BJPsych The British Journal of Psychiatry (2015) 207, 279–280 doi: 10.1192/bjp.207.3.279

From the Editor's desk

By Kamaldeep Bhui

Earnest endeavours

> 'They are always degrading truths into facts. When a truth becomes a fact it loses all its intellectual value.' Oscar Wilde, *The Importance of Being Earnest* (1895)*.

The public psychiatry paradox

Public psychiatry has been and remains the subject of debate and controversy. Jacobs & Griffith's definition of public psychiatry includes psychiatry practised in the publicly funded services as a safety net for disadvantaged, vulnerable, mentally ill and addicted individuals in the community.[1] The competencies needed include the assessment and management of psychiatric disability, psychosocial and vocational rehabilitation, addictions, and expertise in recovery, integrated care and population health.[1] The contested issues, largely absent from conventional definitions of public psychiatry, include the extent of the role of the profession of psychiatry as an actor in a broader arena of mental health promotion, early intervention and the prevention of mental illness, alongside the generally accepted role of psychiatry in the assessment and treatment of mental illnesses.[1,2] The Royal College of Psychiatrists' position statement seeks a more extensive and integrating set of competencies for psychiatrists working in public health.[3] There are significant benefits for public health if psychiatrists become more involved in public mental health practices given their expertise in biopsychosocial antecedents and consequences of mental distress, the integration of social, behavioural, psychological and pharmacological interventions, and skills in assessment and management of comorbid physical illnesses as causes of premature mortality (see Ng *et al* (pp. 262–268) on HIV and Messerli-Bürgy *et al* (pp. 256–261) on cardiac comorbidities). Psychiatrists should have a complementary role to other health professionals, while supporting the rapid integration of emerging research evidence into routine practice (see Public Health England guidance on workforce development).[4] Psychiatrists already work in diverse settings, including schools, communities and businesses and with local government as well as with primary care, criminal justice systems, and in national policy and regulatory bodies. Greater exposure to social and cultural systems beyond the hospital offers scope for intervention at population levels; such ambitions may be limited by stigma if this restricts the public's and health professionals' engagement with new opportunities.[5,6]

This month's *BJPsych* includes a series of editorials by senior national leaders in public mental health, each presenting a case for evidence-based practice and for more exacting and thorough analysis of what public mental health is, and what place psychiatrists can legitimately take up (see editorials by Mehta & Davies (pp. 187–188), Foreman (pp. 189–191), Stewart-Brown (pp. 192–194) and de Cates *et al* (pp. 195–197)). There is a substantial body of evidence for population interventions[7] but the quality and implications of such evidence are not beyond dispute.[8,9] Cautions around overinterpretation of the evidence in order to ensure progressive and measured responses are also the subject of critical objection.[10] As a consequence, professionals (in public health, psychiatry, psychology, nursing, medicine and allied health professions) must be perplexed about how to engineer the magic trick of delivering effective treatments to individuals with mental illness alongside expanding their roles and remit to populations; and all this needs to happen at a time of austerity and recession, a time of greater need and less investment. Perhaps our models of mental illness, mental health, well-being and the respective risk and protective factors require rethinking. For example, Van Os suggests we stop thinking of populations of individuals with equal vulnerability but rather we should recognise 'dynamic adaptation' as an individual and collective property that links brain disease to public health.[11] We still need stronger models of mental illness and health, the best evidence on new interventions and how to improve our existing armoury.

Sadness, psychosis and song: powerful new interventions and insights

Physical activity offers greater improvements in depression symptoms in older people when added to antidepressants (Belvederi Murri *et al*, pp. 235–242), and group singing improves mental health-related of quality of life in older people (Coulton *et al*, pp. 250–255). Physical activity and internet-based cognitive–behavioural therapy are effective at reducing depressive symptoms compared with usual treatment, but appear not to have a specific effect on work capacity (Hallgren *et al*, pp. 227–234).

Depression has harmful intergenerational and longitudinal effects. Plant *et al* (pp. 213–220) show that offspring of mothers who experienced depression in pregnancy were more likely to have a diagnosis of depression in early adulthood, mediated by more experiences of child maltreatment. Longitudinal analyses show that depression is associated with continued smoking (Shahab *et al*, pp. 243–249) rather than smoking leading to depression. Protecting people from violence is one of the most important public health interventions. Intimate partner violence is more common among people with chronic mental illness, and suicide attempts were more likely among those experiencing such violence (see Khalifeh *et al*, pp. 207–212).

We also must improve and broaden treatment opportunities and reduce inequalities in treatment. Lewer *et al* (pp. 221–226) show that the spend on antidepressants is associated with higher levels of national healthcare spending and with beliefs that people suffering with mental illness were dangerous; negative attitudes towards people with mental illness were associated with less use of antidepressants. The quality of life of people with subthreshold levels of psychosis (failing to meet diagnostic criteria) is as poor as those with diagnosed psychosis, suggesting that more intervention is needed in these groups who are otherwise neglected (Fusar-Poli *et al*, pp. 198–206).

Person-centred care requires highly competent and confident practitioners who can apply emerging research on the varieties of mental illnesses, and marshal the evolving evidence for each patient, for patient groups, as well as for populations. Continuing to engage with the earnest endeavours, negotiating truths and facts, and reconfiguring our knowledge about mental illnesses are critical duties. Optimising public knowledge about research evidence, especially on individual and population health behaviours, is a further challenge.

*Taken from the manuscript versions; post-1899 editions of the play omit this (see Jackson R (ed.) *Oscar Wilde* The Importance of Being Earnest. A & C Black, 1980).

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https://doi.org/10.1192/bjp.207.3.279 Published online by Cambridge University Press