Chairman: Thank you. I’d like to welcome you to the third enquiry session in the All Party Parliamentary Group on Mental Health’s inquiry into parity of esteem for mental health. Today’s session is looking at making mental health a public health priority. I’m delighted to welcome Jane Ellison MP, who is the Minister for Public Health, who is going to talk to us initially. So over to you Jane.

Jane Ellison: Thank you very much James and thank you for launching such an interesting and important review. You’ve obviously got amazing range of stakeholders here and I think as with all of these sorts of inquiries, we have as much to learn from your review as we have to contribute to it. So it’s something that we will be looking at when you’ve concluded. I’m the Public Health Minister, so I’m not the lead on mental health in the Department of Health, that’s my colleague Norman Lamb, who I know you’ve had evidence from. I can only be with you for just under half an hour, but I’m delighted that my colleague Dr Heema Shukla from Public Health England, a consultant in public health and mental health, is with me and will be staying for the whole meeting and she’s here to give me a bit of technical back up, as well as hopefully be able to pick up any questions I can’t answer and also to give me feedback from those parts of the meetings I’m not able to stay for.

Some of you I think I did meet when I attended with Norman Lamb’s Round Table not so long ago. So from my point of view, my starting point is from what I’ve learnt, which was a surprise to me in many ways about some of the statistics about people within my public health statistics, where people with mental illness sit. My starting point is it’s almost impossible for anyone to deliver successfully on most of the key public health indicators, without taking seriously the problem of addressing mental health-, you wouldn’t be able to move your overall statistics, your overall indicators without seriously addressing the problems that people with mental illness find. So for me that’s one of the key drivers within public health, as to why I believe it is being taken seriously and has to be taken seriously going forward. So I’m going to lay out some top level thoughts and also some of the practical things that we’re doing and developing and again, Heema will be in a position to expand on that if we need to. But also very happy to expand if anyone wants to pick up, write to me after the meeting or through James.
You will be very familiar with some of the statistics. Average life expectancy 20 years less than the general population for the individual with mental illness. It’s a non-acceptable disparity in any way, shape or form and so we need to pay greater attention to mental health throughout the public health system. I am very enthusiastic about the re-organisation of public health to give local authority the lead, I think from my own evidence of being out on the road and seeing a lot of things in action and from the feedback I’ve had, I believe that that re-organisation is going through a real driver of innovation and we’re already seeing that, but obviously it’s important that we get a system lead from the Department of Health and Public Health England. I also think the creation of Public Health England is in of itself a really important milestone on this journey to parity esteem, because certainly in this area and public health and mental health, PHE are amassing a sort of enormous evidence base and being able to pull all that together into a really coherent body of opinion, of evidence and we’re going to talk a bit about some of the work that’s being done to provide tools and helpful things for people who are working on the front line.

The Department of Health is working with NHS England and Public Health England, to drive that improvement at a national level and also working with Health and Wellbeing Boards locally, to ensure that they are assessing the mental health needs of their local population and commissioning the right services and the programmes to meet those needs.

For many people when they come to set out their joint strategic needs assessment, they are going to look at something for example like smoking. For the first time we’ve dipped under 20% as a nation smoking and as Heema said to me earlier, the low hanging fruit has to some extent been picked, so that means that smoking cessation programme, for example, are going to have to look at some of those much harder to reach groups and that certainly includes people with mental health challenges. We know that compared to that just under 20% of the general population, we’re looking at 34% of people with mental illness who smoke. So again, you’ve got that driver of key public health indicator, driving the need to look more closely at people with mental illness.

Some of you may know that we recently published ‘Living Well For Longer.’ This document, and some of you might have been at the launch event, seeks to try and make sure that it’s really obvious how important we feel this is. We actually mention the health and equalities aspects and the parity of esteem aspects round public health and mental health in the foreword to the document and there are lots of useful examples of practical things that there needs to be a focus on, and I hope that it will be a useful document- very much something people can dip in and out of and get inspiration for ideas at work, as well as evidence based for your own programmes. It’s something we’ll be updating and continue to add to.

The ‘Living Well for Longer’ document is very much a resource for local health and wellbeing boards. I’m extremely keen that as much as possible we try and avoid people re-inventing the wheel when it comes to the data and the science. You know we have got exceptional resource in Public Health England, both at a national and a regional office level and I want to make sure that we try and concentrate the evidence gathering and the science in PHE and that they then disseminate that out for people to use that in the way that then helps them deliver local programmes, and helps to shape services accordingly so we’re not getting people to do too much of that themselves and using under-pressure resources to do something that hopefully we’re already doing. So that’s very much how I see that structure working and as I said before, that overall effort is very much addressing the needs of people and then health performance is a key strand of this work and will continue to be.
We know that as well as the smoking example I’ve given, that people with mental health problems are more likely to misuse alcohol and I’ve just come from an inter-ministerial meeting on drug policy and the subject came up there, again about the complexity of the social factors involved, which means it’s quite hard to pull apart people who have just got a drug problem, as they are often people with very complex needs. We know physical activity is a big challenge, I think that for some people with mental health problems, we haven’t really thought through how inappropriate some traditional responses in this field are and how much more we need to rethink them and re-invent them and make sure that we’re actually reaching people who were once perhaps being left behind. We know that poor diet, again, is particularly concentrated with some people who have got mental health problems as well.

I’m very conscious throughout saying all of this that there’s a very wide spectrum of problems and one of the things that PHE are doing and working on, is making sure that when we provide tools and evidence, that we do pull apart a little bit the different mental health challenges along the spectrum and we don’t take a one size fits all approach because we know it doesn’t work. We must understand that within the tools that we provide, we must make sure that we reflect the complexity with the (mental health) spectrum that we’re talking about.

The more severe somebody’s mental health problems are, we know that it’s much more likely they’ll suffer from physical health problems - that gradient is very well established, that inter-relationship and we also know that people with mental health difficulties experience up to three times more physical health problems than the general population. I don’t have the stats on A&E admission, but I could make a very educated guess that you could see (mental health), for example showing up on things like regularity of presentation A&E. We know for example that a lot of people end up in A&E because they have taken medicine inappropriately or ceased to take medicine and that that is definitely a link again there of people with mental illness. So there are all sorts of ways in which driving parity of esteem actually feeds into the sustainability agenda for our health services right across the piece.

We are aware that these problems are further compounded by stigma, discrimination, disadvantage, lack of employment and education opportunities - all topics that we will address in the course of this enquiry.

One of the things I think that is encouraging about why public health is a really important mechanism for getting some of these important conversations going, is the ubiquity of public health interventions and the incessancy with which we’re all told about the need to think about diet, to think about weight, think about smoking - actually that very ubiquity means that the public health interventions are I think quite a non-discriminatory and sort of non-stigmatised way into some of the conversations with someone who might not have otherwise presented with mental health problems. It’s actually you know become so normal for people to put their hand up to say, “I know I don’t do enough exercise, I know I don’t have quite the right diet” and actually that might be a way into conversations and where in other areas actually it’s harder to self-identify and I think that one of the challenges for the whole health system is making every contact count, and I don’t think we’re there yet on that.

Some of the things we’re doing to address the issues I’ve outlined are: PHE are working to ensure that all the national public health programmes are designed to improve life, that are designed to
improve those very lifestyle factors, all meeting the needs of people dealing with mental illness, so we’re developing a smoking sensation campaign, that’s targeted at individuals with common or serious mental health problems and pushing for more mental health residential units to become smoke free environments. It’s quite a contentious area, the smoke free environment and you could go to lots of different hospitals up and down the country and you can sometimes find it’s a smoke free environment, you can sometimes find people outside the front gates having a fag. It’s always a bit of an eye-opener when that happens, but this isn’t easy and we’re all aware of the significant contention around the whole issue of smoke free prisons, which is an ongoing debate and again, has a link in as we know, to mental health.

We’re working to ensure that commissioners can opt for weight management clinics, whose staff are trained to address mental health problems and working with key stakeholders, some of which I suspect are in this room. We’re working to promote, as I said, those structured physical activity interventions with measurable outputs for people with mental health problems and I’ve asked Public Health England to report back on the physical activity framework they are developing in the Autumn. We’ve run that alongside another strand of physical activity work that we’re doing, sort of Olympic legacy work and all of that has been fed into Public Health England’s consultation and what I hope when they report back in the framework- the challenge I’ve set to PHE- is that I really want a whole set of gold standard physical activity programmes and interventions that people in, particularly in local Government, can essentially just pluck and say, “That worked, we know it works, it’s been tested and it’s something we can actually put into effect”. Within that one plank of that framework is around people with mental illness, so that will be a specific piece of work within that wider physical activity framework.

PHE are also researching the uptake of breast, bowel, colon cancer screening amongst people with mental health problems. We know we’ve got some challenges- most financial screening programmes are world leading, but it’s really easy when you look at some of the overall success rates and some of the high uptakes, to miss the fact that the lower uptake rates are heavily concentrated in certain groups within our society and so we’re trying to make sure that we are very conscious of that and this piece of work is going to look at that. It’s something I’ve asked screening units around the country about when I’ve been on visits, but I think it’s something that’s very much on our radar and a piece of work is going on to look at how we might address that and make sure that people aren’t missing out on literally life-saving interventions, because we haven’t got the work around access correct.

I’m also working on improving access to NHS health checks and immunisation programmes. I had a big meeting yesterday about immunisation and vaccination, again it’s one of those things where we have world leading programmes, we have some very high uptake rates, but when you look at certain communities, the lower uptake, or indeed the non-uptake, is heavily concentrated and some of those groups are all again around those with mental health problems, so we’re looking at that. NHS Health Check is a very good example of one of those ubiquitous programmes, where everyone over 40 is invited on a cycle to come in and have that. In some parts of the country it’s working brilliantly, but in some parts of the country we’ve got further to go. But it’s a great gateway opportunity, because everyone is invited for it. So again there’s no stigma and if that conversation turns out to be a jumping off point, as I say as a universe of public health intervention, if that is a useful jumping off point for people to also start to provide a conversation about mental health, then that will be a good thing.
In terms of training, in order to make sure all these efforts are really effective, we have to make sure that mental health is a matter for all health professions and professionals, so training at all levels needs to reflect that. Health Education England is designing courses for both mental health and the physical health professionals, to ensure that they are aware of the links and we make those contacts count. This ties in with that initiative – making every contact count and that’s about encouraging every member of front line staff to help people stay in good health right across the mental and physical health. So we see in Salford that “making every contact count” is being delivered by a wide range of their public, front line public sector and first sector workers and that includes porters in hospitals, call centre staff in the local authority and reception staff in local social enterprises, so really exciting work there, that truly is making it universal.

Just to update you on some of the data and tools, PHE has got some really good work going on here, some of which is about to be launched quite imminently. Public Health England is launching on the 18th June, the Mental Health Intelligence Network which is designed to support commissioners in addressing the issues faced by people with mental health problems, providing really good evidence on need and unmet need, evidence on interventions and case studies of services targeted at people with mental illness. One of the things that really came back to us as feedback when we launched ‘Living Well For Longer’ was just how useful case studies are. If someone has cracked it somewhere in the country, found an intervention that really works, we have to find ways of popularising and spreading the word. I think it’s the only slight downside to a localised public health lead in the system, but we need to make sure that we don’t just spread the word about what works by accident. We have to have a way of speeding that up and making sure that people don’t hear three years later, about an intervention that actually works really well and it’s only 50 miles down the road. It’s something we have talked to the LGA about a lot as well and that work will include the delivery of what’s called a Lester Resource, which is based on an algorithm, which is a clinical tool, so very evidence based, and it aims to improve the methodical screening that people do and to ensure that both physical and mental health conditions are jointly addressed. That has been developed jointly with the Royal College of Psychiatrist and Royal College of General Practitioners, along with third sector partners, and if you’ve been part of that, thank you for that work. Again, that’s due to be launched very shortly and as I said I mentioned ‘Living Well For Longer’ which also has some of those examples and PHE is also running engagement events across all the 15 Public Health England centres. They are looking to publish the findings from that in the Autumn and again, that’s very much focused on practical examples of interventions and programmes that work.

I hope that gives you a sense that there’s actually quite a lot being done in the area of public health to realise the ambition of parity of esteem for physical and mental health. We are working hard to understand the particular problems that have been long overlooked in some areas, but also to understand the particular issues that people with mental health problems face and to make sure that they are not in any way left behind by a set of public health indicators, which despite what you tend to read in the papers and hear in the media, are actually broadly going in positive direction. But the challenge I think for all of us is to make sure that those people who are not benefitting from that general direction of travel in the right direction are not left behind, just because we haven’t framed interventions that work for them.

I look forward to the enquiry’s report, we’ll certainly make sure if there are any issues and challenges for us in the area of public health, that we’ll respond to that and obviously very, very welcome to in
the meantime for people to feed into the Public Health England consultations, it’s not too late, even if it’s officially closed, I would encourage you to feed in if you haven’t already, because we do need a few more of those examples. But it’s a really important agenda and I’m grateful for the opportunity to come and talk to you all.

Chairman: Thank you Jane. We’ve got time for about five, six minutes of questions from the floor, so if anybody wants to ask me some questions. Can you just say who you are, which organisation you are from?

Adrian James, Royal College of Psychiatrists: Thanks very much and thank you Minister, I’m Adrian James and I am a Forensics Psychiatrist from the West Country and I speak on behalf of the Royal College of Psychiatrists. Just to show that I practice what I preach, I work in a no-smoking unit. There’s a lot being done, but a lot can still be done. My concern is in terms of the parity agenda, is the amount of money that’s being spent upon mental health related activity against physical health. As you know 23% of the disease burden is mental health related but in terms of the public health England budget, a very small proportion of that is spent on centralised public mental health areas. I think what is being done by Public Health England in terms of the Mental Health Intelligence launch next week is a major piece of work and they’ve done a fantastic piece of work with that. However in terms of the programmes, I spend a lot of my time with commissioners and they say, “We’d love to do all this stuff, we just don’t have the money” and I know money is an issue. I don’t want to dodge it, but in terms of the proportion for mental health against physical health, are we aware of total budget, can we do something about it, who actually holds it?

Jane Ellison: I don’t want to comment too much on this, because I know it’s something Norman is working really hard on. I think the challenge within public health is less acute, because as I said, local authorities have got £5.4 billion of public money so it’s a significant amount of money, and you can’t successfully address most of the big public health challenges in your local authority area if you don’t also have programmes designed to address the needs of people who have got mental health needs. It’s nye on impossible, because of the disproportionate numbers of people with mental health problems within those groups who are also facing big public health challenges. So I think that’s a real driver, I don’t see how you could have a rigorous programme addressing all those issues around diet, smoking, alcohol etc, if the mental health strand of that wasn’t pronounced and specific. But it’s a good challenge and a very good question for us to ask of local authorities and I know it’s something that Duncan Selbie has asked. Duncan has now visited all local authorities in this country and I know it’s one of the questions he asked. But we know the funding challenge more generally, but within public health I’m very happy to make sure I ask this as one of the questions when I’m talking, when I next speak with the LGA.

Lucy Smith, Public Health Manager from Suffolk: You talked a lot about promoting health for people with mental health problems, I just wondered what you had to say about promoting good mental health for all of us, because there’s people without mental health problems, but who are not necessarily having a great time of it, who may benefit if they have, for example, better housing, better education, maybe access to opportunities or even just health literacy messages about how you can take care of your own mental health. I just wondered if you had any thoughts about that?

Jane Ellison: You’re talking really about all the social determinants of health. Duncan Selbie (Chief Executive of Public England) starts most speeches to conferences by saying the best thing for your health is to have a job and better still a job you’re going to enjoy. So I’m very well aware of all those wider social determinates and I wasn’t trying to minimize them. Norman (Lamb) is our leader on
some of those issues, but I would argue that actually e.g. today’s job statistics show that more people are in work than ever before and that more people have got back into work, which is an important factor. So the way we address some of those wider society factors are very important. Public health is a very wide bridge, it touches every aspect of most people’s lives, so I think that by driving (mental health) within the public health agenda I’m doing my bit to address it, but it touches virtually every aspect of Government policy in wider society so we have to keep saying it.

**James Warner, Chair of the Old Age Faculty at the Royal College of Psychiatrists:** A million people in this country who are over 65, have probably got a different set of needs than the ones you’ve outlined, so do you have any thoughts about things like encouraging mobility, independence, nutrition and particularly tackling social isolation, which we know is very corrosive and potent cause of mental illness. Two thirds of this population who have a mental illness, don’t have dementia and we mustn’t forget that route.

**Jane Ellison:** I’m really passionate about the issue of old people. The good news is we’re doing quite a lot of cross department working on physical activity, because we want to take it out of the silo of health. I think a model which says the Chief Medical Officer is going to tell the nation to do more exercise just doesn’t work, it’s been tried and it just doesn’t work. We’ve got to embed physical activity right across this, so the Department of Transport is as important as the Department of Health.

Within that sort of cross ministerial working, I’m trying to put special focus on all people. I passionately believe that social isolation is in itself a driver of poor health both mental and physical, but my contention about where physical activity comes into that, is that you could show me very, very few physically active older people who were also socially isolated, because the very nature of physical activity drives against social isolation. So it’s a real parity for me, it’s something I raised at a physical activity networking a Round Table event with lots of stakeholders and professionals recently, so it’s something I do set great stall by and I can give you that assurance that it’s something we raise all the time and it’s also something very much on the sort of minds of all departments. We’ve got a physical activity network within the responsibility deal and the Secretary of State made a major speech about eight/nine months ago about social isolation. So it’s very high on our agenda, I think that older people and physical activity often sits off the radar, because everyone gets really into school sport and children and obese children being taken into care, which gets every headline. But I can only tell you that within ministerial groups, this is very much a priority, but I think it’s a good push back as well, to remind us that it’s not all about dementia too. So that’s a good challenge, point taken.

**Michelle Hayward, representing Rethink Mental Illness and Recovery Road:** What we’ve done in Lincoln is actually set up our own health group whereby we’ve done health checks- measuring blood pressure, height, weight- because we felt in Lincoln that the health checks weren’t being done. We’ve contacted our GP’s for these health checks and we’re having to tell the GPs what health checks we actually need and we know that many people with mental illness don’t even know what health checks they should be asking for. So my question is are you going to really clamp down on the GP’s, keep an eye on them?

**Jane Ellison:** That does sound a bit concerning if GPs aren’t doing this. We know the picture is not consistent, we’re not there yet at all. I think my remarks about the education piece is really important, but you’ve got to make sure that all the health professionals coming through the pipeline,
that (mental health) is just part of the DNA into the future. But we know it’s an inconsistent picture, and I would start by speaking to the Chairman of your local Health and Wellbeing Board. And Members of Parliament are very welcome to write to Health Ministers and ask them what they think about the situation

**Sarah Stewart Brown, Professor of Public Health in Warwick:** I just wanted to pick up again on the point that Lucy made, “what happened to mental wellbeing?” Because the conversation has been around an extremely important point, but it’s been people with mental illness and the contribution to public health comes through that and the genius of public mental health agenda is that it has in this component about the focus on the positive. It is the new boy on the block, it is the thing which can transform public health but there’s also fundamental things that we can do across the population. We can support parenting which drives into a whole host of other agendas, we can support work in schools and we can support work with the adult population and one of the key things there is disseminating work that I think is even going on here, on things like mindfulness on approaches that support resilience and the capacity to grow learning developing adulthood. My conversation with people from Rethink and the Mental Health Foundation is actually that’s what they want in mental illness services as well, that it isn’t just for the healthier population, it’s across the board to switch a focus onto thinking about the positive assets, strengths, what people can do.

**Jane Ellison:** You’re exactly right, I think all of those things are important, some of the public health work going on with young people for example, I’m really excited about, because instead of thinking about whether you do a programme for young people about drugs or about alcohol? Instead they are thinking about how do we build resilience, how do we actually create programmes that just help young people deal with everything that life throws at you, because that will stand you in good stead as you grow older and also prepare for the challenges that you don’t anticipate. So I think there’s a really good piece of work going on there, which I’m very keen to champion across Government. I sit on quite a few cross Government committees and the most exciting ones are all around those things like troubled families, with some of the interventions that will set families down a different road and result in the next generation growing up in this family having the capability to cope with what life throws?

There’s a lot of this kind of work going on – in the Department of Health we have interventions like the Family Nurse Partnership and some of those are very important in terms of walking alongside someone, trying to help them get back on their feet and prepare them for the inevitable buffeting of life, making sure that they don’t fall over really, especially if we know they are particularly vulnerable. So there’s a lot of that work going on, I think it is very exciting.

**Chairman:** Thank you very much Jane for coming along, I think that was a very useful overview of what’s happened. So thanks very much for your time.

**Jane Ellison:** You’re very welcome.

**Chairman:** I’d like to move on now to the next section of the session. We’ve got three speakers who are going to just speak for five minutes on the topic and we’ll start with Dr Jonathan Campion who is the Director of Public Mental Health and a Consultant Psychiatrist at South London’s Maudsley NHS Foundation Trust.
Dr Jonathan Campion: Thank you very much. I’m delighted to be here at this event. I’ve been asked to give evidence on the development and implementation of local and national public mental health strategy. So I wanted to start with a bit of national public mental health strategy, then go onto the coverage of public mental health intervention, so both interventions to treatment disorder, prevent mental disorder and promote wellbeing, just to come to a serious point there and then to actually look at the coverage of public mental health information in needs assessments at the moment and then make a couple of suggestions around how to make mental health perhaps more of a public health priority.

So just to start off with first of all, the development of national public mental health strategy. I was very fortunate to be involved in the Department of Health’s Public Mental Health evidence lead there for a couple of years and it essentially involved incorporating a range of evidence into a couple of mental health strategies, a public health white paper and a public mental health strategy and I think the things that jumped out at me during that time was certainly, something Adrian has already mentioned, that the burden of disease from mental disorder and the various reasons for that including prevalence and also the broad range of impacts of mental disorder across the life course. Similarly we were looking at the broad range of impacts of mental wellbeing and so really trying to sort of integrate that into the national policy, into the different policies coming out and I think one of the things that jumped out was that these different impacts had a very disproportionate impact on what could be seen as traditional public health priorities.

We’ve got a lot of evidence about interventions that work, both the treatment of mental health conditions, promotion of wellbeing and prevention of those conditions and a lot of that evidence is in NICE guidance and due to the fact that we’ve got all this evidence about also the impacts, we know that if we could get the coverage of those interventions, it would have huge public health impacts. As I said trying to distinguish both a treatment but also upstream prevention of the mental health conditions arising in the first place and promotion of wellbeing.

The second area is the coverage of public mental health, which is what parity is focused on, and the reality at the moment is despite all the evidence that we have, it’s only a minority of people with mental health conditions in this country that receive any treatment, except psychosis that is. Furthermore, although we have interventions to think about the upstream promotion of wellbeing, in terms of preventing mental health conditions, there’s even less coverage of that. So I think it’s really important that we’re clear about that in terms of where we’re starting from and I think also the fact that that intervention gap has a broad range of impacts and costs, even in the short term.

The third area is about the coverage of mental health in needs assessments. Joint Strategic Needs Assessments are essentially owned and carried out by public health and they inform commissioning health and wellbeing plans. However a couple of recent reviews have highlighted that mental health is not well covered in the Joint Strategic Needs Assessment, so we’ve just done another audit covering a six million population and again there’s a lack of information really about both the impacts of mental health conditions, the impacts of wellbeing locally.

Therefore there are a couple of suggestions really to support mental health as a public health priority. Certainly the development of local public mental health strategies through better mental health information in the JSNAs would be really helpful. At the Royal College of Psychiatrists we, together with the Royal College of GP’s and a range of other sort of third sector organisations, have developed some public mental health commissioning guidance. I’ve been involved in implementing that at local level and certainly what we’ve found is when that happens, it has a big impact on public
health, but also on the JSNA, on Health and Wellbeing Board priorities. So I think there’s something there that could be helpful and certainly the Mental Health Challenge, which has buy in from a range of organizations works to support the questions that can be asked to a local council.

I’ve also being involved in trying to develop further the ability to offer comprehensive mental health needs assessment, to often very over-worked public health teams, so that actually it’s easier to bring that information together and PHE I think is also doing a fantastic job there in terms of the Mental Health Intelligence Network. Hopefully that will be also be able to contribute in that area and I think overall this can facilitate much better coordination between public health, social care, primary care, secondary care, so there’s very much a joined up approach. I think a couple of other things mentioned by the Minister, certainly training, is very important. I used to be a GP and we know that mental health is often very poorly covered in GP training and so there’s an opportunity also to have mental health and public mental health training to a broad range of sort of professionals and other key stakeholders, including public health. I think the last area that has also been mentioned is budgets. Public mental health budgets within public health would be really helpful, because I think at the moment lots of public health teams don’t have a specified budget for public mental health and I think with that budget I think there is a recognition of its importance. Thank you.

Chairman: Thanks very much. Now the perspective of Meradin Peachey who is the Tri-Borough Director of Public Health.

Meradin Peachey: Thank you. I’ve been the tri-borough Director of Public Health now for three months, and I was Director of Public Health for eleven years in Kent.

I thought it might be helpful if I give some of our thoughts from the Tri-borough. What are some of the drivers of our approach around mental wellbeing and mental illness? In the tri-borough we have particularly high rates of severe enduring mental illness, particularly in places in Chelsea. We’re in the top ten boroughs in terms of the numbers claiming incapacity benefits and the big one for us is we have quite high numbers of employment support allowance, people with mental illness, which indicates that people with mental health are less likely to be employed and employment is such a big part of good physical and mental health.

What sort of actions does that lead us to? These are just a few thoughts at the moment and you some thoughts from our members. Firstly, a lot of mental illness starts before the age of 18, therefore early intervention in children and families is absolutely critical and to me it’s about getting some of the basics right, which is about ensuring that all children centres are offering parenting programmes and things like that.

Secondly is looking at employability programmes, for those who are a bit vulnerable, particularly with mental illness, sometimes they need additional support to help them get into the employment market and so one of the things we’re looking at is around investing in our the whole road to employability programmes. But one of the things that we’d like to really put on the table is that, for us, investing in things like employability programmes, we don’t necessarily get the savings benefit if we reduce the number of people on the ESA allowance. So we’d like to be able to share the savings and that would give us added incentives to actually be putting more money into helping mentally ill people back to work.
Thirdly, is the healthy workplace charter. You have a healthy workforce, you have a better economy and the largest reason for people being off work is around mental illness, particularly around depression and anxiety. So if we’re looking at whether we can meet all the standards of the workplace charter, looking at ourselves as councils as well, we can set up ourselves up as good role models, and then we can start to work with businesses, whether it be through environmental health or others, looking at extending the workplace charter and a big part of that workplace charter needs to be mental wellbeing in the workplace.

There is one particularly interesting scenario and working particularly in Westminster with the million of people that come into Westminster to work every day is if we invest in the workplace in Westminster, we’re actually investing in people who don’t necessarily live in Westminster. So it’s a particular scenario for us which obviously we’re willing to do and there’s a big benefit for Westminster in terms of the economy in particular. So that’s just a few thoughts on our approach.

**Chairman:** Shalini, who is an expert by experience, is going to talk about her experience of interacting with public health, mental health system.

**Shalini Bhalla:** Thank you very much. Around 10 years ago I was diagnosed with a debilitating life threatening illness, except many around me didn’t see it as that. I didn’t have cancer, I don’t have diabetes, neither did I have a heart problem, I had clinical depression. Some people said, “Pull your socks up,” some said, “Oh a holiday will sort it out.” But my GP, my first point of contact saved my life. You see he believed me, he validated my symptoms. He did not dismiss me when so many others did. By signposting me to a psychiatric consultant who then hospitalised me and oversaw my therapy, my GP ensured that I got the help I needed when I needed and had he not, I’m not sure I would be here today.

Depression is all consuming, I literally felt like I was walking in a fuzzy grey haze all the time. Even the smallest basic everyday tasks were a huge effort, taking a shower, brushing my teeth, getting dressed. They were all exhausting. I couldn’t eat, I couldn’t sleep, I couldn’t concentrate on anything. Basically I had lost the taste for life.

The grey haze got thicker and thicker until one day I was leaving for work and I physically couldn’t open the door and I was on the floor shaking, crying, gasping for breath. It was only later I realised I’d had a panic attack and so within a few days I was hospitalised into a mental hospital as an inpatient. The only thing I remember about that day was as I walked through the hospital doors I thought, I hope no one recognises me. I hope no one ever finds out about this, because the shame was just too much to bear.

My illness changed my life. I had to leave my highly paid successful career and learn to focus on the day to day. The healing process was slow and it was painful and there’s no one thing I can say made a difference. It was a combination of things. The love and understanding of my partner Jeremy, the hours of painful therapy, the pills that made me function during the day and gave me respite by night, so that I could sleep. I learnt many coping skills from my therapist, from learning about my condition and also some just by accident, so with the mind being in a constant fuzzy haze all the time, I could only focus on any one given thing at any given time.

This living in the present moment helped me recover. I had accidentally stumbled on this now popular concept of mindfulness. I practice that and meditation to this day and I now teach mindfulness, but at the same time I also re-discovered my love for dance. I had always loved dancing
as a child and one of my childhood memories is of me on stage three years old, surrounded by a lot of older girls and I was the centre of attention. But at 18 my mother decided that actually dance was not a suitable career for the good Indian girl, so I went into a proper job and life was tough, a number of personal and professional challenges lead me to falling ill with clinical depression and being hospitalised.

A few weeks into my stay in hospital, I happened to play “An invocation to the Hindu God Krishna” on my small sound system and something just took over and I began to move to the music, each word being portrayed by hand gestures. I had forgotten just how much I loved to dance. But because of the cocktail of medication, lack of sleep and sheer mental exhaustion, my hands were shaking, I was unsteady on my feet. It was not my funniest performance, but yet it was my saving grace. For the first time in ages I felt alive. There was a glimmer of hope.

I continued to practice dance once I left hospital and with time my strength began to return. I was able to get off my medication and began to lead a somewhat normal life. I started running Bollywood dance workshops for schools, charities and community groups. It was inspiring work and with so many different people I was able to make a small difference and I wanted to find a way to reach even more people. So I created ‘Just Jhoom,’ which is a Bollywood dance fitness programme. ‘Just Jhoom’ means ‘Just Dance in Hindi and it’s the only accredited training programme of its kind for Bollywood dance fitness in the UK. We train dance teachers and fitness instructors to run classes in the community, schools, care homes, with older people all over the UK. ‘Just Jhoom’ is inspired by Bollywood music, Indian folk and classical dance and I consider it as mindful movement.

Through our training programmes I’m able to share my love and passion for Bollywood inspired dance, with people of all ages from all walks of life, with all fitness abilities. Our message is that keeping fit and healthy is about the mind, the body and the spirit and should be fun and fulfilling. So ‘Just Jhoom’ has so many benefits, physical, mental, spiritual, social, emotional. When I’m in a ‘Just Jhoom’ class, I literally exercise from my eyes to my toes, dancing on the whole burns fat, it tones the body, we use upper body and hands, so we have hand gestures, flag, fist, lotus. It’s all fun, it makes one smile, it releases endorphins, it makes me happy.

But equally important ‘Just Jhoom’ is a workout for the mind too. By being engaged in what you’re doing at that present moment, you are able to lead the regrets of the past and the worries of the future at the door. You’re really focusing on the here and now, it is a form of mindful movement and so it works with the same principles as mindfulness.

So for example, if I did my upper body, when my hand goes, my gaze goes. When my gaze goes, my mind goes, when my mind goes, my feeling goes, so it is ... I don’t know if you all know a box step, it’s a very ugly step, you put in a little bit of hand gesture and it makes it look beautiful.

Today I run classes for the community and they come to me for various reasons. Some to learn a new skill, some to get fit, some for the social connection that they get with other likeminded people. Some to engage in a dance session that they know will make them feel better. Many have had a mental health problem in the past and some are still suffering and getting better slowly, but for others it is just part of their daily routine, to keep fit both physically and mentally.

Just to finish I’d like to say this holistic approach to keeping well, looking after both the body and the mind, is the key to overall wellbeing. We know we have to train our bodies to keep fit, so why not
our minds too? In this fast pace frantic and stressful world that we live in, our minds need nourishment and care more than ever before. Statistics suggest that the chances of me having depression again are high, I don’t want to be another statistic. I don’t want depression to defy me, yes depression has made me who I am and I had to learn to cope, but now I don’t want to just cope, I want to thrive.

When the stresses of life get on top of me and let’s face it, they do, I turn to dance. For me dance is a form of meditation and when I’m dancing, I’m at one with my body and mind. I find a completeness that I’m unable to find in any other part of my physical life, it centres me, it brings me happiness and it brings me peace and these are the aspects that I can then carry on through my daily life. Through my physical, mental and spiritual wellbeing, brought about by dance, mindfulness and meditation, I feel that I finally have now got balance in my life. Surely this is something that every human being has a right to. Thank you.

[Applause]

**Chairman:** Thank you very much for that powerful story. What I want to do now is open it up for further questions to the panel and to be able to get a discussion going on around some of the issues.

**Kerry, mental health service user in York with a Masters in Public Health:** I’ve been hearing some brilliant ideas today, I’ve been hearing brilliant ideas at a lot of mental health events that I go to lately, but a lot of policies that are going on at the moment seem to be underlining the things which give us good mental health and I’d like to use the example of housing. For example in York, there is no way I can get a room on housing benefits, housing benefits in York are about £60-£65 a week for a single room and the cheapest room on the York press website is £85 a week for a room you can barely fit a single, double bed in, there’s no way I could live with my partner on that and we’d only be allowed one lot of single room allowance housing benefit. This is happening in a lot of places all over the country- that people are being forced to move away from their communities and their family ties, because of cuts to housing benefit and benefit caps and things like that and that destroys your mental health, it destroys your connections with the community. The nearest place I could afford to live is Selby, that’s 15 miles away from York, I’d be in a completely different NHS Trust, in a different local authority, I’ve got no friends there, I’d have to leave my part time paid work, I’d just have to leave everything that supports me. If I couldn’t find someone who’s willing to rent to me well below market rate, I obviously couldn’t live with my partner and that’s made a huge difference to my wellbeing and care. We know that this is a good example as a targeted universalism, because housing contributes to good mental health from whether it’s better communities which helps older people with depression and anxiety. There is £11,000 – £20,000 per person annual savings from housing schemes for men with enduring mental illness and £120,000 per person annual savings from supported housing for women with multiple complex need. This is just one example of how a lot of policies at the moment are breaking the foundations of recovery for those of us with mental health problems, and also creating more mental health problems. Because you face all these economic and social disadvantages, you end up relying on benefits and I’m hearing some wonderful policies and some wonderful ideas here, but unless public mental health and public health in general is a cross cutting theme across all Government policies, it’s going to be like putting sprinkles on top of the cake, only excuse my language, it’s a sh** cake.
June from South London and Maudsley NHS Trust: I’m listening because when we teach about good mental health, how to take care of it, what looks after you, we have to put in wellbeing, rather than use the word ‘mental’. It allows people who engage with us engage with that conversation. If we’re looking at parity of esteem or parity of esteem for BME communities, who disproportionately end up in any patient services, who also have long term health conditions and a whole range of other conditions. We need to start to really think about how we are going to bring in the aim to the tools that we want to use and what we’re going to bring into the training that we have with the front line staff? Because yes, I agree we need to have conversations, that people don’t think they are being hit over the head to talk about mental health and we can have it underpinned in other conversations. But whether it’s the GP or whoever it is, the front line staff need to realise they are the first point of call and it’s really, really important that the conversation with GP’s happen with public health and everybody else. Because we’re saying, “We want you to have greater access, earlier access to improvement,” but I don’t know what modern criteria is for the GP’s and the front line staff to realise they are the first point of call.

So we don’t want to make the work that we’re doing null and void. We want to improve wellbeing, but understand that often at the moment it is a negative conversation we bring in the communities and it has been for over 30 years and the same issues we see on our wards disproportionately. When you go into the communities you don’t see them in the centres that we have closed rapidly. So the conversation is the part of the wider determinates of health, but it’s a specific conversation because they are being written out of these policies.

Health trainer from Lincoln: Most people don’t know what a health trainer is, most people think it’s about physical activity and going to the gym so people think that that’s what we do, solely. I work in deprived area of Lincoln so (my work is) basically around healthy eating, say physical activity, but it’s literally thinking, getting out of the house basically e.g. going for a walk, and not just smoking and alcohol.

I was quite surprised when I was looking at figures that Lincolnshire (a very rural county) has a high level of people with mental health problems. This is part of the reason why health trainers have come about and we’ve been around about eight years now and we’ve had massive success in terms of our work through weight loss. When we talk to a client with mental health issues, we are that go between, because obviously there’s a lot of stats and facts and figures and very educated, big words, but it’s nice to be able to simplify things and people that are scared to go to their GP’s and we, as health trainers, we get aspects of all. So we signpost a lot of mental health groups, we’re constantly learning and training. We’ve got a low level of service, especially in Lincolnshire and sometimes when you speak to people, they’ve never even heard of us and I think sometimes if they could be more aware there’s some health trainers nationally, because it’s not a high paid job, but we do a lot of good work. Thank you.

Meradin Peachey: Just one thought, when people talk about professionals and training and everybody providing the same sort of support, it was interesting when I was in Kent recently, the term, “Every Contact Counts”, which came from the NHS policy, I asked the police, “What do you think of the ‘Every Contact Counts” and they said, “We’ve never heard of it.” So I have to say, unless it’s multi-agency, and I’ve said the same thing locally to social care, “What does it mean to you?” the members have picked up on it and said, “Actually it’s a term we should be operating on right throughout to public sector,” because unless the public sector use the same sort of terminology, they talk about different things, whether it be mental wellbeing or anything else.
Chairman: Dr Campion, do you have any thoughts?

Dr Jonathan Campion: A couple of thoughts, first of all, Kerry, you highlighted some really good examples of housing and I think you were quoting Department of Health figures around the cost of not housing people with mental illness and I think there are tremendous savings to be accrued through actually what are very positive interventions to promote wellbeing. I think our housing, where we live is an example of that and I think if we’ve got a mismatch between perhaps where Government policy is going, even sometimes at odds with public health policies, it can be really, really helpful to have those examples at a local level and then maybe linking that example into the joint strategic needs assessment, and then to link up public health and social care. I think the health training again is very important. You were highlighting that almost one in four of us will experience some mental health condition each year and I think also our wellbeing very much fluctuates and I think there’s very much an inter-relationship between mental health conditions and wellbeing. If you develop a mental health condition, obviously it will impact on our wellbeing, and if our wellbeing is poor, then actually we’ve got less resilience to then deal with a mental health condition later, so I think certainly that kind of support in terms of literacy and signposting is really very important.

Jess, Public Health consultant in Kent: I used to work with Meradin and I’ve worked in public health now for quite some time. When I worked leading in sexual health and smoking cessation services, there was a clear public health programme that was expected that we would follow, with good NICE guidance right from intervention through to treatment, a programme approach. I’ve been working in public mental health since 1999 and have really been trying to find where this kind of programme approach for public mental health is mapped out and by and large it’s very patchy. I asked colleagues of mine, who work in other areas around public mental health, I said, “what are you doing (around mental health)?” And often they just go, “Well we only need to do suicide prevention” and that’s as big or as small as you want to make it. And given the fact that we’ve had millions of pounds going into e.g. Chlamydia screening, we haven’t had the comparable funding for mental wellbeing. I’ve spent quite a long time trying to develop what is a systematic programme for mental health, starting with good data and joint strategic needs assessments, so in every area that I’ve worked in public mental health has always had a good needs assessment, both for adults and for children (and those are linked together), and also with commissioners on service design and equity audit, which is really important as often commissioners don’t recognise public health’s value within public mental health.

More recently, Meradin really helped when she was Director of the Public Health in Kent, by actually sticking her neck out and saying, “Here you are Jess, you’ve been banging on about this for years and years and years, have some money.” So here we had for the first time in my recorded history, a systematic programme for wellbeing that I could now develop, that wasn’t just borrowing a little bit of money, put here, finding a bit of money under a bit of lettuce leaf over here. So what we’ve got now is tier two plans within the public mental health remit, a wellbeing campaign that goes right across Kent, a community development, particularly focused on men, because of this high suicide rate and some innovating programmes working with veterans and ex-military, called sort of ‘The Shed Programme.’ If you don’t know about it, have a look, it’s very good. Mental health training and bespoke training to professionals, such as GP’s who cannot take three days out of their busy schedules to go to do e.g. mental health first aid. So it’s bespoke training. Mental wellbeing impact assessment, working with libraries, working with arts, asset mapping, which looks at poverty mitigation locally- in terms of what the local context is and of course work placed health, social prescribing and the re-design of day centres and employment services for people who have mental health problems.
Now if we can span that whole system and that’s a mental health peripheral, I’d like to ask Public Health England, how are we going to get this information out to everybody, so actually consultants in public health realise they’ve got a responsibility to have a whole programme approach and not just do a little bit around suicide prevention, ‘because that’s the only target we’ve got on mental health.

Voluntary sector worker: I manage the mental health crisis housing and leadership. At present there is a big issue around legal highs within the county, especially around the coastal areas, which are effecting people’s physical and mental health. I just wondered if there is any work being done around that?

Dr Heema Shukla, Public Health England: I think I totally agree with you and what with Public Health England setting up and bringing mental health into public health, we have that opportunity to have that systematic approach to mental wellbeing. We started that and I haven’t seen the stats, but that’s what we’re doing- that mental health should be in everybody’s job description, it’s not something where you’ve got mental health specialists and you’ve got public health/physical health (specialists). So I think one thing is it has to be in everybody’s portfolio, and whatever you do has got to impact on that mental wellbeing. The Mental Health Intelligence Network is going to start doing exactly what you’re saying, providing that information in terms of everybody getting the data and being very systematic.

We’ve been running 15 events across the country to look at exactly what good practice is out there and how do we share that? That will be coming out in Autumn and then we are obviously working on what are evidence based practices. It’s across the whole thing and we’ve got two streams, one is mental wellbeing and other is mental illness and I think when talk about mental health, it’s important we don’t forget that we have got a bit of both. So it’s not about either/or, it’s actually both in terms of that. So I totally agree with you and this is where I think PHE has got to.

We’ve got some fantastic studies across the country which we could share and PHE is a national body, it can share that across.

Meradin Peachey: It was interesting during the whole process of trying to identify the public health budgets in the NHS, to transfer local authority, there was a loan called Public Health Mental Health and it’s amazing, in Kent our submission said zero. The people running the mental health commission kept telling me, “No we don’t spend anything.” Yes, we only just became mental health workers, I mean and yes social care were doing some, so it’s not that there wasn’t anything, but it was interesting that it came back as a zero and so one of my thoughts was, about 4% of the budget in the NHS is being used on prevention and it probably wasn’t meant to be used this way, but I thought if you’re going to spend 4%, if you spend 40 million on mental health, shouldn’t you be spending 1.4 million on mental health prevention and actually that’s what spurred me on, is that this isn’t about a few thousand here, a few thousand here, it’s about a million pound programme investing in people’s mental wellbeing.

Dr Jonathan Campion: Thanks Jess. I think there are undoubtedly some public health teams that are doing fantastic work, as you’re highlighting. I think it’s rather hit and miss though and I think in terms of getting that coverage of these evidence based broad ranges that promote wellbeing across populations, that would be fantastic. I think one of the things, again linking to Heema’s point, we also need to be thinking about is proportionately who do we need to focus on? Whose wellbeing is particularly low, and obviously there are different high risk groups or different groups at high risk of low wellbeing. But I think obviously one of those groups are people with mental health conditions and therefore I think one of the points made earlier, we need to target these wellbeing promotion
interventions as an integral part of recovery. I think having a systematic approach is where this actually this is. I think that comes back also to the point about budgets, because clearly if we’re thinking about wellbeing promotion to the general population, that’s going to be potentially a public health issue. So I mean I think that sounds very exciting.

I think with legal highs and again if we’re thinking more broadly around wellbeing and low wellbeing, in terms of how all of this deals with when our wellbeing is a bit low, we will sometimes top it up in sometimes healthy ways. If we’re thinking around, for instance mindfulness, sometimes less healthy ways, going for a pint of beer- obviously that’s nice and we have a bit of social connection with friends, but I think again if we’re thinking about people who are maybe relying on legal highs, because their wellbeing is so low, again as a public health opportunity to think around, okay so how do we frame wellbeing for those target groups.

Sarah Stewart Brown, Professor of Public Health, Warwick: I wanted just to reflect on the idea that we might, in public health, develop a kind of recipe for public mental health and wanting just to allow more flexibility in it. In doing public mental health and really addressing the wellbeing agenda, we are trying to shift the whole system and for the population to go to a new level. I think you may want to start in one place with parenting, because there’s actually a lot of parenting provision there and are lots of people who can take on that role and run it, but another place may not have anybody on the ground who has got the skills to really start with that and there might be some fantastic initiative around something else. You need to be clear and have a plan and an approach and to be seen to be spending money on it. But to say that we all want to start at the same place, there’s so much you can do, you can have dance, you can have yoga, you know all these kind of things, but in one patch singing is another extremely good way to promote mental wellbeing, but in any one patch we need to start with the assets that are raised in that place and to build on them and support them.

Kevin from Sunderland: I’ve had to go back to the statistic quoted about the 20 years loss of life for people with severe and enduring mental illness. It was mentioned there about staff in terms of mental health services, we know that gradually mental health services will become less public. We know from our own experience in Broadmoor where I work, it’s entirely non-smoking, and is a highly effective intervention because it’s no smoking.

Brian, Rethink Mental Illness: I just want to pick up on a couple of things that Meradin said, about the importance of early intervention and preventing and particularly about early intervention in psychosis services, because I think that needs to be a really key part of any discussion about parity and really because those services have brilliant outcomes. A lot of the problem areas that arise from the start lack of parity and so for example, whether that comes from physical health, for helping young people go out to work or to stay in education and just really for helping people avoid long term life long illness. But earlier this year we released a report called ‘Lost Generation,’ which showed that a lot of these services are facing really severe cuts to the point that there have been lost in some parts of the country or even the person just doesn’t exist there anymore and means that we’re not saving money where we could be saving money as well. So I think that that’s a really key issue that we need to address if we’re going to make parity a reality.

Meradin Peachey: I totally agree with you- we know for example that contact and behavioural disorders start at a very early age and if we don’t pick them up and support them at that age, you have lost a whole generation. Again, this comes back to what we were saying, we need to look at the whole range of things that we need to do- to both prevent, support and recover on one hand, but on the other hand
is the mental wellbeing, and that’s the biggest win we can make. There’s evidence, there’s good evidence of what we can do and we should be doing it, no doubt about that.

**Dr Jonathan Campion:** I totally agree that we’ve got really fantastic evidence for early intervention, psychosis services and also in the Government’s mental health strategy they highlight that for each pound you spend on early intervention psychosis services, you have net savings of £18. So I think we know that actually if you intervene early, you tend to require lower doses of medication, which get just generally broader, better outcomes. So again, it doesn’t make sense even economically, let alone in terms of outcomes for patient’s family and community (to not invest).

I think the smoking issue is really important, we have very high smoking rates, but for people with mental health conditions across the board and that’s the largest single determinant of their premature mortality and I think there is an issue around coverage, which links to what I said at the beginning. At the moment NHS Stop Smoking Services are the single largest provider and they cover about 9% of smokers, half of whom will give up, so actually we’re only actually successfully getting to one in 20 smokers. This is the largest single cause of premature death and also it doubles your doses of anti-psychotic medication that you require, which you can reduce by half within four weeks of stopping. So I think there are multiple benefits of focusing on smoking. There’s huge gaps, and I think particularly for those groups with very high levels of mental health conditions and also poor wellbeing.

**Meradin Peachey:** Regarding the early intervention psychosis- it was a pilot we started in Kent and I’d be really interested in the outcome of this, doing online mental health support in schools and there’s one we started piloting and that way you started recovery from day one. It’s online, it’s what young people like and obviously having seen the results of it and I think there’s a number of pilots, but I’d really like to see some really good research, some outcomes out of that. But one thing I’m quite interested around the whole school scenario, in my sort of 15, 20 years working in public health, schools are continually saying, “We don’t get support for kids with early behavioural issues, early mental wellbeing” and to such an extent I visited one school in Kent and they said, “We employ two psychologists because we don’t get any support for mental wellbeing for children.” So I think that’s again a whole area which we can focus a lot more on and I think if an online solution works, it’s an awful lot cheaper than running CAMHS services and clinics and professionals- I think we could look at alternatives.

**Dr Heema Shukla:** London is just piloting an additional service, so London is very much looking at this together, PHE London is looking at that and that’s an easy way.

**Helen, Mind:** A lot of the stuff that’s been said so far about making every contact count for mental health is really welcome and I think more work is going on in terms of working with public sector staff to increase understanding, knowledge of mental health which is great. But I just wondered what the panel thinks about how we go beyond statutory services? I’m particularly thinking about faith groups, which are quite often the first port of call for people when they start to feel anxious and stress and many people who do have a personal faith don’t necessarily distinguish between mental health, spiritual health and how we can work with those groups to increase that support. But also all other non-statutory services, so Re-Think and also a number of organisations are working on the Mental Health Challenge, where we’re supporting councillors to increase their mental health and wellbeing literacy, both so that they can work with their public health team, but also support in their constituents, their case work, so they can support local wellbeing.
But I wondered if the panel, and particularly Shalini, has views on the local health groups as well, so people that come along to your dance group who are very lucky to have a teacher that understands the wellbeing benefits of the activities they are taking part in, but how we can increase that level of literacy across the whole population?

**Dr Heema Shukla:** Just picking up on some of the issues about training and “making every contact count” and it being everyone’s responsibility, I think there’s some work being done in the public health workforce and I think it’s critical that we don’t think in narrow silos, but thinking that you know the person most able to support you - maybe a manager of the workplace. It may be a teacher, it may be a dance teacher, so I think that one of the contributions that PHE is hoping to make in this space is by looking at the public mental health workforce very, very broadly and thinking what are the competencies, what are the skills, what is the knowledge that people who are not traditionally seen as public health professionals need - what are their assets, what do they bring to change the system approach? So I think that’s absolutely critical.

**Chairman:** I think just some final comments from the panel members, broadly sort of any summary or response to those questions and then we need to wrap up?

**Shalini:** This one is to Helen. We are often the first point of contact and we I’m lucky in that I have an understanding of mental health and mindfulness and meditation, but a lot of our dance teachers don’t and they don’t have adequate training. I haven’t heard of a health trainer before, those are the kind of people that we need to be speaking to and being able to then signpost people from our classes to health trainers. So I feel that it’s very, it’s very patchy, we just don’t seem to have a network. We will often say that your first point of contact is your GP and I’m just picking up on what Jess said and June said earlier, your GP is often your first point of contact. I was really lucky, my GP got it, but a lot of my ladies have come back and said their GP doesn’t - the first thing they did was just say, “Okay, take some anti-depressants,” but they don’t want to look any further than that and one lady she said, “Oh I went to a therapist and the therapist looked like she was 12 years old and I didn’t go back” and she said, “When I went there, I had to fill in loads of forms, when I’m suffering from depression, the form just looks like another thing that I couldn’t cope with” and she said, “Okay I didn’t go back and the GP never followed up on it” and I understand they are busy, etc, but where is that net to catch these people? So we can’t be that net, we don’t have that training, so there’s that patchiness that I really struggle with.

**Meradin Peachey:** Just a very quick final comment on the whole concept of making ‘Every Contact Counts,’ I actually think comes much more naturally to people like MIND and faith groups, than it does to professionals. While I think it’s the professionals that we need to work on, so that we haven’t got 18, 20 people working with a family. But I think the point about whether faith and voluntary sector and others are actually much more involved in actually how they can contribute to mental wellbeing is a very good point.

**Dr Jonathan Campion:** I think that certainly the broader sectors do have a really very important role, I think the health trainer colleague was just highlighting that signposting. I just wanted to highlight some work by my colleague who had done some really interesting work in South London with faith groups, very much promoting mental health literacy and when people first arrived often with quite severe mental illness from black and minority ethnic groups, these pastors are then in a position to then signpost on and I think that’s worked, that seems to have had very impressive results. It’s just an example.
Chairman: Thank you very much for the contribution from the panel and from the audience, sorry for people who couldn’t get in and thanks very much for your contributions. It’s been a very interesting session.

MEETING ADJOURNED