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..

The interventions include relaxation, meditation, mindfulness training, job stress management, cognitive behavioral therapy, biofeedback, exercise, health education, social networking, etc.. The strategies include health promotion, improvement of mental health services, reduction of stigma, fight for human rights, etc.. The author concludes that challenges remain in identifying risk, protective and resilience factors for mental health problems across the lifespan, and developing effective and evidence-based public mental health interventions.

One cannot disagree with the mandate. However, the breadth is overwhelming. Many of the actions described require partnerships well beyond public health, psychiatry or even medicine, and fall in the domain of social policy, government, and the will of the people in a functioning democracy. The actions impinge upon social values and the limits of governmental reach, which vary considerably by culture or country. Consider the public health problems of violence, which are often related to firearms. Prevention may engage issues such as enforcement of gun control legislation, raising minimum age requirements for gun ownership, reforming gun licensing, and imposing restrictions on gun purchases. Identifying the risk factors and health education alone may be insufficient.

Safe food practices, immunization, public health education, and improved sanitation have been successful over the past century in increasing life expectancy and improving quality of life (2). Parallel public health initiatives for mental wellness will require a similar mobilization of government and business efforts based on known risks. Although social change itself may improve mental health, there will need to be a confluence of the common good for this to happen. Even then, there is little guarantee that programs will be effective or resources sufficient to sustain them (3).

Challenges exist on several levels. Governments move slowly, individuals seldom agree on priorities and fiscal considerations, and the public and large corporations resist increased taxation. How do you implement a policy that bridges the gap between public health evidence and clinical practice? Studies of community rates and risks of psychiatric disorders are now available in many parts of the world, and psychiatric epidemiology has been linked to the global study of disability. While the rates of psychiatric disorders vary by country, the risk factors are reasonably consistent across countries and cultures. The phrase "no health without mental health" is not merely a slogan; linkages between mental and physical illness are strong and bidirectional. Therefore, reducing psychiatric disorders and especially intervening early can have widespread beneficial effects.

Defining public mental health is a challenge and one with which the field has struggled. I would begin by focusing on evidence-based interventions applied to early manifestations of psychiatric disorders. Cross-national epidemiologic research documents long delays between psychiatric disorder onset and first treatment contact. The promotion of mental health, wellbeing or positive mental health or happiness does not easily fit in this early detection model (2).

In countries at all levels of economic development, much of the detection of mental illness occurs within primary care. With the Affordable Care Act in the U.S., the role of primary care providers in the detection of mental illness is likely to expand. We need to combine public health models with brief evidence-based psychosocial interventions in clinical practice for patients with early signs of disorder.

Why would one recommend a psychosocial intervention or psychotherapy? The reasons are not obscure. Patients in distress overwhelmingly express a preference for talking to someone or for counseling (4). Controlled clinical trials convincingly demonstrate the efficacy of several brief psychotherapies. These interventions have been defined in manuals and have been adapted to different ages and cultures (5,6).

Let me propose a new profession or a subspeciality of older ones. I call it applied public mental health. Applied public mental health would link training in public health, which is not a clinical profession, with one of the clinical professions. Social work might be a natural partner, but there may be others.

The focus would be on reduction of psychiatric illness and early symptoms rather than mental wellness, although increasing "wellness" might be an important by-product. This new profession would be grounded in an understanding of psychiatric risk factors, skills in several evidence-based psychotherapies, adaptation of treatments to different cultures and contexts, and developing new interventions or amalgamating old ones. Traditional roles providing direct assistance with access to social services and other resources would, of course, be included.

There are urgent calls for this change. An editorial appeared in September 2012 in *Nature* was entitled "Therapy deficit: studies to enhance psychosocial treatments are scandalously undersupported" (7). The World Health Organization is already incorporating brief evidence-based psychotherapies into its portfolio and has issued guidelines for managing care in health settings (8). While psychotherapy is fading from consciousness and practice in some developed countries, it is being enthusiastically embraced in developing countries hurt by HIV, natural disasters, wars, or political strife (9). With this model, a victim of natural disaster may be helped to deal psychologically with loss and grief as well as receive emergency provisions and an application for housing. Persons with serious, recurrent psychiatric disorders would be triaged to psychiatrists and other physicians (10,11).

Brief evidence-based psychotherapies are being applied in many situations all over the world (9). The problem is that training in these treatments is a cottage industry and developed in an *ad hoc* manner for each situation. While the training for these programs can be of very high quality, this approach is inef-

ficient, insufficient, and not sustainable. In the U.S., with the exception of cognitive behavioral therapy in psychiatric residency training programs, courses in evidence-based psychotherapy are now not an accreditation requirement (12). Certification standards are either absent or *ad hoc*. Applied public mental health could be a subspeciality of public health and a clinical profession, for which training in brief evidence-based psychotherapies would be essential.

Rates of psychiatric disorders, particularly depression and anxiety, are high in primary care patients, and among victims of natural disasters, civil wars, violence, sexual abuse, chronic medical illness, the unemployed, new mothers, recently divorced, etc.. These individuals frequently need social, economic and legal services. In order for these services to be effective, however, the distressed individuals also need a therapeutic alliance and someone to talk to and sort out their history, their resources and concerns. I am not advocating long-term psychotherapy except where it is indicated for the small number of people with severe and enduring psychiatric disorders.

In the context of Wahlbeck's comprehensive proposal, a focus on short-term evidence-based psychotherapy implemented with the guidance of public mental health specialists is modest. The broader goals should not be lost, recognizing they require advocacy and the public will. In the meantime, however, small but dedicated efforts to improve the delivery of mental health care that are cost-effective and evidence-based should be sought. The guiding principles should include a focus on early intervention, integration with primary care where possible, a patient centered orientation, and an integration of clinical and public health perspectives. It is more efficient to have psychosocial interventions taught in formal educational programs than in grass roots *ad hoc* training courses.

At present, public health programs identify risks but do not teach clinical applications, while social work and other counseling programs are not grounded in public health, and training in evidence-based psychotherapies is rarely required. These disciplines have much to offer each other in bridging the gap.

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Mental disorder: a public health problem stuck in an individual-level brain disease perspective?

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K. Wahlbeck provides a range of cogent arguments supporting the view that the natural perspective for mental health is in the realm of public health. In reality, however, the perspective of public health is not dominant in academic psychiatry or in the way mental health services are organized. The dominant model in academic psychiatry is embedded in an individual-level perspective of brain disease, although there is considerable debate as to how successful this dominant approach has been (1).

A student wanting to find out about psychiatry may get the impression that two languages are spoken in mental health: a public health one, taking into account the natural perspectives of high prevalence, graded trajectories from health to illness, social determinants, empowerment and self-determination, resilience, positive mental health and prevention; and a biomedical one, focusing on illness and diagnostic labels, brain disease, animal research, genetic liability, biological determinants and pharmacological interventions.

The existence of two languages in mental health research is one of the explanations of the limited crosstalk between areas distributed over the public health and natural sciences, even though