

Royal College of Psychiatrists Consultation Response



DATE: 10th June 2011

RESPONSE OF: THE ROYAL COLLEGE OF PSYCHIATRISTS

RESPONSE TO: *The creation of Public Health England within the Department of Health*

The Royal College of Psychiatrists is the leading medical authority on mental health in the United Kingdom and is the professional and educational organisation for doctors specialising in psychiatry.

We are pleased to respond to this consultation. This consultation was prepared by Prof Kam Bhui, Dr Jonathan Champion and Richard Meier of the College Policy Unit.

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Response to Public Health: *The creation of Public Health England within the Department of Health*

The College has a long-standing commitment to public *mental* health as integral to public health. Last year it collected together evidence to show why mental health must be at the core of the public health agenda, and published this in the form of a position statement (*No Health without Public Mental Health*).¹

The evidence cited in this position statement demonstrated the impact of mental health on a range of public health issues, and is both robust and startling. For example:

- people with mental disorder smoke almost half of all tobacco consumed and account for almost half of all smoking-related deaths
- depression doubles the risk of developing coronary heart disease
- half of all mental illnesses begin by the age of 14 and three-quarters by mid-20s
- people with two or more long-term physical illnesses have a seven-fold greater risk of depression
- children from the poorest households have a three-fold greater risk of mental ill health than children from the richest households.

Despite the Government's apparent understanding of the centrality of mental health to public health as a whole (as evinced by documents such as the *Mental Health Strategy*) the College is very concerned that there appear to be few, or no, commitments or resources within either the Department of Health or Public Health England to take the public mental health agenda forward. This is despite the clear evidence that public mental health interventions could

¹<http://www.rcpsych.ac.uk/policy/policyandparliamentary/parliamentandpublicaffairs/neilspages/publicmentalhealth.aspx>

prevent a significant proportion of mental illness and associated consequences, as well as result in considerable economic savings as highlighted in the recent *Mental Health Strategy*.

The College believes that to realise the Government's public health ambitions there is a need for specialist capacity (i.e. expertise in public mental health commissioning, policy, management and practice) within Government alongside greater clarity within the new structures (e.g. Public Health England) about where responsibility for the public *mental* health agenda lies.

The future role of local government in public health (including arrangements for the appointment of Directors of Public Health; and the role of Health and Wellbeing Boards, Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies)

The College does not believe that the neat division of responsibility for these functions and services between local authorities, Public Health England, consortia and the NHS Commissioning Board is sensible, particularly in relation to public mental health.

Leaving public mental health entirely to Local Authorities will mean that the opportunity for consortia, local authorities and national agencies to work in consort to achieve outcomes will be lost. Furthermore, given the fundamental relationship of mental health and well-being to almost all other aspects of individual and public health, the handing of responsibility for public mental health solely to local authorities will have deleterious consequences for achieving good outcomes in relation to public health more generally. Public mental health is definitely about social conditions but it is not only about social conditions and social care services.

Introducing new bodies to prioritise and commission initiatives to improve public health are welcomed. However, a re-organisation of commissioning processes and structures for care services is also proposed. Public mental

health initiatives that focus on social factors alone like housing and leisure might best be commissioned by local authorities, but relocating commissioning of specialist mental health care to local authorities which do not have a track record in this area, nor sufficient interface with other sectors of health, risks fragmenting commissioning and health care for physical and mental health problems. The two should both be commissioned by NHS agencies. The place of forensic psychiatric services, separately commissioned at present, is also not sufficiently integrated.

Arrangements for public health involvement in the commissioning of NHS services

Discussion at national and local levels must take place in order to align outcomes between GP consortia and public health, with the health and wellbeing board serving as a facilitator of such discussion. The College feels it is important to note that - since half of lifetime mental illness arises by the age of 14 (as stated in the Mental Health Strategy) - prevention, and early intervention once mental illness has arisen, are crucial, both of which have considerable implications for commissioning.

GP consortia will need to engage with public health priorities; as some of the commissioning that public health will be doing will be buying in through GP consortia an incentive measure can be used to help achieve this. There is a very great spectrum of conditions, contexts, and interventions that will need to be understood, for competent commissioning to happen.

The College also has specific concerns about where forensic care services will sit, given that these represent a key component of mental health provision and that the interface between forensic and generic mental health services (both dealing with safety and risk) already needs to be improved.

Arrangements for commissioning public health services

It is clear that NHS, social care and public health have to align their outcomes and programmed activity to achieve a reduction in health inequalities. Given this overlap, health and wellbeing boards will have a huge responsibility to interact with public health commissioners and GP consortia to ensure that outcomes are achieved through buying in pathways for each disorder across preventive to tertiary care (including social care) rather than focusing on individual components of care.

The structure and purpose of the Public Health Outcomes Framework;

The Royal College of Psychiatrists welcomes the Public Health Outcomes Framework and believes that it will work most effectively if it is simple, concise and is truly focused on outcomes rather than processes. However, at a time of such significant financial pressures, the College is concerned that there may not be sufficient resources to fund these good intentions. The College recognises that this represents a major change and upheaval for public health and recommends that a reasonable period of time is allowed to see whether these changes have been effective before any further restructuring is carried out.

A general criticism the College has of the draft framework however is that it makes far too little mention of mental health. This, we believe, is a major oversight given that the mental state, psychological wellbeing and inherited psychological makeup transmitted from parents through experience of parenting are all important in preventing future ill-health. Key public mental health outcomes that the College would like to see include:

- Reductions in the rate of mortality and physical ill-health of people with mental illness
- More people with mental illness in employment
- Reduced prevalence of maternal smoking

- Reduction in smoking rate of people with serious mental illness as well as other mental illness, alcohol problems and drug misuse
- Improved health-related quality of life for older people
- Reduction in the suicide rate
- Increased levels of resilience in children and young people
- Reduction in alcohol-related problems and other addictions
- Reduced levels of stigma related to mental illness and discrimination as a factor in the genesis of mental distress.

We therefore feel that the absence of sufficient attention to mental illness and mental health in the outcome framework renders the current public health strategy as a whole less effective, since it fails to address an important determinant of human behaviour and one of the most important that links behavioural change with better health outcomes. We feel that, were these concerns to be adequately addressed, then the framework and overall strategy could be effective.

The future of the public health workforce (including the regulation of public health professionals)

In terms of the role of public mental health professionals, the College asserts the need for mental health specialists to take one of these routes:

- a) training in public health through an accredited training process equivalent to other public health professions;
- b) qualifying in public health through passing an RCP and RCPsych jointly-accredited exam;
- c) following a pathway which is recognised as a special certification in public mental health but not equivalent to public health qualifications and career paths in general.

Non-psychiatrists in the mental health workforce may also benefit from route *b* (through their own training bodies) or route *c*, although route *a* would be the ideal one to follow.

However, an alternative would be to ensure public health specialists are specialist in public *mental* health rather than relying on mental health professions to take up public health roles.

How the Government is responding to the Marmot Review on health inequalities.

Although the Marmot review is referred to, there seems not to be sufficient attention to the social or cultural determinants of ill-health within the Outcomes Framework, for example, work, finance and housing. The draft framework does not pay sufficient attention to well-being and positive aspects of protecting mental health (sometimes referred to as mental capital); these are important for population health.

These all interact and are central to healthy lifestyles and behavioural changes, in prevention and intervention. As yet the document is poor at outlining how these issues will be addressed in the Outcomes Framework.

Public health directors will need to identify and explore factors contributing to health inequality in a local authority catchment area. This intelligence will then inform the prioritisation of local projects, and the outcomes framework will have to take in to account the goals set by such projects. This means that there will have to be a bidirectional movement in terms of outcomes with the local authorities being offered outcomes on health issues on a national basis, whilst local authorities through health and wellbeing boards informing the centre about the locally agreed outcomes.

In spite of the proposal to introduce a health premium, the College remains concerned that those areas which are poorest and with the greatest need will

continue to lag and, therefore, that the whole strategy might compound inequalities unless those in the poorest areas or the poorest performing areas are given specific targeted interventions and have adequate resources.

The College feels that a system of measurement needs to be put in place to allow for review of performance against the outcomes put forward in the framework. There will need to be a mechanism for identifying oversights, for example inequalities being compounded. The College would like to see a specific set of outcomes for inequalities by age, gender and ethnicity.

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