the wealth of a few is privileged over the welfare of the majority and where social justice and equity, both within and between nations, are not considered pre-eminent values to promote healthy populations, is one in which mental health problems will inevitably become more common. Public mental health must not only equip people and communities to better cope with the stressors created by a dysfunctional world, but also target the very drivers of this dysfunction.

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Public mental health: evidence to policy

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Public mental health is difficult to define, because there are contested boundaries and terminology. In producing the Chief Medical Officer's Annual Report 2013 (1), we became increasingly concerned about the lack of consensus over fundamental issues in public mental health in England, including: a) the definition and key components of public mental health; b) the relation of concepts within mental health to one another; c) how mental health variations of importance are measured and experienced; d) the value placed on mental health and its consistency across society; e) our approach to the generation, accumulation and use of evidence in policy.

Public mental health came into focus in England in 2008, when the Government Office for Science published the Foresight Report on the topic of "mental capital" and "wellbeing" (2). That report provided a major impetus for political and policy interest in framing mental health policy in terms of "wellbeing", which continues to gather pace. Foresight suggested that "achieving a small change in the average level of wellbeing across the population would produce a large decrease in the percentage with mental disorder, and also in the percentage who have sub-clinical disorder (those 'languishing')" (2).

With the tempting prospect of a "wellbeing" approach to public mental health potentially promising the primary prevention of mental disorder, the "wellbeing" agenda and a diversity of associated narratives have since been prominently embedded throughout mental health policy in England. A necessary concurrent step in the rapid ascendancy of wellbeing would obviously need to be the production of a robust supporting evidence base, using clear and agreed definitions and metrics. We reviewed the evidence in depth and found it wanting (3).

Concerns have crystallized that wellbeing is difficult to define, difficult to measure and therefore difficult to integrate in any meaningful way into public mental health (4-6). When combined with contested boundaries within mental health and the widespread use by researchers and policy makers of an array of unvalidated proxy wellbeing measures of varying lengths and sophistication, the production of a body of wellbeing related evidence that is scientifically robust enough to support policy making is difficult. In particular, we reject the use of items validated for measurement of disorder – most notably the General Health Questionnaire (GHQ) – as a measure of wellbeing (7-10).

The psychometric relationships between "positive" and "negative" mental health variations of importance in populations are not yet sufficiently un-

derstood, but they almost certainly do not exist on a continuum (3). This is a complex field, and those promoting a wellbeing approach to mental health simply must engage with new combinations of items. Furthermore, we cannot say with confidence that wellbeing narratives are safe for low scorers on the widely used wellbeing scale, the Warwick Edinburgh Mental Wellbeing Scale (WEMWBS), in which psychiatric distress in terms of probable GHQ morbidity remains a key unresolved question (3).

A further cause for concern is that an approach to mental wellbeing that incorporates measures of disorder has spawned a policy agenda in which terms describing very different populations are used interchangeably. The result is inconsistent blurring of the boundaries between population approaches to positive mental health and wellbeing promotion, prevention of mental illness, and treatment and rehabilitation, with little or no thought about the interrelated concepts in question. This has resulted in much of the wellbeing evidence review literature, on which public mental health policy in England has been built, inappropriately describing the results of studies in more established disciplines into the prevention and treatment of mental illness as part of a "wellbeing" evidence base to which they cannot scientifically be said to apply. "Proxy" outcomes are

unscientifically rebadged as “wellbeing” outcomes, critically compromising the evidence base upon which policy is built and funding allocated.

The Foresight hypothesis – namely that wellbeing interventions in mental health can be effective in the primary prevention of mental disorder – is unlikely to be true, since wellbeing and mental disorder do not exist on a clear continuum (3). Indeed, since this argument and mathematical model was first articulated in 1996 (11), evidence for wellbeing (or indeed any) interventions in public mental health that “shift the population curve”, originally described by G. Rose (12), has simply not been forthcoming. In the absence of any empirical evidence, we reject the appropriateness of continuing to build policy upon this premise at this time.

Much of the commonly cited evidence in policy circles for wellbeing intervention evaluations as related to mental health is located within the grey literature – i.e., papers and reports which have not been subjected to independent peer review and are often published by the organization which carried out the research. Other fields within mental health already self-govern within the space of the accepted hierarchy of evidence. Yet we continue to hear concerning and irresponsible pronouncements that grey literature should be considered as of equal importance in the evidence base for wellbeing, and that the Chief Medical Officer should take a “leap of faith” regarding the case for wellbeing in mental health.

In reviewing the evidence and policy for public mental health, we argue, therefore, that it should no longer be framed in terms of “wellbeing”. Instead

we call for public mental health in England to follow the model developed by the World Health Organization (WHO) during the last decade, culminating in the WHO Mental Health Action Plan in 2013 (13-15). Drawing upon those reports, we conceptualize public mental health as consisting of “mental health promotion”, “mental illness prevention” and “treatment and rehabilitation”, terms which enjoy greater consensus about their definition (16) and are not mired in the significant challenges we have identified.

If we take this approach and ignore all studies and reports that do not meet scientific standards, we are left with a field of wellbeing that is much diminished in size and relative importance to the concept of public mental health. Generic statements about “improving wellbeing and mental health” should give way to a far more refined approach: at both a local and national level there are ample opportunities in England for mental health promotion, mental illness prevention and treatment and recovery from common mental disorder that we have the potential – and the evidence base – to address effectively (1).

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Applied public mental health: bridging the gap between evidence and clinical practice

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Wahlbeck (1) describes a public mental health approach at a population level. His proposal is far reaching, including not only the reduction of mental illness or specific psychiatric

disorders, but the promotion of mental wellbeing, positive mental health and happiness. The targets vary widely, including parenting, education, housing, employment, justice, etc..