BJPsych | The British Journal of Psychiatry (2011) 199, 340–343

Correspondence

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Preventive psychiatry within public health

Thank you, *BJPsych*, for your timely editorial on population mental health.[1] It is a pity that the authors did not mention the strategy for England entitled No Health without Mental Health, launched in February (before their final submission) as this strategy did involve precisely the teamwork of psychiatrists, public health specialists and economists that they see as 'the challenge'. Their 'must list' for psychiatry begins with help 'to remedy the consequences of adversity and vulnerabilities'.

A key weakness of UK attempts to address health inequalities has been a failure of leadership[2] – and the common mental disorders show a steeper social gradient than common physical illnesses such as heart disease. Can the Royal College of Psychiatrists take a lead in addressing the antecedents of adversity and vulnerability, not just the 'consequences'? Desolate, impoverished neighbourhoods spawn childhood mental illness[3] and rising unemployment breeds desperate drinking and suicidal despair.[4] In the original National Health Service Act 1946, maternity services were the exemplar of planning equitable care on the basis of population health needs . . . but in England today many maternity services are at breaking point, with antenatal care services widely sacrificed to maintain staffing for deliveries. The College could speak with unique authority on the need for better antenatal care, to prevent a generation blighted by neurodevelopmental problems.[5]

I suspect that consultant psychiatrists are, on average, better educated, more articulate and able to reflect than, say, Members of Parliament. Urban degeneration, unemployment and the breakdown of comprehensive health services need to be linked explicitly to escalating economic and social costs of mental illness. Only the College could 'join up the dots' convincingly for MPs to respond to urgent population mental health needs.

There is a timely opportunity to test such specialist influence on national policy. Thanks to heroic lobbying by thousands of women before the last election, the training and deployment of 4200 extra health visitors became one of the goverment's top 10 priorities.[6] The editorial on preventive psychiatry describes 'opportunities to break the intergenerational transmission of risk'. Can psychiatric expertise now permeate into the skill set and effective practice of these 4200 public health practitioners?

Declaration of interest

W.C. is Editor of the *Journal of Public Mental Health* and currently involved with the national demonstration site for a Victims and Vulnerable Persons Index in North Lincolnshire.

1 Bhui K, Dinos S. Preventive psychiatry: a paradigm to improve population mental health and well-being. *Br J Psychiatry* 2011; **198**: 417–9.

2 Caan W. UK public accounts committee report on health inequalities. *Lancet* 2011; **377**: 207.

3 Booth KJ, Caan W. Poverty and mental health. *BMJ* 2005; **330**: 307.

4 Caan W. Unemployment and suicide: is alcohol the missing link? *Lancet* 2009; **374**: 1241–2.

5 Caan W. Being of sound mind, in the beginning. *Department of Health Mental Health Promotion Update* 2005; **2**: 13–5.

6 Policy Watch. Re-energising health visiting. *NMC Review* 2011; **1**: 30–1.

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doi: 10.1192/bjp.199.4.340

Authors' reply: We are indebted to Caan for an opportunity to further debate the potential of preventive psychiatry within a public health context. A failure to address inequalities reflects not only a failure of leadership but also lack of commitment by all sectors to recognise potential benefits in human capital and economic savings over the next decades. The Royal College of Psychiatrists' position statement,[1] which informed the Department of Health strategy No Health without Mental Health, sets out the evidence base and the need for further research. Recognising the role of psychiatrists and specialists in primary, secondary and tertiary prevention as well as the need for further development to include a role for specialists with appropriate training and accreditation processes is vital.

Preventive psychiatry is not new and remedying the consequences of adversity and vulnerabilities are but one of a number of preventive activities that already take place within existing psychiatric practice. The editorial sets this out alongside the new challenges facing specialists but also the wider public health community.[2] The prevention of violence and hostility between adults and young people has been long recognised as a core task of preventive psychiatry.[3] As set out in the College's position statement,[1] protecting and promoting health and optimal maturation of young people while taking account of complex interactions between biology and the environment are key objectives and are also at the heart of more complex approaches to medicine in general;[4] preventing gender violence, sexual exploitation and abuse, promoting best parenting, nutrition, exercise, and education, protecting mental capital and physical health, and delivering interventions that develop mature adults who enjoy the responsibilities of adulthood while still enjoying the pleasures of life over the life-course are clearly important objectives. These policy priorities, although challenged by the need for more evidence and related research questions, are as important in low- and middle-income countries as in their higher-income neighbours.[5]

These ambitious frameworks require local adaptations and actions, which incorporate an understanding of people's lifestyle, attitudes, beliefs, cultures and status reflected in the delivery of interventions.[5] Existing universal and global policies are being challenged by socially excluded groups and by people with multiple health problems, as well as those presenting with novel phenotypes.[4] There is a role for specialists to be central to both policy and delivery, and to inform other stakeholders of the many varieties of personal distress and illness that are often lumped together under the title of mental health; an approach that would not be acceptable, say, for infectious diseases (see Lemkau[6]). Inclusive and progressive policies and practices must protect the health and well-being of the population as a whole but also of the most vulnerable, including those victim to inequalities and social exclusion or those with complex needs that do not conform to unitary concepts of what constitutes mental health, illness and mental disorder;[7] these opportunities must be seized while also

https://doi.org/10.1192/bjp.199.4.340 Published online by Cambridge University Press