audience. We also collect valuable information about what would facilitate the work of staff at a system level and are able to feed this back to policy and decision-makers. However, given the time-limited nature of our work, we are at present not able to track progress over the longer term. We are keen to further develop approaches to evaluating outcomes and influence over time, and to build research capacity in countries to enable them to undertake such long-term evaluations of outcomes.

However, there are a number of valuable examples of the influence Maudsley International's work has had internationally. Programmes delivered by Maudsley International have raised awareness of mental health priorities at national, regional and local levels, and have influenced policy revision (Loukidou *et al*, 2013a) and implementation (Sharkey, 2017). Making the involvement of patients and carers a necessity has also been attributed to the work of Maudsley International (Loukidou *et al*, 2013b). Maudsley International hosted the FundaMentalSDG project, which has resulted in the United Nations including mental health-related targets and indicators in its sustainable development goals (Agenda2030) for the first time (Votruba *et al*, 2016). The development of an e-programme to support international careers for psychiatrists working in global mental health has been another contribution of Maudsley International (Eaton *et al*, 2015).

Throughout its 10 years, Maudsley International has acquired extensive experience and shared learning regarding the benefits and problems of mental health service system development, and working with organisations and individuals to develop and sustain comprehensive mental healthcare. Following recent calls for – and the development of – a greater number of implementation programmes in global mental health (Kleinman, 2013; De Silva & Ryan, 2016), Maudsley International's activities bridge the gap between mental health research, strategy and service development, by supporting implementation programmes with evidence-based methods and tools.

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EDITORIAL

Public mental health: key challenges and opportunities

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Public mental health involves a population approach to mental health, and includes treatment of mental disorder, prevention of associated impacts, prevention of mental disorder and promotion of mental well-being, including for those people recovering from mental disorder. Such interventions can result in a broad range of impacts and associated economic savings even in the short term. However, even in high-income countries only a minority of people with mental disorder receive any treatment, while provision is far less in low- and middle-income countries. Coverage of interventions to prevent mental disorder and promote mental well-being is far less even in high-income countries, despite such interventions being required for sustainable reduction in the burden of mental disorder. This implementation gap results in a broad set of impacts and associated economic

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costs. Mental health needs assessments represent an important framework and mechanism to address this implementation gap – in low- and middle-income as well as high-income countries. Training and support to perform mental health needs assessments is important, as is the use of information derived from such assessments to more effectively advocate for the required level of resources to address the implementation gap. Such a public health approach to mental health represents an opportunity for psychiatrists to advocate more effectively for resources at both the local and national level. This can improve the coverage and outcomes of a range of public mental health interventions that result in broad impacts and associated economic savings, which can be estimated.

Impact of mental disorder and well-being

The proportion of disease burden due to mental disorders and self-harm, as measured by years lived with disability, is 22.0% globally, 24.4% in Europe and 23.6% in the UK (WHO, 2016). Such a large impact occurs for several reasons (Campion *et al*, 2012; Campion, 2013). First, mental disorder is common, with a 12-month global prevalence of 9.8–19.1% for anxiety, mood, externalising (attention-deficit hyperactivity disorder, oppositional defiant disorder and conduct disorder) and substance use disorders and 0.8–6.8% for serious mental illness (Kessler *et al*, 2009), with rates varying by region and country. Second, most lifetime mental disorder arises before adulthood and then often recurs across the life course. Third, a broad range of impacts of mental disorder include suicide, health risk behaviour, physical illness, 10–20-year premature mortality, poorer education and employment outcomes, stigma, crime and violence. Taking the example of smoking, which is the single largest cause of preventable death, 43% of smokers aged 11–16 in the UK have either an emotional or conduct disorder, while 42% of adult tobacco consumption in England is by people with mental disorder.

Mental well-being also has a broad range of important impacts across health, health risk behaviours, education, employment and crime (Campion *et al*, 2012; Campion & Fitch, 2015), although well-being levels vary across regions and countries. People with poor mental well-being are at several fold increased risk of mental disorder (McManus *et al*, 2016).

Public mental health interventions

A range of cost-effective interventions exist to treat mental disorder, prevent associated impacts, prevent mental disorder from arising and promote mental well-being (Campion *et al*, 2012; Campion & Fitch, 2015). Such interventions can also be divided into primary, secondary and tertiary levels of mental disorder prevention and mental well-being promotion. Interventions are provided by different sectors, including primary care, secondary care, social care, public health and other providers.

Primary prevention addresses risk factors for mental disorder. Particularly important risk factors to address include socioeconomic inequalities (Campion *et al*, 2013), parental mental disorder (Campion *et al*, 2012) and child adversity, the last of these accounting for 30% of adult mental disorder (Kessler *et al*, 2010). Dementia prevention can occur through various interventions, including treatment of hypertension (Campion *et al*, 2012; Campion & Fitch, 2015). Secondary prevention involves early intervention for mental disorder to treat it and prevent its progression. Childhood and adolescence is the period that provides the greatest opportunity for early treatment, given that most lifetime mental disorder arises before adulthood; delivery of secondary prevention initiatives in childhood and adolescence can thus prevent a proportion of adult mental disorder and associated suicide. Tertiary prevention involves intervention for people with established mental disorder to prevent relapse and associated outcomes such as health risk behaviour, physical illness and premature mortality.

Primary promotion involves promoting protective factors for mental well-being across the population, including physical activity, adequate housing, education, employment and meaningful activity (Campion *et al*, 2012; Campion & Fitch, 2015). Secondary promotion involves early intervention to promote protective factors for mental well-being in people with poor mental well-being. Tertiary promotion involves activities to promote the mental well-being of people with long-standing poor mental well-being.

Particular groups are at higher risk of mental disorder and poor well-being (Campion *et al*, 2012; Campion & Fitch, 2015), and these require proportionately greater levels of intervention to prevent widening of inequalities (Campion *et al*, 2013). Examples of child and adolescent higher-risk groups include children with intellectual disability and/or physical illness, with a parent with mental disorder, and looked-after children (i.e. those in the care of the state). Examples of adult higher-risk groups include particular Black and minority ethnic groups, homeless people, prisoners and people with learning disabilities. While higher-risk groups benefit more from prevention strategies, larger groups of people at less elevated risk also benefit.

Public health campaigns and media and digital marketing of resources can improve the mental health literacy of the population to facilitate early recognition and treatment of mental disorders (Campion & Fitch, 2015). Similar approaches to address the stigma associated with mental disorder can increase the numbers of individuals seeking treatment, facilitate earlier presentation, prevent

relapse and support improved resourcing for public mental health interventions. Such information campaigns need to be directed towards groups such as children and young people, parents, teachers and health professionals, particularly those in primary care.

Public mental health related policy

Many mental health policies are adopting a public mental health approach. For instance, the objectives of the UK's 2011 mental health strategy (HMG, 2011) include the prevention of mental disorder and promotion of mental well-being. Similarly, the World Health Organization's 2013 mental health action plan (WHO, 2013) highlights the need to promote mental well-being and prevent mental disorder, as well as treatment and prevention of associated outcomes. More recently, the 2016 United Nations Sustainable Development Agenda (UN, 2016) committed to the treatment and prevention of non-communicable disease, including mental disorder, and the promotion of mental well-being.

Public mental health intervention gap

Despite the existence of cost-effective evidence-based treatments (Campion *et al*, 2012; Campion & Fitch, 2015) and public mental health relevant policy, only 10% of people with mental disorder across the European Union received notionally adequate treatment (Wittchen *et al*, 2011), with coverage far poorer in low- and middle-income countries (WHO, 2015). There is even less coverage of effective interventions to prevent associated impacts of mental disorder such as health risk behaviour and physical illness. This implementation gap results in not only suffering to affected individuals and their families but also a broad range of associated impacts and economic costs. Furthermore, there is almost a complete lack of interventions to prevent mental disorder or promote mental well-being at a primary level even in high-income countries. This is important because a sustainable reduction in the disease burden from mental disorder can be achieved only with such interventions (Campion *et al*, 2012). Lack of access to public mental health interventions also represents a denial of the right to health (Bhugra *et al*, 2015; Campion & Knapp, 2018).

The reasons for the implementation gap include lack of financial and human resources, mental health services (WHO, 2015), mental health literacy and public mental health knowledge (Campion *et al*, 2017). Many countries still lack a mental health policy (WHO, 2015), although even when such policies are present, they are not implemented to the required scale. Systematic discriminatory attitudes towards mental health underlie many of these factors (Campion *et al*, 2012; Campion, 2013).

Public mental health practice to address the gap

The population impact of public mental health interventions depends on their coverage and outcomes. Public mental health practice can support improved provision in four steps. The first involves assessment of the size, impact and cost of unmet need for effective public mental health interventions at local, regional or national level, as well as the impact and estimated economic savings from improved provision (Campion, 2013; Campion *et al*, 2017; Campion & Knapp, 2018). This is followed by the use of such information to inform strategic development, commissioning plans, required resources, inter-agency coordination and wider advocacy to improve the coverage of effective public mental health interventions. The third step involves implementation at population level, with each level of prevention and promotion (as outlined above) requiring different interventions from different organisations. Finally, the coverage and outcomes of the interventions require evaluation to inform further implementation.

Assessment of the local, regional and national levels of unmet public mental health need (step 1) is important because of substantial variation in the levels of unmet need. Assessment of mental health need requires information on (Campion *et al*, 2017):

(a) Prevalence of mental disorder and poor well-being
(b) Prevalence of risk and protective factors
(c) Proportion of the population from different higher-risk groups
(d) Coverage and outcomes of public mental health interventions
(e) Estimated economic costs of mental disorder to the health and other sectors
(f) Estimated size, impact and cost of the gap in provision of public mental health interventions
(g) Expenditure on different types of public mental health intervention
(h) Estimated economic savings to different sectors from improved coverage of different public mental health interventions.

In the UK, the public health sector carries out this task (Campion, 2013), although psychiatrists can also play an important role (Royal College of Psychiatrists, 2010). Unfortunately, mental health is poorly covered in needs assessments. There are several reasons for this, including lack of relevant public health training, which perpetuates the implementation gap (Campion *et al*, 2017). However, mental health needs assessments carried out by the author have supported inclusion of mental-health-relevant information highlighted above across many local authorities in England. This, in turn, has supported inter-agency coordination, strategic development and commissioning decisions. Such assessment is also required at national level to inform transparent

decisions about acceptable levels of intervention coverage and required resource (Campion & Knapp, 2018). Since most professionals from national policy, commissioning, public health, primary care, secondary mental health care and social care sectors are unaware of the size, impact and cost of different levels of public mental health unmet need, this perpetuates the poor coverage and coordination of public mental health interventions. Targeted training and support to improve public mental health practice will help address this important issue.

Conclusion

Cost-effective public mental health interventions exist which result in a broad range of outcomes and economic savings even in the short term. Only a minority of the people who would benefit from such interventions actually receive them; this failure to implement public mental health interventions according to population need results in a broad range of impacts, including human suffering and economic costs. Mental health needs assessments represent an important framework and mechanism to address the implementation gap, including in low- and middle-income countries. Assessment of the size, impact and cost of the intervention gap at both national and more local levels is a key part of public mental health practice to support improved coverage of public mental health interventions, which both reduces the burden of mental disorder and improves population mental well-being. Training and support to perform such assessments is important, as is the use of such information to highlight more effectively the broad impacts and associated economic savings of improved coverage, particularly in view of inadequate public mental health resource. This approach facilitates advocacy for the required level of resources to address the implementation gap.

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EDITORIAL

A call for more evidence-based practice

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Our theme this month concerns the burgeoning call for the provision of evidence-based practice (EBP) in low- and middle-income countries (LMIC). It is worth remembering that EBP is not universally accepted by the psychiatric profession. For instance, there is still controversy about