



# A Public Health Response to Mental Health 39

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## Abstract

There is a high global burden of mental health disorders that is widely acknowledged, and the increasing demand on services coupled with insufficient funds and capacity in existing services calls for a more joined-up approach to better support children and young people (CYP). This chapter provides an overview of a suggested public health response to address the increasing burden of mental health disorders globally.

The ► [Chap. 38, “Mental Health Strategy and Policy”](#) provides information about developing services in Low and Middle-Income Countries (LMICs) and the

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challenges that arise. This chapter considers key approaches and strategies that can be adopted to assure the global need for child and adolescent mental health services is met and key considerations in planning services and determining the most appropriate response.

There has been global recognition of the importance of mental health and well-being in the last decade. The UN Sustainable Development Goals (SDGs), particularly Goal 3, relate to overall health and well-being for all at all ages (Saxena et al., 2015). The World Health Organisation's (WHO) MH Action Plan (Saxena et al., 2015) was a milestone for mental health, putting international focus on a long-known but previously neglected problem. It aims to (1) strengthen effective leadership and governance for mental health; (2) provide comprehensive, integrated, and responsive mental health and social care services in community-based settings; (3) implement strategies for promotion and prevention in mental health; and (4) strengthen information systems, evidence, and research for mental health (WHO, Draft comprehensive mental health action plan 2013–2020.Pdf, pp 1–27, 2013). Through an increased focus on whole population mental health promotion, mental disorder prevention, and early intervention, the future cost and impact can be reduced (Campion, Public mental health: evidence, practice and commissioning. Royal Society for Public Health, May 2019).

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**Keywords**

Global mental health · Public health · Community-based · School-based

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**Introduction**

By taking a public health approach, this chapter will outline key areas for consideration in developing services to support CYP MH. The Centers for Disease Control and Prevention (CDC) developed public health emergency management (PHEM) principles to help nations strengthen public health emergency management. These principles can be applied to mental health as they provide guidance around anticipating, preventing, preparing for, detecting, responding to, controlling, and recovering from consequences of public health threats in order to minimize health and economic impacts. PHEM principles can be employed to guide the development of services to support CYP mental health and prevent disorder. The global burden of mental illness accounts for 32.4% of years lived with disability (YLDs) and 13.0% of disability-adjusted life-years (DALYs), which is more than previously has been estimated (Vigo et al. 2016). The increasing rates of mental health difficulties and likely underestimated global burden of mental health make mental health a priority, if not a public health emergency. Multiagency working, evidence-based strategies, sharing of information, clear guidance and communication of key messages, and coordinated implementation of intervention/services are therefore crucial to planning services.

## The Need

Globally, there are increasing rates of mental health problems in children and young people (Kieling et al. 2011; Moffitt 2009; Prince et al. 2007). This is confounded with the fact that despite the high level of need, there is a considerable treatment gap – CYP with the highest level of need are the least likely to access services, and only a minority of people with mental disorder receive treatment (WHO 2018). For many of those who do receive treatment, the treatment is minimally adequate (Thornicroft et al. 2017). In 2004, only 30–40% of children and young people in the UK who experienced clinically significant mental disorder were offered evidence-based interventions at the earliest opportunity (Green et al. 2005). The treatment gap is likely due to a range of factors such as stigma, lack of detection, limited help seeking and awareness, poor mental health literacy, perceived need (Campion 2019), lack of clinical skills, negative attitudes toward treatment, low-quality treatment, as well as discrimination, and availability of services. In addition there is a public mental health implementation gap due to lack of public mental health knowledge and training, lack of targeted policy, inadequate resource allocation, and limited understanding of the unmet need (Campion 2019). Overburdening of clinical professionals, staff shortages, lack of mental health policy, and not meeting thresholds for services are all barriers to accessing services. These issues are exacerbated in low-income settings (Omigbodun 2008), and children from low SES backgrounds are at higher risk than those from high SES backgrounds (Spencer et al. 2015). Therefore, the development of any services to support CYP needs to address these challenges and take into consideration at-risk groups to better support CYP.

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## Innovation and Scale-Up of Services

Since the Lancet Commission in 2007 (Lancet Global Mental Health Group et al. 2007; Prince et al. 2007) calling for action in relation to mental health, there have been a number of calls to scale-up services in order to treat, detect, and support the recovery of CYP with mental health disorders. The WHO made three key recommendations for the policy, planning, and service organization: (1) to deinstitutionalize mental health care; (2) to integrate mental health into general health care; and (3) to develop community mental health services (WHO 2010). The WHO's Movement for Global Mental Health (MGMH) has called for scaling up curative mental health services, particularly in low-resource settings drawing on evidence-based and human rights-based principles. The most recent Lancet Commission in 2018, 12 years after the first, also calls for a scaling up of services (Patel et al. 2018); Box 1 highlights four key innovations in global health interventions that should be scaled up. A number of challenges related to the treatment and implementation gaps need to be addressed for a scaling up of services to be feasible, such as stigma, mental health literacy, negative attitudes toward treatment, and treatment quality (Campion 2019). In addition, scaling up needs to go beyond reactionary services and include preventative services as well.

**Box 1 (Patel et al. 2018)****Four innovations in global mental health interventions should be scaled up:**

- Task sharing of psychosocial interventions to nonspecialized workers as the foundation of the mental health-care system
- Coordination of this foundation with primary and specialist care to achieve a balanced model of care
- Adoption of digital platforms to facilitate the delivery of interventions across the continuum of care
- Implementation of community-based interventions to enhance the demand for care

The sections below will discuss how these innovations can be implemented and the challenges overcome particularly in regard to policy, task sharing, setting-based approach, and multiagency working, drawing on and contributing to evidence-based practice.

The Lancet Commission makes key recommendations as to how to reframe mental health needs within the sustainable development framework so that (1) mental health is recognized as an essential component of universal care coverage, (2) mental health is protected with public policies and care frameworks, (3) there is strengthened public awareness of and engagement with people with mental disorders, and (4) enhanced investments are made for mental health, innovation, and implementation guided by research which will strengthen monitoring and accountability for global mental health (Patel et al. 2018). Box 2 describes the aspects of mental health care deemed pioneering by the Lancet Commission.

**Box 2 (Patel et al. 2018)****Aspects of mental health care that are pioneering across the whole of health care:**

- The reconfiguration of care away from hospitals and into community settings
- A commitment to involving patients and family members in planning and providing services
- Providing aspects of social interventions alongside psychological and pharmacological treatments tailored to the needs of a specific individual (the hallmark of person-centered care) through multidisciplinary teams
- A focus on comorbidity and multimorbidity across mental and physical long-term conditions

## Policy-Based Approaches

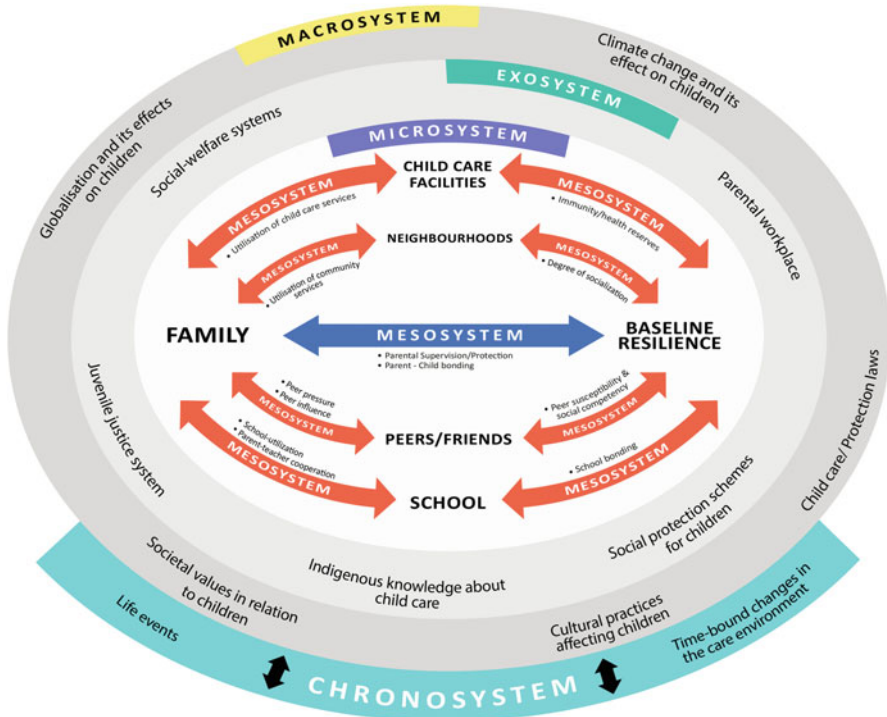
Despite mental health taking a more prominent role globally since the 2007 Lancet series “No health without mental health” and a number of other global initiatives (e. g., MH Action Plan and WHO MHGap), few WHO member states have mental health policies. Of the 177 WHO member states that completed the most recent Atlas questionnaire (91% of total), only 48% have developed or updated their policies or plans for mental health in line with international and regional human rights instruments (Hanna et al. 2018). Clear mental health policies are vital to planning services and creating a public mental health agenda locally.

There are numerous social determinants of mental health and well-being (as highlighted in ► Chap. 38, “Mental Health Strategy and Policy”) which have cultural influences and variations (Canino and Alegria 2008) and need to be reflected in local mental health policies. A biomedical model treats mental health disorders as having a biological, organic, or physical cause, focusing on genetics, neurotransmitters, neurophysiology, etc., and relies heavily on diagnostic criteria for the classification of disorders (Andreassen 1985). The Biopsychosocial model recognizes the interaction of a person and their environment and that mental health difficulties arise from the interaction of biological, psychological, and social factors (Engel 1977). Psychological mediation models build on the biopsychosocial model and propose that the disruption or dysfunction in psychological processes can be the final determinant in the development of mental disorder as the biological, social, and individual factors act on psychological factors concurrently (Kinderman 2005, 2009). There is emerging evidence that an integrated approach supports multi-agency- and community-based approaches to mental health support and provides better support to complex needs (Naylor et al. 2017). There has also been a push to move away from diagnostic models which may be harmful and to focus on alternative evidence-based models (Timimi 2014). Appropriate models should be considered in policy and planning, as cultural factors need to be considered.

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## A Whole Systems Approach

Mental health policies need to take in the wider system around the child and be culturally appropriate. Atilola adapted Bronfenbrenner’s ecological model (Fig. 1) to take into account the care system around a child (Atilola 2017). Although developed with the sub-Saharan African context in mind, this theoretical methodology can be useful to conceptualizing the development of mental health policies and services globally. Tackling risk factors for mental disorder such as parental factors (e.g., poor attachment, poor-quality relationship, parental mental disorder) and childhood adversity are key to promoting mental health and well-being (Campion 2019). Services that are family centered and community based, engage youth, and are culturally sensitive will be most conducive to creating a supportive environment for CYP (see ► Chap. 38, “Mental Health Strategy and Policy”). A setting-based approach can facilitate the consideration of the care system around the child.



**Fig. 1** Ecological care environment of children from mental health perspectives, adapted from Bronfenbrenner's ecological model. (Adapted from Atilola 2017)

A whole systems approach is conducive to a stepped care model in which access to services gradually increases access with severity of difficulties; low-level difficulties could rely on self-help-type interventions, those with moderate difficulties receive support in community settings, and those with more severe difficulties would see a specialist or psychiatrist (Patel et al. 2018). A stepped care approach can help alleviate burden on existing services and improve access, providing more acceptable access to lower-level care at home or in the community (see ► Chap. 38, “Mental Health Strategy and Policy” for challenges in service access).

Public mental health interventions include mental disorder prevention as well as mental health promotion at primary, secondary, and tertiary levels. Champion (2019) suggests ways for facilitating improved coverage for primary, secondary, and tertiary prevention of mental disorder (Table 1). Alongside these methods, mental health and well-being promotion should be accounted for in mental health policy, taking into account the levels of the care environment depicted above.

The following sections discuss a setting-based approach, joint working, digital technology, and evidence-based strategies as key points in primary, secondary, and tertiary prevention.

**Table 1** Facilitating improved coverage of primary, secondary, and tertiary prevention

Primary prevention	Secondary and tertiary prevention
(1) Setting-based approaches	(1) Screening and education
(2) Addressing socioeconomic inequalities	(2) Improving population literacy
(3) Particular interventions including parenting interventions, addressing parental mental disorder and child adversity	(3) Setting-based approaches
(4) Digital technology	(4) Maximizing existing resources through self-help, less intense intervention, improving concordance with treatment, and task shifting
(5) Legislation and regulation	(5) Digital technology
	(6) Parenting interventions
	(7) Legislation and regulation

Note: *Primary prevention* aims to prevent mental disorder from happening in the first place by addressing risk factors. *Secondary prevention* involves the early identification and treatment of mental disorder. *Tertiary prevention* involves the prevention of relapse and associated impacts of mental disorder including reduced life expectancy from physical illness, health risk behavior, suicide, and stigma

## Setting-Based Approach

Recent recommendations favor a decentralization of services and a shift toward a setting-based approach (Eaton et al. 2011; Patel et al. 2007, 2018; Saxena et al. 2015). This will move support into communities, through community centers, antenatal groups, schools, and general practice (Campion 2019), and provide better access to otherwise hard to reach groups. It also may reduce the stigma associated with accessing help and subsequently improve access (Pinto-Foltz and Logsdon 2009). As part of this decentralization, programs can be scaled up within primary care settings alongside robust evaluation (Eaton et al. 2018). Schools offer a key community-based setting to support and promote CYP mental health and well-being and provide a unique opportunity to reach more CYP than clinical services alone. School-based services provide access to a large proportion of CYP who may otherwise not access services and can have a positive impact on the psychological, educational, and social impact (Cortina et al. 2008; Rones and Hoagwood 2000) and have shown positive effects (Sanchez et al. 2018). Targeted, school-based programs, particularly in primary schools, can positively support the MH of CYP (Wolpert et al. 2013). Moving services into the community creates a wider reach, imbedding them into society, and enables the maintenance of cultural appropriateness. This approach can work particularly well in low-income areas with limited access to services. It can involve training up local staff which in turn frees up more experienced staff to deal with higher levels of difficulties and offers the opportunity for earlier intervention (Caulfield et al. 2019). With this model, CAMH practitioners will still play a key role, but resources can be managed better with the decentralization of services (see ► Chap. 38, “Mental Health Strategy and Policy”).

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## Making Use of Existing Services

A setting-based approach can improve access to services, increase the uptake of currently existing services, remove a barrier to accessing such services, and improve the perspectives on the need for care. However, this decentralization relies heavily on task sharing, a shift whereby basic mental health training is provided across sectors (Patel et al. 2018). Task sharing (sometimes referred to as task shifting) allows for care to be transferred away from hospitals and into community settings.

Involving children and young people in the planning of services will help to identify area-specific priorities, as success is more likely when service users and parents/carer are involved in the planning and implementation of services (Naylor et al. 2017). Co-production with service users in terms of planning and development will enable services to be more acceptable and, ultimately, effective (Mental Task Force 2016).

A balanced care model can take the ecological care environment of the child into consideration and offer a flexible and evidence-based approach to intervention. Figure 2 depicts the different characteristics of services across varying income levels, drawing on setting-based services and collaborative working across sectors (Patel et al. 2018).

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## Promotion of Joint Working Across Sectors

Mental health is “the unique outcome of the interaction of environmental, biological, and developmental factors across the life course” (Patel et al. 2018). In light of this, a multipronged and multidisciplinary approach is essential. There needs to be a culture of cross-sector working, particularly in hard to reach areas, in order for there to be a public health response to mental health. Those supporting CYP cannot work in isolation – there are numerous social determinants of mental health that need to be addressed alongside prevention and intervention services (WHO and Calouste Gulbenkian Foundation 2014). Intersectoral working brings together city planners, schools, policy makers, psychiatric and nonpsychiatric professionals, primary care professionals, nurses, and all relevant stakeholders alongside families and service users (Chandra and Chand 2018). For example, in England, the Mental Health Services and Schools and Colleges Link Programme, a groundbreaking initiative, funded by the Department for Education (DfE), to help clinical commissioning groups (CCGs) and local authorities (LAs) work together with schools and colleges and other key stakeholders to provide timely mental health support to children and young people has been rolled out nationally. It works to empower staff by brokering contact, sharing expertise, and developing a joint vision for CYP mental health and well-being in each locality. Joint working, however, does not come without challenges, which are discussed in ► Chap. 38, “Mental Health Strategy and Policy” in relation to both rural and urban areas. A shared language around mental health is crucial to overcoming these barriers as it can help tackle stigma (Richards 2018) and promote joint working (Salmon 2004). Joint working can help maintain a



Low-resource settings			
<p>Community (provided across relevant sectors)</p> <ul style="list-style-type: none"> <li>• Basic opportunities for occupation/employment and social inclusion</li> <li>• Basic community interventions to promote understanding for mental health</li> <li>• Interventions to reduce stigma and promote help seeking</li> <li>• Range of community-level suicide prevention programmes</li> <li>• Early childhood and parenting intervention programmes</li> <li>• Promotion of self-care interventions</li> <li>• Integration of mental health into community-based rehabilitation and community-based inclusive development programmes</li> <li>• Home-based care to promote treatment adherence</li> <li>• Activating social networks</li> </ul>	<p>Primary health care (provided by general primary care workers)</p> <ul style="list-style-type: none"> <li>• Case identification</li> <li>• Basic evidence-based psychosocial interventions</li> <li>• Basic evidence-based pharmacological interventions</li> <li>• Basic referral pathways to secondary care</li> </ul>	<p>Secondary health care (provided in general hospitals)</p> <ul style="list-style-type: none"> <li>• Training, support, and supervision of primary care staff</li> <li>• Outpatient clinics</li> <li>• Acute inpatient care in general hospitals</li> <li>• Basic referral pathways to tertiary care</li> </ul>	<p>Tertiary health care (provided by mental health specialist services)</p> <ul style="list-style-type: none"> <li>• Improve quality of care in psychiatric hospitals</li> <li>• Initiate move of mental health inpatient services from psychiatric hospitals to general hospitals</li> <li>• Initiative closure of long-stay institutions and develop alternatives in community settings</li> <li>• Establish means of licensing all practitioners treating people with mental disorder, including non-formal care facilities</li> <li>• Range of evidence-based psychological treatments</li> <li>• Ensure compliance with relevant human rights conventions</li> <li>• Initiate consultation-liaison services in collaboration with other medical departments and improve physical health care of people in mental health services</li> </ul>
Medium-resource settings			
<p>Community</p> <ul style="list-style-type: none"> <li>• Services as provided in low-resource settings and:</li> <li>• Coordinated opportunities for occupation/employment and social inclusion</li> <li>• Coordinated community interventions to promote understanding of mental health</li> <li>• Coordinated interventions to reduce stigma and promote help-seeking</li> <li>• City-wide and district-wide coordination of integrated mental health-care plans</li> <li>• Attention to mental health in policy across all sectors</li> <li>• Range of independent and supported accommodation for people with long-term mental disorders</li> <li>• Drug and alcohol use prevention programmes</li> <li>• Range of services for homeless people with mental or substance use disorders</li> <li>• Community-based rehabilitation for people with psychosocial disabilities</li> </ul>	<p>Primary health care</p> <ul style="list-style-type: none"> <li>• Services as provided in low-resource settings and:</li> <li>• Equitable geographical coverage of mental health care integrated in primary care</li> <li>• Coordinated, collaborative care across service delivery platforms</li> <li>• Comprehensive mental health training for general health-care staff</li> </ul>	<p>Secondary health care</p> <ul style="list-style-type: none"> <li>• Services as provided in low-resource settings and:</li> <li>• Multidisciplinary mobile community mental health teams for people with severe mental disorders</li> <li>• Integration of mental health care with other secondary health care (eg. maternal and child health, HIV)</li> </ul>	<p>Tertiary health care</p> <ul style="list-style-type: none"> <li>• Services as provided in low-resource settings and:</li> <li>• Consolidate move of mental health inpatient services from psychiatric hospitals to general hospitals</li> <li>• Basic range of targeted specialised services (eg. for children and young people, older adults, forensic settings)</li> <li>• Consolidate consultation-liaison services</li> </ul>
High-resource settings			
<p>Community</p> <ul style="list-style-type: none"> <li>• Services as provided in low-resource settings and:</li> <li>• Intensive opportunities for occupation/employment and social inclusion</li> <li>• Intensive community interventions to promote understanding of mental health</li> <li>• Intensive interventions to reduce stigma and promote help-seeking</li> <li>• Full range of independent and supported accommodation for people with long-term mental disorders</li> <li>• Range of evidence-based services in community platforms (eg. in schools, colleges and workplaces)</li> <li>• Intensive drug and alcohol use prevention programmes</li> <li>• Intensive childhood and parenting intervention programmes (eg. life-skills training)</li> <li>• Intensive community-level suicide prevention programmes (eg. reduce access to means of self-harm, hotlines, media training)</li> </ul>	<p>Primary health care</p> <ul style="list-style-type: none"> <li>• Services as provided in low-resource settings and:</li> <li>• Full geographic coverage of mental health care integrated in primary care</li> <li>• Collaborative care model with specialists supporting primary care practitioners</li> </ul>	<p>Secondary health care</p> <ul style="list-style-type: none"> <li>• Services as provided in low-resource settings and:</li> <li>• Full range of evidence-based psychosocial interventions delivered by trained experts</li> <li>• Full range of evidence-based pharmacological interventions available</li> </ul>	<p>Tertiary health care</p> <ul style="list-style-type: none"> <li>• Services as provided in low-resource settings and:</li> <li>• Complete move of mental health inpatient services from psychiatric hospitals to general hospitals</li> <li>• Full range of targeted specialist services (eg. for early intervention for psychoses, for children and young people, older adults, addictions, and forensic settings)</li> </ul>

Fig. 2 Characteristics of services across income levels. (Adapted from Patel et al. 2018)

person-centered approach but requires a shared understanding of the roles, remit, and responsibilities of other agencies (Salmon 2004).

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## Assessment of Need Across Sectors

Alongside appropriate mental health policy and a setting-based approach, a mental health needs assessment is essential to adequately plan services. This should involve an appraisal of the levels of mental disorder and well-being, risk and protective factors, current services and uptake, epidemiology of high-risk groups, coverage and outcomes of other public health interventions, estimated economic costs of mental disorders, the size and cost of the gap in provision, current expenditure on mental health, and estimated impact and associated economic savings (Campion 2019). Local needs assessments can help to understand patterns of problems and priorities (Harrington et al. 1999). A workforce assessment should also be carried out in order to determine the level and availability of skills (see ► Chap. 38, “Mental Health Strategy and Policy”) and need for additional training. Mental health is typically lacking in Joint Strategic Needs Assessment (JSNA) with fewer than half of the JSNA in England including mental health (Campion et al. 2017). The authors suggest that mental health needs assessments are necessary across primary and secondary care for both mental health promotion and mental health disorder prevention as well as well-being promotion which can help build an evidence base.

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## Evidence-Based Strategies

Service planning should draw on and contribute to the existing evidence base. The mental health evidence base varies depending on disorder and level of difficulty. For example, children with developmental disorders benefit from community-based, family-focused rehabilitation programs (Patel et al. 2018). School-based interventions have been shown to be effective (see above and ► Chap. 38, “Mental Health Strategy and Policy”). Much of the data, however, on the effectiveness or impact of interventions are not centralized, making it challenging for policy makers and service planners to utilize. The Mental Health Innovation Network (MHIN) aims to “support bold ideas to improve treatments and expand access to care for mental disorders through transformational, affordable and cost-effective innovations that have potential to be sustainable at scale” and build an evidence base that can more easily be drawn upon (Mackenzie 2014). Learning and development from the MHIN evidence base can help inform mental health policies and the development of services to support children and young people’s mental health.

Routine monitoring and evaluation are imperative to ensure that context appropriate progress is being made, which is even more important when funding is limited. Providing services that are not working as well as they could when funding is scarce is not a responsible use of resource. Services and programmes need to be monitored so that the limited funding available can be allocated appropriately and

effectively and, where possible, adaptations made. The coordination of this data globally can help build a robust evidence base and contribute to a profile on CYP mental health (Patton et al. 2012).

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## Conclusion

Although much progress has been made in regard to the objectives of the mental health action plan, considerable work still needs to be done (Hanna et al. 2018). An evidence-based and public health approach, focusing on different levels of intervention and utilizing integrated working across sectors, is key to developing mental health services for children and young people. Simply targeting disorders through clinical services is not enough – there need to be a joined-up approach and task shifting, decentralizing services and moving them into more accessible primary care, community, and school settings. There are numerous evidence-based interventions for mental health problems that can have a positive impact on CYP. Needs assessments in local areas can help identify the appropriate way forward alongside service-user involvement in planning. We can learn greatly from public health: it will be more effective to tackle the problems of mental health from multiple angles in order to create sustainable change and better support and healthy development for children and young people.

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## Cross-References

► [Mental Health Strategy and Policy](#)

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