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Editorial

The importance of psychiatry in public mental health

Nisha Mehta and Sally C. Davies

Summary
There is a lack of consensus over fundamental issues in public mental health in England. A move away from poorly evidenced 'well-being' policy approaches is needed. The authors have developed a more inclusive model using the World Health Organization's approach to public mental health. Public mental health policy makers must acknowledge the importance of psychiatry within the field.

Declaration of interest
N.M is the Editor-in-Chief of the *Annual Report of the Chief Medical Officer 2013*. S.C.D. is the Chief Medical Officer, England.

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Background

The *Annual Report of the Chief Medical Officer 2013. Public Mental Health Priorities: Investing in the Evidence*, was published in England in September 2014.[1] The report contains 17 chapters within the following sections: Chief Medical Officer's introduction; science and technology; mental health across the life course; the economic case for better mental health; parity of esteem; and needs and safety.

The report brings together the evidence about mental health and sets it within a contemporary policy context. The chapters are written by experts and provide the best evidence to inform the Chief Medical Officer's recommendations, against which there is an expectation of progress in England. Public mental health is difficult to define because there are contested boundaries and terminology. In producing the annual report we (N.M. and S.C.D.) consulted extensively on this issue and considered views and evidence from policy makers, academics, healthcare professionals, charities and service users. As the work progressed, we became increasingly concerned about the lack of consensus over fundamental issues in public mental health in England, including:

(a) the definition and key components of public mental health;

(b) the relationship of concepts within mental health to one another;

(c) how mental health variations of importance are measured and experienced;

(d) the value placed on mental health and its consistency across society;

(e) our approach to the generation, accumulation and use of evidence in policy.

The rise of the 'well-being' approach to public mental health

We explore these issues in depth in an introductory chapter in the report.[2] The chapter contains a much needed appraisal of the evidence underpinning core elements of public mental health policy in England. Since the publication of the Government Office for Science *Foresight Report* in 2008,[3] the concept and language of 'well-being' in public mental health has gained great prominence. Foresight had reiterated an unproven hypothesis from 1996: that improving the population's well-being would result in primary prevention of mental disorder.[4] We found no credible evidence to support this. Instead we found public mental health policy in 2013 being developed as if this hypothesis had long been proven correct. We also discovered that 'well-being' has not to date been scientifically defined, measured or robustly related to well-established and measurable variations in populations with mental illness – i.e. the psychometrics of 'well-being' in mental health simply do not stack up.[5] There is virtually no robust, peer-reviewed evidence to support a 'well-being' approach to mental health. Yet there continues to be published a stream of poor-quality and high-profile 'well-being' reports within the non-peer reviewed 'grey' literature, urging commissioners to take a well-being approach to public mental health, mental healthcare and even resource allocation.[6] The evidence provided to justify this approach includes the following.[2,5]

(a) Irresponsible 're-badging' of evidence from psychiatric research as 'well-being evidence' without qualification or explanation.

(b) Publicly funded, yet poor-quality, well-being 'interventions' with evaluations carried out by the organisation that conducted the research, which then promotes exaggerated and misleading results to policy makers.

(c) Declarations that 'well-being' is such an important field, it should be excused from 'unreasonably high standards' of evidence that apply elsewhere in health.

(d) An approach to mental health policy in which existing and often unvalidated proxy measures of well-being are unsafe for use in populations with mental illness.

Upon raising these concerns the Chief Medical Officer was asked to take a 'leap of faith' that 'well-being works' in mental

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health. Another common and alarming argument for the importance of the 'well-being' agenda was that the 'medical model' of mental health does not belong within public mental health and a 'well-being' focus would instead 'allow a focus on what actually matters', yet apparently without the need for any supporting evidence. We heard the contribution of psychiatry and, indeed, medicine to public mental health frequently dismissed by non-medical practitioners in the field as 'biomedical', 'reductionist', 'narrow' and even 'irrelevant'. We strongly dispute this: indeed the 'biopsychosocial' model of health was developed in 1977 by a psychiatrist,[7] and forms a key element of the Royal College of General Practitioners core curriculum for trainees. Within psychiatry, interdisciplinary practice remains at the heart of the specialty.

The biopsychosocial model

Chapters in the report clearly demonstrate that the biomedical and psychosocial models of mental health and illness are not antithetical, but are increasingly conceptualised within a single unifying framework.[8,9] For example, advances in epigenetics enhance our understanding of the effect of the environment on gene regulation. New insights into 'gene–environment interactions' (GEs) offer a methodological approach for the integration of biological and psychological factors in a single model. As Pariante & Nair describe in their chapter on neuroscience and mental illness, these areas of research have 'potentially profound public health implications, as (they) clearly highlight the primacy of individual vulnerability or resilience (determined by a combination of genetic make-up and early life experience) in the trajectory to the development of mental illness(es)'.[8] Noting that school-based resilience programmes in the UK developed by the 'positive psychology' movement were unsuccessful, Fonagy examines developmental psychopathology from a neuroscience perspective.[9] In his chapter, Fonagy describes exciting developments that will allow us to target specific neurobiological systems in children, known to underpin developmental paths to disorder. 'Real-world' interventions might include computer-based brain training or ecologically valid interventions in homes, classrooms and Sure Start centres. Fonagy concludes: 'The future lies in genuinely vertically integrated (bi-generational) programmes that build on the revolution in life science knowledge, both biological and psychological, which simultaneously address the problems of the parents and the child to help them break out from what is likely to be an almost Lamarckian epigenetic trap that otherwise dictates that not just history, but also biology, will repeat itself'.[9]

Such developments within the biopsychosocial model of mental health are exciting and full of promise for the future of public mental health. As this model matures into a compelling evidence base for truly integrated public mental health policy, there can no longer be any excuse for evidence-based mental health to be given less emphasis than other areas of health by policy makers, commissioners, medical undergraduate curricula and postgraduate training programmes. To help realise this emerging vision for a truly biopsychosocial approach to public mental health we ask that activists, patient and service user groups, public health practitioners and policy makers begin an open and honest debate about the issues raised in the report. We fear they will do the field a great disservice if they do not build a common discourse with psychiatrists and other medical professionals to ensure that evidence-based public mental health is developed and delivered. We must move on from a 'bunker' mentality and towards a sophisticated consideration of evidence on its merits.

To facilitate this we advocate widespread adoption of a model of public mental health that we developed for the report using a decade of work from the World Health Organization.[10–12] Public mental health should be conceptualised as consisting of the inter-related and robust concepts of mental health promotion, mental illness prevention and treatment/rehabilitation.[2,5] This model allows all relevant evidence to be included on its merits, rather than trying to shoe-horn public mental health into a 'well-being' narrative. Public mental health should not be framed using political terms containing hidden agendas. And the input of one group of professionals should not be dismissed out of hand as part of a prejudiced and knee-jerk reaction to legitimate academic challenge.

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