors of Public Health
    - Faculty of Public Health
    - Institute of Health Equity
    - Office for Health Improvement and Disparities
    - Public Health Agency Northern Ireland
    - Public Health Wales
    - Public Health Scotland
    - Royal Society for Public Health
- Local Government Association, Convention of Scottish Local Authorities
- Commissioners
- Third sector organisations, including:
    - Centre for Mental Health
    - Equally Well
    - Mental Health Foundation
    - Mind
    - Scottish Association for Mental Health
- Internationally, through College members based outside the UK and the College's international strategy, and organisations such as:
    - Organisation for Economic Co-operation and Development
    - United Nations
    - World Psychiatric Association
    - World Health Organization (WHO)

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