

This August, the seven UK research funding councils came together for a new strategy, “Widening cross-disciplinary research for mental health.” Creative new research collaborations will be sought for public mental health, prevention and wellbeing ([www.rcuk.ac.uk/documents/documents/cross-disciplinary-mental-health-research-agenda-pdf/](http://www.rcuk.ac.uk/documents/documents/cross-disciplinary-mental-health-research-agenda-pdf/)). I hope that many *JPMH* readers will consider networking in cross-disciplinary ways, involving partners both in the world of academic research and beyond (Caan and Lee, 2017).

Creative collaborations are also important for service development. In this issue of the *JPMH*, Friedrich and Mason (2017) report on using football to promote public mental health and Collins et al. (2017) describe involving young people in developing mental health services. Previously, Youth Health Champions identified by the Royal Society for Public Health have demonstrated creative ways to engage communities, for example in suicide prevention (Caan, 2016).

Globally, the greatest unmet needs for improved mental health are not among young people, but peak in midlife (Daly, 2012) especially in communities where there are major social inequalities. Poverty and debt cause and perpetuate poor mental health (Foster, 2017a). In this issue, Ahmad (2017) profiles the problems experienced by adults in India who work under extreme hardship, in unregulated quarries. World Mental Health Day is approaching (on 10 October) and the global theme in 2017 is Mental Health in the Workplace.

O’Connor (2017) summarised a longitudinal study of 1,000 people who had been unemployed in the recession of 2009-2010:

The people who moved into poor quality work – low paid, low autonomy, high insecurity – had the highest levels of chronic stress, higher than the people who remained unemployed. People who moved into high quality work were the healthiest of all. In other words, unemployment is bad for you, but some jobs might actually be worse.

In Britain, poor quality work is typified by zero-hours contracts and bullying management, that corrodes the health of employees (Foster, 2017b). Even in the National Health Service, staff health is “a low priority for leadership” (Johnson, 2017) even though absences for common health problems like depression cost the NHS at least £2.4 billion, annually. Fortunately, we have good research evidence on what sort of group (“shared”) activities develop the wellbeing of a workforce (What Works Wellbeing, 2017). Among features that build shared wellbeing are “inclusivity” across workers, sustaining activities over time, welcoming contributions from all team members and inviting “external” input beyond the team.

In the past, inter-professional teamwork in mental health services was researched frequently (Caan, 2000) but effective teamwork in public health services was rarely studied. I took part in Kenneth Calman’s 1997 project to strengthen multi-disciplinary public health (as a member of his primary care team). Soon the Department of Health reported “the multi-disciplinary nature of public health is now accepted widely” (Donaldson, 2001), but no one had evidence about how to make the new cross-disciplinary working effective. The only certain recommendation was that the old ways were not meeting the needs of the UK population: “Public health capacity and capability (people, skills and other resources) must be increased” (Donaldson, 2001).

In the next decade, the English public health workforce was dispersed across new teams in new employers. In 2015, an estimated 800 medical and 400 non-medical professionals made up the “specialist” workforce (Bannon, 2016), including 510 employed by local authorities and 411 in Public Health England. Only a small minority are specialists in “public mental health”. Hardly anyone has that job title, but based on the current special interest groups and recent

meetings of professional bodies, my guess is the national human resource numbers a core of about 30 experts in public mental health (many connected to *JPMH*) and another 150 or so specialists in local authorities whose responsibilities include mental health improvement. Higher education employs thousands of population scientists, behavioural scientists, social policy researchers and others who could contribute to future public mental health, but when the last National Academic Public Health R & D Capacity Survey for England was completed in 2001, very few respondents focused on mental health. More recently, Public Health England (2016) considered the wider workforce of about 15,000,000 people whose work might, potentially, impact on health. They noted within that review a specific gap in the public health workforce:

Strategic leadership for public mental health should be embedded in leadership development programmes.

Meanwhile, the UK Government continues to make promises to expand mental health provision (e.g. 21,400 extra, professional posts: Health Education England, 2017). It does this without a joined-up, systems approach that includes both service provision and public mental health capacity (Caan, 2017).

So on World Mental Health Day, I plan to reflect on what makes for good work, including fulfilling public health roles and the capability of local teams. For global health improvement, there is much food for thought in the new Prevention Concordat for Better Mental Health (Public Health England, 2017):

There must be joint cross-sectoral action to deliver an increased focus on the prevention of mental health problems and the promotion of good mental health at local level.

### **Public Health Pixels**

The Face of Public Health

Is made from many parts –

Each contributes their light,

Their brains, their hands and hearts.

The vision Public Health

Projects depends on you:

Chaotic, or brilliant,

A broken or joined-up view

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