Faculty of Public Health

Of the Royal Colleges of Physicians of the United Kingdom

Working to improve the public's health

P 69

Ymchwiliad i'r Adolygiad Blaenoriaethau ar gyfer y Pwyllgor Iechyd, Gofal Cymdeithasol a Chwaraeon

Inquiry into the Priorities for the Health, Social Care and Sport Committee

Ymateb gan: Cyfadran Iechyd y Cyhoedd

Response from: Faculty of Public Health

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UK Faculty of Public Health response to the National Assembly for Wales' Consultation on Priorities for the Health, Social Care and Sport Committee

About the UK Faculty of Public Health

The UK Faculty of Public Health (FPH) is the standard setting body for specialists in public health in the UK. FPH is the professional home for close to 4,000 professionals working in public health. Our members come from a range of professional backgrounds (including clinical, academic and policy) and are employed in a variety of settings, usually working at a strategic or specialist level.

The UK Faculty of Public Health FPH is a joint faculty of the three Royal Colleges of Public Health Physicians of the United Kingdom (London, Edinburgh and Glasgow). In addition, FPH advocates on key public health issues and provides practical information and guidance for public health professionals, aiming to advance the health of the population through three key areas of work: health promotion, health protection and healthcare improvement.

FPH welcomes this opportunity to respond to the National Assembly for Wales' Consultation on Priorities for the Health, Social Care and Sport Committee. At the outset, FPH is pleased to endorse the response to this consultation submitted by Public Health Wales.

FPH is encouraged by the broad range of areas the Committee wishes to consider, and, in particular, welcomes the attention given to the integration of health and social care services, to waiting times and to primary care. We also support the recognition given to gambling addiction, often insufficiently addressed, and support the proposal to undertake an inquiry looking at awareness of gambling addiction, the provision of support services, and the steps that could be taken to reduce harm.

However, we commend to you the 12-ambitions outlined within FPH's manifesto for public health, *Start Well, Live Better*[1]. This document is the culmination of an extensive consultation with our members about the top public health priorities for government and local action. These we feel would strengthen the Welsh proposals.

The scale of the obesity epidemic, the cost to our society of cheap alcohol, and the continued dangers from tobacco are major public health threats that need legislative and regulatory interventions – especially to protect children and young people. The interventions which are needed are of the kind that only the Government can implement.

We believe there should be a firm commitment to upstream legislative action to ensure health is at the heart of all national and local government policy formulation – thereby reducing health inequalities by taking action across all social and economic determinants of health. The Faculty of Public Health strongly advocates that a framework for health in all policies should form a central pillar of public health policy, ensuring strong cross-sectoral collaborative links may be made and a strategic national approach adopted, supported by local initiatives.

Accordingly, the Faculty of Public Health places a firm emphasis on the introduction of a statutory duty on Ministers to consider the health impact of all policies which will be of practical utility in improving health outcomes and reducing health inequalities. This will ensure that public health is at the heart of wide ranging departmental portfolios and central to policy formulation, e.g. in relation to the economy, transport, town planning, housing and the environment, early years, mental health and wellbeing and education (including adult education).

We note that the Healthy Schools initiative is still available across Wales and this could be used as existing infrastructure to tackle childhood obesity. There is also a further opportunity to use the Childhood Measurement Programme as an opportunity to promote local opportunities for physical activity to each family. A bespoke response with nearest parks, play spaces, open space and local clubs is possible from the Local Development Plan and Local Authority work on mapping activity options.

[1] http://www.fph.org.uk/uploads/FPH_14056_FPH%20Manifesto%20FINAL%20low-res.pdf

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Improved cycling and walking routes is another area that should be a priority and some of the work the Health Improvement Group have recently done on cycling and walking could be used in this response too. This is a win-win for climate change and building activity back into people's lives.

FPH further notes that the Welsh Policies of Wellbeing of Future Generations and Social Services and Wellbeing (Wales) Act need to be used as effective levers by Public Health to get the most from them.

Results from the first Welsh Adverse Childhood Experience (ACE) study show that suffering four or more harmful experiences in childhood increases the chances of high-risk drinking in adulthood by four times, being a smoker by six times and being involved in violence in the last year by around 14 times. FPH supports and highlights the ongoing work in this area.

Public Health Wales (PHW) has recently produced key actions to make a difference document (attached with this response) and if all of these things were being done systematically this would have an impact. FPH is keen to support PHW in the wide implementation of these key programmes.

The issue of antipsychotics use in people with dementia is being tackled at the local level in each area. FPH would welcome greater focus and strengthening on this area.

Waiting times continue to be an issue, as they are across the UK, and FPH stresses the importance of return on investment and value for money of prevention. To that end, we urge the Committee to read our response to the Health Select Committee inquiry on Public health post-2013 - structures, organisation, funding and delivery http://bit.ly/28WgY0z, and case study in relation to healthcare public health http://bit.ly/2b8nRsw.

FPH identifies evidence based measures that will have a direct impact on physical activity and health, including the reinstatement of at least two hours per week of physical activity in schools and investment in public and active transport.

However, of equal importance, FPH also identifies indirect measures and upstream legislative action that will be critical to reducing rates of cardiovascular and non-communicable disease, e.g. stopping the marketing of foods high in sugar, fat and salt before the 9pm watershed on TV and tightening of online marketing restrictions; and the introduction of a 20% duty (per litre) on sugar sweetened beverages. FPH is pleased to attach our new Manifesto alongside this submission.

FPH is committed to working with the Welsh government, Public Health Wales, NHS Wales, local government and stakeholders across the field to develop strong evidence based public health policies to improve and protect people's health and wellbeing. FPH is concerned that at present we are, as the Health Select Committee suggests, "losing the fight and simply encouraging a 'normalisation' of obesity." Current voluntary mechanisms to address physical activity are "distracting from prevention and early intervention," – necessary in order to address the current 'obesogenic' environment.

If you require any further information, please contact xxxx, Senior Policy Officer for the UK Faculty of Public Health – xxxx, xxxx

Yours sincerely,

Professor xxxx
President
UK Faculty of Public Health

Appendices:

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FPH has published expert resources on a range of issues connected to the relationship between physical activity and health that demonstrate the importance of an integrated approach to improving people's health, and make recommendations for action to tackle the issues they address.
These position and briefing statements can be found at the following links, and summaries of the recommendations are presented within this response

- The built environment and physical activity briefing statement (pdf)
- The built environment position statement (pdf)
- Food marketing to children (pdf)
- Obesity (pdf) and
- Transport and health position statement (pdf)
- Transport and health briefing statement (pdf)
- Sugar sweetened beverages (pdf)
- Alcohol (pdf)

We furthermore draw the Committee's attention to the comprehensive evidence reviews and published guidance on 'what works' undertaken by NICE, and to the wealth of information known about the impact of obesity and of physical activity on health.

For evidence on physical activity, please refer to the HSE 2012 report chapters on this:
www.hscic.gov.uk/catalogue/PUB13218/HSE2012-Ch3-Phys-act-child.pdf and
www.hscic.gov.uk/catalogue/PUB13218/HSE2012-Ch2-Phys-act-adults.pdf

For evidence on obesity, please see the HSE 2013 report chapters on this:
www.hscic.gov.uk/catalogue/PUB16076/HSE2013-Ch10-Adult-anth-meas.pdf and
www.hscic.gov.uk/catalogue/PUB16076/HSE2013-Ch11-Child-BMI.pdf

In terms of causation & prevention of non-communicable disease, poor diet is more powerful than tobacco, alcohol & smoking combined. [2]Thus, FPH recommends food policy as an area that the Committee may wish to prioritise. Achieving weight control in healthy populations requires work at legislative, policy, and environmental level, with individual interventions, while important, nonetheless not the focus of activity.

FPH emphasises that one of the most important messages is the strong evidence that weight loss programmes do not achieve useful long-term weight loss, as most recently demonstrated by the new Systematic Review commissioned by NICE [3]and discussed in a recent BMJ blog[4] and highlighted by Sarah Boseley in her book *The Shape We Are In*.

FPH notes that for cardiovascular disease prevention, there is clear evidence that the Mediterranean diet, even just a handful of nuts and or liberal consumption of olive oil, is effective[5], and could lead to a rapid 30% reduction in deaths & non-fatal events. Furthermore, this demonstrates that a healthy diet is more powerful than statins.

Finally, within this response, we stress that mental health problems have increasingly been shown to precede, and be important in the recovery from, physical health problems. It is important that this – and the parity of esteem between physical and mental health – is considered by the Health Committee.

Appendix 1 – The Built Environment and Physical Activity:
FPH makes the following recommendations in relation to the built environment and physical activity:

- Physical activity has an important impact on physical and mental health and wellbeing – in particular for children and young people, their educational attainment and future life chances;

[2] Global Burden of Metabolic Risk Factors for Chronic Diseases Collaboration.Lancet Diabetes Endocrinol. 2014 Aug;2(8):634-47. doi: 10.1016/S2213-8587(14)70102-0. Epub 2014 May 16. Cardiovascular disease, chronic kidney disease, and diabetes mortality burden of cardiometabolic risk factors from 1980 to 2010: a comparative risk assessment.
[3] University of Oxford, Weight regain after behavioural weight management programmes
[4] BMJ – Spending Money on Weight Management Services
[5] New England Journal of Medicine, Primary Prevention of Cardiovascular Disease with a Mediterranean Diet

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- It can reduce their risk of chronic conditions in later life such as coronary heart disease, type 2 diabetes, mental health problems and obesity;
- Strong cross-sectoral relationships are needed, including with councillors, planning, regeneration and transport teams in the local authority, local employers and clinical commissioning groups
- Public health must be considered in local plans and strategies including the Local Development Framework, Supplementary Planning Guidance and Sustainable Communities Strategy
- Ensure that built environment and planning are considered in the Joint Strategic Needs Assessment and Health and Wellbeing strategy
- Public health input must be factored in at the earliest stages of planning proposals, and the potential health impacts of proposals must be assessed
- Non mainstream sports that are popular with boys should be promoted such as skateboarding, surfing, free running and martial arts for those who are not interested in team games.
- The recommendations of the FPH Position Statement on Transport must be followed to deliver measures that achieve a shift away from cars in favour of walking, cycling and public transport.

Appendix 2 – Food Marketing to Children

FPH makes the following recommendations in relation to food marketing to children:

- What is defined as high fat, sugar salt (HFSS) foods and drinks must be clearly communicated
- Schools, early years settings, youth, leisure and other settings 'where children gather' must be supported to:
    - discuss the reasons why children need to be protected from the marketing of HFSS foods and drinks
    - develop local food policies so that they are free from all forms of marketing of foods high in saturated fats, transfatty acids, free sugars or salt
- Services commissioned by the NHS and local authorities must not have any marketing of foods that are high in saturated fats, transfatty acids, free sugars or salt, by including this in service specifications
- Stakeholders must be influenced to ensure cultural and sporting activities in the local areas are free from marketing of foods high in saturated fats, transfatty acids, free sugars or salt.
- Enforcement agencies such as environmental health officers and other partners must work together to monitor these actions and explore further opportunities
- Awareness raising and education of the wider public health workforce about the impact of food advertising to children, and the wide range of forms food marketing can take must be made
- Local media can help to advocate the messages

Appendix 3 – Obesity

It is critical to ensure that the right emphasis is placed on prevention, and to that end, the Faculty of Public Health make the following recommendations:

- For Government to consider fiscal and regulatory policies
- Local Directors of Public Health and Health Boards should act as strong advocates for the most effective evidence-based interventions
- Joint strategic needs assessments should reflect the obesity burden in populations
- Health Boards should consider the guidance produced by the National Institute for Health and Care Excellence on obesity, active travel, physical activity and other relevant guidance, and how the guidance should be implemented locally
- Free water must be available in all children's environments, including schools, parks, playgrounds, sports stadia and cinemas
- A ban on all junk food (high in saturated fat, salt or refined sugars) and sugary drink marketing to children must be implemented
- Schools (including academies) and early years environments should abide by the nutritional standards of the Children's Food Trust and the School Food Plan
- Active encouragement of breastfeeding should be made by national and local government
- Policies to increase active travel (cycling and walking), such as lower speed limits, changes to road design, designated cycle routes and cycle storage should be implemented

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- Schools should encourage active travel through policies such as walking – buses, bike storage and cycle training
- All planning permission decisions should take the impact on health into consideration, including through the use of Health Impact Assessments
- Reformulation will also be necessary, to substantially reduce the added sugars hidden in junk food and sugary drinks (Mandatory reformulation consistently works better than voluntary reformulation)
- To inform consumers, we need legislation requiring all manufacturers to adopt the consistent food nutritional labelling system

We draw attention the report by the Academy of Medical Royal Colleges, "*Measuring Up – the medical profession's prescription to the obesity crisis*", which sets out a range of practical recommendations that we would urge the Government to adopt as part of a strategy on the most effective and coherent way to tackle obesity, as set out below:

1. **Education and training programmes for healthcare professionals:** Royal Colleges, Faculties and other professional clinical bodies should promote targeted education and training programmes within the next two years for healthcare professionals in both primary and secondary care to ensure 'making every contact count' becomes a reality, particularly for those who have most influence on patient behaviour

2. **Weight management services:** The departments of health in the four nations should together invest at least £100m in each of the next three financial years to extend and increase provision of weight management services across the country, to mirror the provision of smoking cessation services. This should include both early intervention programmes and, greater provision for severe and complicated obesity, including bariatric surgery. Adjustments could then be made to the Quality and Outcomes Framework, providing incentives for GPs to refer patients to such services

3. **Nutritional standards for food in hospitals:** Food-based standards in line with those put in place for schools in England in 2006 should be introduced in all UK hospitals in the next 18 months. Commissioners should work with a delivery agent similar to the Children's Food Trust to put these measures into place

4. **Increasing support for new parents:** The current expansion of the health visitor workforce in England should be accompanied by 'skilling up' the wider early years workforce to deliver basic food preparation skills to new mothers and fathers, and to guide appropriate food choices which will ensure nutritionally balanced meals, encourage breastfeeding and use existing guidance in the Personal Child Health Record as a tool to support this.

5. **Nutritional standards in schools:** The existing mandatory food- and nutrient-based standards in England should be applied to all schools including free schools and academies. This should be accompanied by a new statutory requirement on all schools to provide food skills, including cooking, and growing – alongside a sound theoretical understanding of the long-term effects of food on health and the environment from the 2014/15 academic year

6. **Fast food outlets near schools:** Public Health England should, in its first 18 months of operation, undertake an audit of local authority licensing and catering arrangements with the intention of developing formal recommendations on reducing the proximity of fast food outlets to schools, colleges, leisure centres and other places where children gather

7. **Junk food advertising:** A ban on advertising of foods high in saturated fats, sugar and salt before 9pm, and an agreement from commercial broadcasters that they will not allow these foods to be advertised on internet 'on-demand' services.

8. **Sugary drinks tax:** For an initial one year, a duty should be piloted on all sugary soft drinks, increasing the price by at least 20%. This would be an experimental measure, looking at price elasticity, substitution effects, and to what extent it impacts upon consumption patterns and producer/retailer responses

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9. **Food labelling:** Major food manufacturers and supermarkets should agree in the next year a unified system of traffic light food labelling (to be based on percentage of calories for men, women, children and adolescents) and visible calorie indicators for restaurants, especially fast food outlets

10. **The built environment:** Public Health England should provide guidance to Directors of Public Health in working with Local Authorities to encourage active travel and protect or increase green spaces to make the healthy option the easy option. In all four nations, local authority planning decisions should be subject to a mandatory health impact assessment, which would evaluate their potential impact upon the populations' health.

We also draw attention to the 2013 report, *Action on Obesity* by the Royal College of Physicians, which found that the response of the NHS to obesity is patchy at best. The Faculty of Public Health supports the RCP's recommendation that multi-disciplinary weight management clinics be made available to cover severe and complex obesity.

The London Healthy Schools programme is doing an important job of ensuring the Children's Food Trust nutritional standards are met in London's schools which mean that schools meet the FPH's position. The Healthy Schools programme should be continued.

Appendix 4 – Transfats

FPH remains deeply concerned by the substantial on-going health risks presented by IPTFAs. We strongly recommend that these hazards should be controlled through proportionate and cost-saving legislative measures for which there are international precedents, including the Austrian, Danish, Icelandic, Swedish and Swiss models.

Transfats are a poisoner of people and a creator of obesity and therefore likely to negatively impact on active lifestyles – with the impacts felt more acutely among the poorest and most vulnerable societal groups.

As demonstrated by the Hierarchy of Effectiveness, "upstream" interventions, (such as legislation) will usually have bigger population benefits than piecemeal local and "downstream" interventions. Hence the NICE guidance on the Prevention of Cardiovascular Disease in Populations (2010), which calls for the "elimination of IPTFAs for human consumption"[6].

FPH is therefore concerned by the likely marginal impact of the current approach, voluntary Responsibility Deal (RD) interventions trying to tackle the harms caused by a substance declared toxic in 2009 by the WHO[7], and described as a "significant health hazard" by NICE in 2010[8]. The absence of robust evaluation mechanisms to assess the progress of the RD is a further concern.

We are also that the Government simply view Transfats as "within current UK recommendations",[9] thus implying that IPTFAs can therefore be ignored. This is wrong for two reasons. Firstly, there is no safe minimum level of IPTFAs. Secondly, even if population average levels are considered acceptable, this ignores important strong socio-economic and demographic gradients – particularly among young, deprived and ethnic minority sub-groups.

It is absolutely critical that all societal groups are protected and the social determinants of health and health inequalities are robustly factored into Government policy on IPTFAs. Yet the most recent Low Income Diet & Nutrition Survey (LIDN) in 2007 indicated that the most deprived 2.5% of the UK population consume over 2.6% of their dietary energy intake from IPTFAs[10]. This group is likely to include a substantial and disproportionate number of deprived children, young people and ethnic minority groups, thus compounding existing health inequalities already suffered by these groups.

[6] NICE, *Public Health Guidance 25: Prevention of Cardiovascular Disease*, June 2010 <http://www.nice.org.uk/nicemedia/live/13024/49273/49273.pdf>, P.10 (Accessed 24 May 2013)
[7] WHO *Scientific Update on trans fatty acids (TFA)* European Journal of Clinical Nutrition, Volume 63, (Supplement 2), May 2009
[8] NICE, *Public Health Guidance 25: Prevention of Cardiovascular Disease*, June 2010 <http://www.nice.org.uk/nicemedia/live/13024/49273/49273.pdf>, P.10 (Accessed 24 May 2013)
[9] Department of Health, Woodeson, Liz, *Artificial Trans Fats: Briefing Note*, 17 December 2012
[10] Food Standards Agency, *Low Income Diet and Nutrition Survey*, 2007, <http://www.food.gov.uk/multimedia/pdfs/lidnssummary.pdf> (accessed 24 May 2013)

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FPH urges the Government to consider again building on the successful international precedents, and implementing the effective, proportionate and cost-saving legislative mechanisms available to address this critical health issue.

Appendix 5 – Transport and Health
FPH makes the following recommendations in relation to transport and health:

- Local MPs and councillors should implement policies which will deliver a shift away from cars in favour of walking, cycling and public transport
- Local authority transport planning teams should identify ways of working stakeholders to deliver a shift away from cars in favour of walking, cycling and public transport
- NHS travel plans should be developed and implemented which deliver a shift away from cars in favour of walking, cycling and public transport
- Good practice, including reducing the need to travel, should be disseminated nationally and locally
- The potential health impacts (including effects on inequalities) of local and regional transport policies and major transport projects must be assessed
- Local authority planners must work collaboratively with other key partners on new residential developments to ensure that the most convenient, sustainable, active and affordable option for short journey stages will be walking and cycling, and for longer journey stages cycling and public transport
- Work should be undertaken by healthcare providers to promote active travel as a convenient and sustainable means of maintaining good health and recovering from illness
- In England, use Health and Wellbeing Boards and local health and wellbeing strategies should include and promote public health and active travel, as well as influence planning and transport policies
- Activity to integrate public health considerations into the design, delivery, adaption and maintenance of the built environment should be undertaken.

Appendix 6 – The relationship between mental health and wellbeing and physical health
At the outset, FPH draws attention to the Royal College of Psychiatrists resource, *Physical Activity and Mental Health*[11] which underscores the strong and positive relationship between physical activity and mental health. Some general principles are set out as follows:

- Physical activity promotes mental health and wellbeing and prevents mental illness
- Fruit and vegetables consumption is very likely to promote mental health and wellbeing too [12]
- Mental health and wellbeing are important for developing and maintaining healthy lifestyles because they support agency, autonomy and motivation
- Mental health and wellbeing is important in the prevention of a range of chronic illnesses and in preventing premature mortality

Mental health is vital to public health; mental wellbeing is profoundly important to quality of life and the capacity to cope with life's ups and downs. It is protective against physical illness, social inequalities and unhealthy lifestyles. There are now a large number of evidence-based approaches to promoting mental wellbeing and preventing mental illness, and these are growing daily. FPH draws attention to our own resource on mental health and wellbeing, which contains many relevant and useful tools to empower individuals and communities: http://www.fph.org.uk/better_mental_health_for_all

We can empower individuals and use community assets to enable them to improve their own health by building on the recommendations of the Marmot review in understanding and building on the growing body of evidence which builds resilience, reduces material inequality and supports the development of social, cultural, community – and individual capital http://www.instituteofhealthequity.org/projects/fair-society-healthy-lives-the-marmot-review

[11] RCPsych, Physical Activity and Mental Health http://www.rcpsych.ac.uk/healthadvice/treatmentswellbeing/physicalactivity.aspx
[12] See for example Saverio Stranges, Preshila Chandimali Samaraweera, Frances Taggart, Ngianga-Bakwin Kandala, Sarah Stewart-Brown Major health-related behaviours and mental well-being in the general population: the Health Survey for England BMJ Open 2014;4:e005878 doi:10.1136/bmjopen-2014-005878 and the quoted refs

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Evidence that there is a strong relationship between mental and physical health has been accumulating over the last few decades. This challenges firmly held attitudes and beliefs in both health care and public health about the mind-body dichotomy [13] [14] in which mental and physical health are seen as separate. Further progress on the physical aspects of public health is likely to depend on changing these attitudes and beliefs, and the development of new interventions and programmes which take this evidence into account.

Mental health problems have increasingly been shown to precede, and be important in the recovery from, physical health problems. For example, the Whitehall Study showed that emotional health, especially negative affect – a general tendency to report 'distress, discomfort, dissatisfaction, and feelings of hopelessness' – predicts the onset of heart disease and recovery from infarcts independently of other risk factors.[15]

Psychological distress is also a risk factor for stroke.[16] For people with a diagnosis of severe mental illness such as depression, the risk of physical illness is high: 46% of people with a mental health problem have a long-term physical health problem such as coronary heart disease or COPD. [17]

Mental illness also increases the risk of cancer,[18] musculoskeletal problems like back pain [19] and psychosomatic problems like irritable bowel [20] and possibly a range of other diseases.[21] Death rates are also higher in people with mental illness compared to people without mental illness, especially deaths from cardiovascular, respiratory and infectious diseases. [22]

Diagnosis of neurotic disorder (mental illness that falls short of psychosis) in general practice increases mortality over the next 11 years by 70% and a self-report of depression in population studies increases mortality by 50%. [23] People with psychotic disorders die on average 25 years earlier than the general population. [24]

People with physical health problems, especially chronic diseases, are at increased risk of poor mental health, particularly depression and anxiety – around 30% of people with a long-term physical health condition also have a mental health problem. [25]In some cases, depression appears to result from specific biological effects of chronic illness.

Examples of this relationship include links between depression and central nervous system disorders such as Parkinson's disease, cerebrovascular disease, or multiple sclerosis, as well as endocrine disorders, such as hypothyroidism.

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[14] Kendell RE. The distinction between mental and physical illness. The British Journal of Psychiatry 2001;178(6): 490-493.

[15] Nabi H, Kivimaki M, De Vogli R, Marmot MG, Singh-Manoux A. Positive and negative affect and risk of coronary heart disease: Whitehall II prospective cohort study. BMJ 2008; 337:a118. (doi): p. 10.1136/bmj.a118.

[16] Surtees P, Wainwright NW, Luben RN, Wareham NJ *et al*. Psychological distress, major depressive disorder, and risk of stroke. Neurology 2008; 70(10): 788-94. do10.1212/01.wnl.0000304109.18563.81.

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[18] Kroenke CH, Bennett GG, Fuchs C, Giovannucci E et al. Depressive symptoms and prospective incidence of colorectal cancer in women. American Journal of Epidemiology. 2005; 162: 839-848.

[19] Larson SL, Clark MR, Eaton WW. Depressive disorder as a long-term antecedent risk factor for incident back pain: a 13-year follow-up study from Baltimore Epidemiological Catchment Area Sample. Psychological Medicine. 2004; 34: 211-219.

[20] Ruigomez A, Garcia Rodriguez LA, Panes J. Risk of irritable bowel syndrome after an episode of bacterial gastroenteritis in general practice: influence of comorbidities. Clinical Gastroenterology & Hepatology. 2007; 5: 465-469.

[21] Prince M, Patel V, Saxena S, Maj M, Maselko J, Phillips MR *et al.* Global mental health 1– no health without mental health. The Lancet 2007; 370:859-877. doi:10.1016/S0140-6736(07)61238-0

[22] Osborn D. The poor physical health of people with mental illness. West J Med 2001; 175(5): 329-32.

[23] Mykletun A, Bjerkeset O, Dewey M, Prince M *et al*. Anxiety, depression and cause-specific mortality: the HUNT study. Psychosomatic Medicine 2007; 69(4):323-331.

[24] Parks J, Svendsen D, Singer P, Forty ME. Morbidity and mortality in people with serious mental illness. National Association of State Mental Health Programme Directors, Technical report No: 13, 2006.

[25] Naylor C, Parsonage M, McDaid D, Knapp M, Fossy M, Galea A. The King's Fund and Centre for Mental Health. 2012.

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In other cases, the association between depression and chronic illness appears to be mediated by behavioural mechanisms, the limitations on activity imposed by the chronic illness leading to gradual withdrawal from rewarding activities.[26] Mental health problems can also increase the overall burden of illness in patients with chronic medical conditions, including the need for healthcare services.

For example, compared with those without depression, medical outpatients with depressive symptoms experienced decrements in quality of life [27] and had almost twice as many days of restricted activity or missed work because of illness.[28] Compliance with treatment for physical health conditions can also be an issue, with depression increasing the risk of non-compliance with treatment recommendations three fold. [29]

Mental health problems associated with physical illness can increase healthcare costs by more than 45% according to some international studies, which, if applied to NHS expenditure could mean that £8-13 billion of long-term physical health care costs are due to poor mental health. [30]

Treatments for mental illness such as anti-psychotic medications have been shown to increase the risk of physical ill-health. [31]More recent evidence has shown that despite the high risk of physical ill-health, people with mental health problems have less access to preventative and early interventions for physical illness including coronary angioplasty [32], [33] and may suffer discrimination in healthcare systems. [34]

The unhealthy lifestyles and behaviours which plague the public's health – smoking, excess alcohol consumption, misuse of illicit drugs, consumption of, sugary foods and over-eating in general – are used because they are effective in managing stress. For example, eating carbohydrates increases serotonin levels, which may boost mood.[35] People find it very difficult to stop these behaviours because they can be addictive.

Other factors like social norms, availability, price and legality also play a role and provide important opportunities for regulation, but a key reason most people find it difficult to change their lifestyle is because the lifestyle assuages emotional distress.

- Almost 50% of all tobacco is now smoked by people with mental illness [36]
- Obesity is more prevalent among people with mental illness [37]
- Alcohol and drug misuse are commonly associated with mental illness [38]
- Mental health problems in childhood predict the adoption of unhealthy lifestyles in adolescence. [39]

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Healthy foods, particularly it would seem fruit and vegetable consumption up to eight portions a day, [40] [41] can positively affect mental as well as physical health. Levels of physical activity can also impact on mental wellbeing in terms of mood, stress, self-esteem, anxiety, dementia and depression. [42]Current NICE guidance recommends the use of structured physical activity in the treatment of depression. [43]

Emerging evidence suggests that improving mental wellbeing can contribute substantially to improving physical health, reducing morbidity and mortality. [44] [45] [46] [47] [48] For example, a meta-analysis found that positive mental well-being including positive affect (eg. positive mood, joy, happiness, vigor, energy) and positive trait-like dispositions (eg. life satisfaction, hopefulness, optimism, sense of humor) were significantly associated with reduced cardiovascular mortality in healthy populations, and with reduced death rates in patients with renal failure and with HIV (human immunodeficiency virus) infection. [49]

An association between positive affective traits and lower morbidity, decreased symptoms and pain has also been demonstrated. [50]Other studies have also shown that mental wellbeing can extend survival in cancer and renal disease. [51] [52]

Conversely, negative affective styles such as anxiety and hostility have been shown to predict increased risk for illness and mortality. [53] [54] Thus, public mental health interventions to promote mental wellbeing can work in conjunction with other public health interventions focused on behaviour change and risk factor reduction to improve physical health.

Social wellbeing – distinct from but interlinked with, and often incorporated into definitions of, mental wellbeing – can also affect physical health and is relevant here. A seminal study from 1979 found that relationships with others – partners, family and friends and to a lesser extent more formal social groups – reduced the risk of mortality. [55]More recent work reinforces the impact of the social context on health. [56]For

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example, a study in Wales showed that neighbourhood social capital is linked to the health of individuals within that neighbourhood. [57]

At present services are provided to address mental health issues independently from services to address unhealthy lifestyles, and although lifestyle interventions are increasingly informed by psychological insights, they do not aim to promote mental health and wellbeing as an important part of the treatment package. Lifestyle change programmes could be more successful if they focused as much on mental health as they did on lifestyles and the interplay between the two. [58]

Good evidence exists for a range of public mental health interventions across the lifecourse that could be commissioned to promote mental wellbeing, encourage a healthy lifestyle and prevent chronic disease and mental illness. [59]

Robust evidence of effectiveness exists for public mental health interventions aimed to give children a good start in life. This is also an opportune time to intervene as 75% of mental illness starts before the age of 25 years [60] and many health risk behaviours such as smoking and substance misuse start in childhood, having a long-lasting adverse effect.

Interventions include a wide range of options to help people 'live well', promote mental health, and prevent the adoption of health risk behaviours, such as targeted approaches for smokers with mental disorder or physical activity programmes for those with depression.

Evidence-based interventions include physical activity to improve mental functioning, reduce mental illness, decrease social isolation and improve wellbeing in older peoplethe elderly, [61]and addressing physical disabilities including hearing loss to improve quality of life and reduced social isolation. [62] [63]

Resources on the relationship between physical and mental health:

- Improving physical and mental health website jointly established by the Royal College of Psychiatrists and the Royal College of General Practitioners;
- Physical Health Project by Rethink.
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Appendix 7 – Alcohol

FPH underscores the contribution of alcohol-derived calories to the alcohol-obesity relation, and notes the clear positive association between alcohol calories and obesity, and that alcohol calories are likely to be a significant contributor to the rise in obesity.[64]

Accordingly, FPH has called for health warnings to be printed on alcohol labelling to give people more information about the risks of drinking. There is evidence that such a move would increase people's knowledge about the potential harm alcohol can cause. It would also make it easier for people to understand the need for minimum pricing per unit of alcohol, which FPH supports.

These health warnings would help educate the public and give them key information before they decide to buy a can or bottle of alcohol. The evidence linking alcohol to over 60 medical conditions is unarguable, so we need factual, not sensational, warnings to help the public understand the risks. People don't realise that drink is associated with a whole range of health harms and has potential long-term implications.

The Faculty of Public Health is a member of the Alcohol Health Alliance UK, and strongly supports the introduction of a minimum unit price per unit. This policy powerfully addresses the growing burden of alcohol harm including liver disease, dementia, violence and accidental injury.

FPH also advocates that licensing authorities must be empowered to tackle alcohol-related harm by controlling total availability for alcohol in their jurisdiction; and that all alcohol advertising and sponsorship should be prohibited. In the short term, alcohol advertising should only be permitted in newspapers and other adult press. Its content should be limited to factual information about brand, provenance and product strength.

Finally, FPH notes that predispositions to addictions, e.g. alcohol and tobacco, are likely to reduce the likelihood of physical activity.

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