

Framework for healthy public policies favouring Mental Health

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Good mental health, in its broad definition, is more than the absence of disease, and consists of a state of 'flourishing,' which is a combination of feeling good and functioning effectively most of the time (The Government Office for Science, 2008; Huppert, 2009; Keyes, 2007; Huppert & So, 2013). It is considered a resource for life for individuals as well as when it is considered at the population level. Defined in this manner, good mental health is the basis of the many skills that are needed for individuals and countries to develop and flourish.

Higher levels of mental health, independently of mental disorders, are associated with positive outcomes in education, physical health, productivity, relationships, recovery rates, employment and earnings, health behaviours and quality of life. In addition the best outcomes are found in those who are 'flourishing' in life, (i.e., those who have good mental health, compared to those who have average or poor mental health). The latter individuals, in turn, have the least favourable outcomes. This is true as well for those who have a mental disorder (Keyes, 2002; 2007).

Mental health just like physical health is, socially-produced and is strongly associated with a number of social determinants. Hence, to improve mental health and reduce mental health inequalities, interventions and policies ought to come from those sectors which can exert influence on social determinants; these determinants are most often found outside of the realm of health services.

Public policies that are favourable for mental health (or healthy public policies favouring mental health) can be considered as a core element of intervention to improve mental health within a population mental health framework for public health (Mantoura, 2014).

Currently, there is a growing interest in how a focus on well-being could influence the future direction of public policy in general (Bok, 2010; Diener, Lucas, Schimmack, & Helliwell, 2009;

Barry, 2009), and this interest can be observed in many domains such as the economy, education, employment, culture, transport, the built environment, etc.

Public policies in these sectors may have a positive or negative effect on mental health. It is therefore necessary to analyze the potential negative effects of policies on mental health (Coggins, Cooke, Friedli, Nicholls, Scott-Samuel, & Stansfield, 2007), and to optimize the positive effects of policies via healthy public policies favouring mental health.

This briefing note will propose a framework for healthy public policies favouring mental health (HPP-FMH). In the first section, we define what is meant by this expression. In the second section, we present the determinants of mental health. The influence that HPP-FMH exert on those determinants is the basis upon which they are expected to have impacts on mental health. In the third section, we propose a conceptual framework to illustrate the policy areas that influence mental health. Finally we present a brief overview of evidence for promising HPP-FMH.

What is meant by Healthy Public Policies Favouring Mental Health (HPP-FMH)?

Public policy refers to "a strategic action led by a public authority in order to limit or increase the presence of certain phenomena within the population" (National Collaborating Centre for Healthy Public Policy, 2012).

Healthy public policy, as proposed by Milio (2001, p. 622) "improves the conditions under which people live: secure, safe, adequate and sustainable livelihoods, lifestyles, and environments, including, housing, education, nutrition, information exchange, child care, transportation, and necessary community and personal social and health services".

Briefing Note

For up-to-date knowledge relating to healthy public policy



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HPP-FMH can therefore be defined as public policies, generally outside the formal mental health sector, that have an impact on mental health and mental health inequalities, such as education policies, policies relating to work-life balance, or fiscal policies, for example.

HPP-FMH aimed at improving mental health in the population have an objective to promote mental health (well-being) in the whole population (while considering inequalities in mental health) to prevent mental health problems and disorders, and to improve the quality of life for people experiencing mental health problems and disorders. They do this by promoting the factors that enhance and/or protect mental health, known as protective factors, or by limiting the factors that impact negatively on mental health, also known as risk factors.

Public policy decisions should be based on the best available evidence. Hence, generating HPP-FMH becomes a question of knowing “what works” and in which contexts (Nutley, Walter, & Davies, 2007).

Knowing the effects policies may have on mental health outcomes is important. However, it is difficult to judge the ultimate effects of a policy. First, effects can take a long time to be observed. Secondly, it is difficult to prove the existence of a cause and effect relationship. Finally, published evidence examining the link between public policies and their ultimate effects is scarce in general (Morestin, 2012); they are even more scarce when it comes to the effects of policies on mental health (Petticrew, Chisholm, Thompson, & Jané-Llopis, 2005; Petticrew, Platt, McCollam, Wilson, & Thomas, 2008).

Given that evidence on the impacts of policy on mental health outcomes is scarce, another type of evidence can also be sought. This alternative kind of evidence is gathered through evaluating the alignment of policies with determinants of mental health (Petticrew et al., 2008), and examining the established evidence between mental health determinants and mental health outcomes.

The established links between people’s living conditions, behaviours, physical health *and* mental health are the basis on which HPP-FMH are expected to impact on mental health and mental health inequalities.

Describing the links between the conditions in which people live, their physical health, behaviours *and* their mental health

Mental health is produced through dynamic interaction between individuals, groups, and the broader environment, throughout the lifespan (Herrman & Jané-Llopis, 2005). Protective and risk factors for mental health operate at many levels; the individual, the family, the community, and the macro level of society. Protective factors contribute to enhanced positive mental health and reduce the likelihood that a disorder will develop (Barry & Friedli, 2008). They enhance people’s capacity to successfully cope with and enjoy life and mitigate the effects of negative events. Risk factors increase the probability that mental health problems and disorders will develop. They can also increase the duration and severity of a mental disorder when it does occur.

The factors that determine mental health can be regrouped according to levels of influence. In this note, we shall refer to individual, social and structural levels of influence on mental health (Herrman & Jané-Llopis, 2012).

These levels are used here not only to categorise the many determinants which affect mental health¹; they also consist of the areas of influence for public policy (Barry & Friedli, 2008; Huppert, 2005; Department of Health - Victoria, Aus., 2012). Some of the most important and frequently-cited determinants of mental health, including risk and protective factors, are summarized in table 1.

¹ Many other lists of factors, categories to classify them, and terms to name these categories exist in the literature (Coggins et al., 2007; Keleher & Armstrong, 2005; Lavikainen, Lahtinen, & Lehtinen, 2000; Marshall Williams, Saxena, & McQueen, 2005; Public Health Agency of Canada, 2006).

Table 1 Determinants of mental health

LEVEL	PROTECTIVE FACTORS	RISK FACTORS
Individual (psychological make-up, behaviours & physical health)	<p>Cognition: ability to problem solve; manage one's thoughts; learn from experience; tolerate life's unpredictability; a flexible cognitive style; etc.</p> <p>Emotion: feeling empowered; sense of control or efficacy; positive emotions; positive sense of self; etc.</p> <p>Social: good social skills (communication, trusting, etc.); sense of belonging; etc.</p> <p>Resilience; good physical health; healthy behaviours, etc.</p>	<p>Cognition: weak problem solving skills; inability to tolerate life's unpredictability; rigid cognitive style; negative temperament; etc.</p> <p>Emotion: low self esteem; feeling a lack of control of one's life; negative emotions; etc.</p> <p>Social: isolation; weak social skills; etc.</p> <p>Certain behaviours such as absence of physical activity, alcohol and drug abuse, poor physical health. Adverse life events, including adverse very early life experiences; etc.</p>
Social (family & community)	<p>Strong emotional attachment; positive, warm, and supportive parent-child relationships throughout childhood and adolescence; secure and satisfying relationships; giving support; high levels of social capital (including reciprocity, social cohesion, sense of belonging, and ability to participate), etc.</p>	<p>Poor attachment in childhood; lack of warm/affectionate parenting and positive relationships throughout childhood and adolescence; insecure or no relationships; isolation; low levels of social capital and belonging; social exclusion; inability to participate socially; domestic abuse and violence, etc.</p>
Structural & environmental	<p>Socio-economic advantage (i.e., higher levels of education, good standards of living, including housing, income, good working conditions); economic security; freedom from discrimination and oppression; low social inequalities; legal recognition of rights; social inclusion; public safety; access to adequate transport; safe urban design and access to green spaces and recreation facilities, etc.</p>	<p>Socio-economic disadvantage (i.e., low education, low material standard of living, including inadequate housing, homelessness, unemployment, inadequate working conditions); economic insecurity and debt; social and cultural oppression and discrimination; war; poverty and social inequalities; exclusion; neighbourhood violence and crime; lack of accessible or safe transport; poor urban design; lack of leisure areas, green spaces, etc.</p>

A framework to illustrate the policy areas of influence on mental health

To illustrate the potential areas of policy intervention for mental health, we present, in Figure 1 below, a conceptual illustration of the influences on mental health.

The illustration shows the influences on mental health on two levels. At the bottom part of the figure, a number of important determinants of mental health are presented; these are specifically some of the main protective factors at the individual, social,

environmental, and structural levels. The policy areas of influence are shown at the upper part of the figure.

LEVELS OF INFLUENCE FOR PUBLIC POLICIES

The structural and environmental level is composed of political influences, modes of governance, as well as the many systems and institutions that affect our lives (cultural, economic, legal, educational, etc.). It is also formed by the life circumstances that forge socio-economic position, and the many settings in which we work, learn, play and love (World Health Organization, 1986).

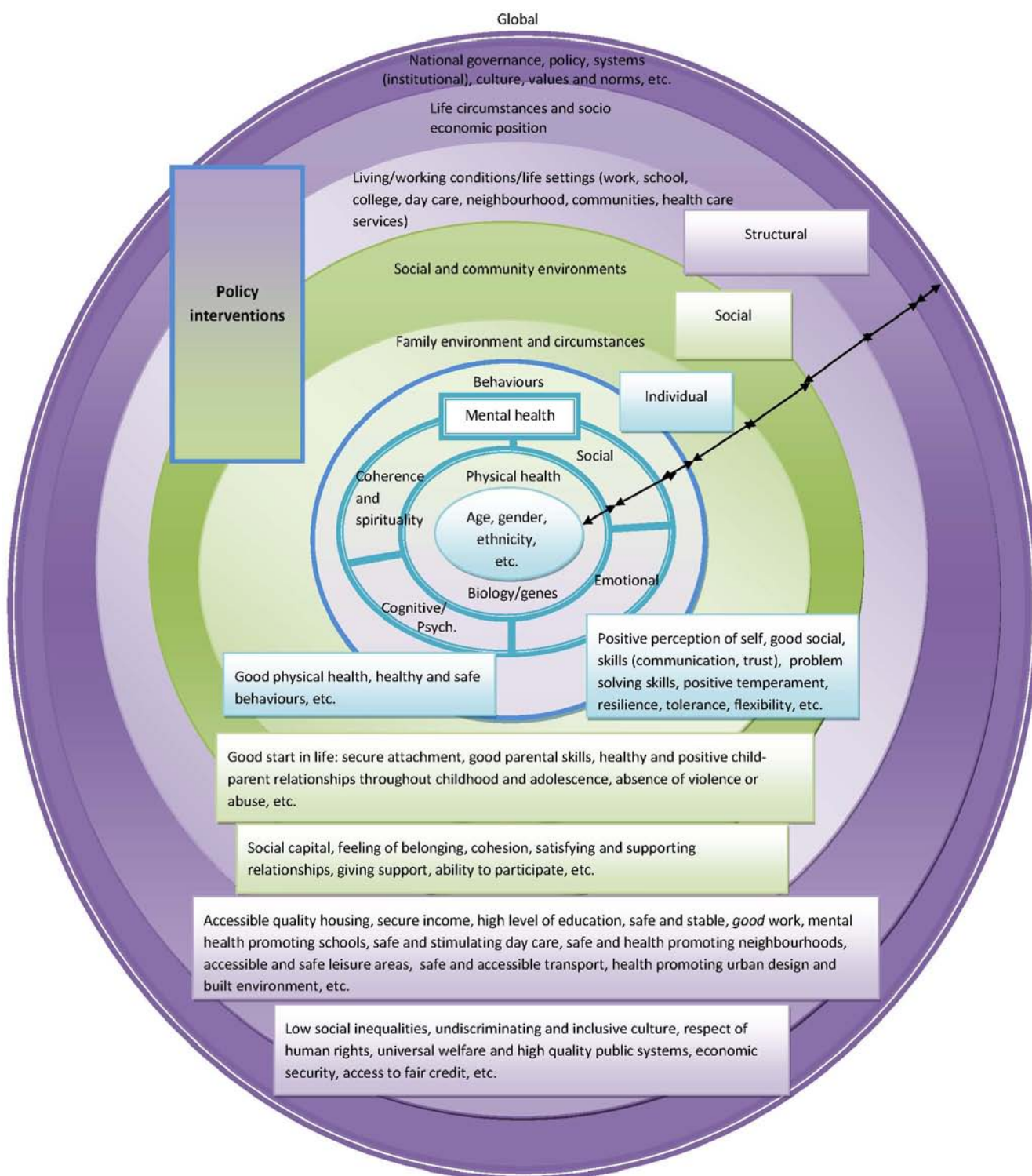


Figure 1 Policy Framework for Mental Health

The social level is composed of the community and family environments and circumstances which shape interactions throughout life.

The individual level is composed of an individual's behaviours, psychological makeup (mental health), physical health, biology and genetics, age, gender, sexual orientation, migrant status and ethnicity.

BEHAVIOURS / LIFESTYLES

Although behaviours or lifestyles are situated as individual-level determinants, they are considered socio-structurally patterned activities, i.e. "collective lifestyles" (Frohlich & Potvin, 1999) or "health practices" (Frohlich & Abel, 2014). That is, they are carried out according to the socio-cultural and contextual influences (such as values and norms about which behaviours are acceptable or expected), to the available resources or material infrastructure (such as access to safe green spaces, or grocery stores offering reasonably priced and high-quality fresh produce), and to individuals' acquired ways of functioning (what people are able to be and do) (Frohlich & Potvin, 1999; Delormier, Frohlich, & Potvin, 2009; Macintyre, Ellaway, & Cummins, 2002; Frohlich & Abel, 2014). These behaviours and lifestyles have important interactions with mental health.

PSYCHOLOGICAL MAKE-UP

The elements that comprise individuals' psychological make-ups include cognitive/psychological (cognitive style and functioning), emotional (affect/feelings), social (relations with others and society) and spiritual (sense of meaning, coherence, and purpose in life) characteristics.

These are the dimensions which often conceptualize mental health and constitute the hedonic (feeling good) and eudemonic (functioning well) dimensions of mental health (Keyes, 2002; Huppert, 2009; Ryan, 2001; Lyubomirsky, King, & Diener, 2005; Huppert & So, 2013). Physical health can also be added as a dimension of mental health (Barry, 2009; Diener et al., 2009).

The individual psychological factors can be conceived as the end result of higher-level psychosocial factors operating upon individuals (Martikainen, Bartley & Lahelma, 2002). Indeed the many factors such as social networks and supports, work control, autonomy, home control and work-

family conflict, are considered meso-level psychosocial concepts, and manifest themselves in interpersonal relationships (Martikainen et al., 2002). These, in turn, affect individual psychological factors. For example, a psychosocial process is operating when unemployment leads to loss of self-esteem and feelings of worthlessness, or when social networks provide emotional support and comfort (Martikainen et al., 2002).

The psychosocial risks or protective factors accumulate during life and the individual psychological characteristics are relevant across the lifespan, and maybe more so during periods of transition (Barry & Friedli, 2008).

PHYSICAL HEALTH

Physical health is thoroughly linked to mental health. Indeed, "health is the top thing people say matters to their wellbeing" (Department of Health - UK, 2014). It is often associated with mental health outcomes, either as a determinant or a consequence of mental health. Also, along with mental health, physical health is an integral part of overall health, as there is "no health without mental health" (Department of Health - UK, 2011). They are both part and parcel of a holistic conceptualization of health.

GENES AND BIOLOGY

Figure 1 illustrates that the relative contribution of genetic inheritance to mental health is also influenced by a wide range of social and environmental factors (Barry, 2009) that trigger the expression of those genetic traits. In the same manner, biology, aside from being a basic element of an individual's health, can also be modified by changes in an individual's psychological characteristics and hence affect physical vulnerability (positively or negatively) through psychobiological processes (Martikainen et al., 2002).

AGE, GENDER, SEXUAL ORIENTATION, MIGRANT STATUS AND ETHNICITY

Finally, age, gender, sexual orientation, migrant status, and ethnicity are also determinants of mental health, and are associated with varied exposure to risk and protective factors. They also influence how poor mental health is expressed, its prevalence and incidence (Barry & Friedli, 2008). Even if these determinants are not modifiable through intervention, the social structure may place individuals and groups with certain characteristics regarding these

determinants at a significantly higher risk of experiencing mental health problems.

There are multiple and complex interactions between the many determinants of mental health, and how they affect mental health and well-being throughout the life course. Therefore identifying direction of causality is not straightforward (Barry, 2009). The varied interactions between all these factors and mental health are represented in Figure 1 by the many arrows which potentially link each and every determinant to each and every other determinant.

For example, consider a socially and economically disadvantaged individual, living in an environment with inadequate welfare support, with weak social protection regulations, and whose mental health is affected by the many daily stresses of difficult life circumstances. This person may develop drinking habits which put him or her at risk of increased trauma, which, in return may cause job loss, which can in turn intensely worsen family circumstances and severely hamper the potential for his or her good mental or physical health. It can also hamper the physical or mental health of those with whom he or she is close, and even that of future generations.

As with the example above, the policy framework for HPP-FMH illustrates that mental health outcomes are profoundly sociostructurally patterned, and involve complex relationships with physical health and behaviours, which are similarly produced through sociostructural influences.

What kinds of policies could be or are HPP-FMH?

Policies that have an influence on mental health can directly influence the structural, environmental, social and individual determinants. It is also important to take into account the life stages and transitions, and their impact on mental health. Early years and childhood, education, adolescence, young adulthood, work, retirement, and ageing have all significant but different impacts for mental health (Bacon, Brophy, Mguni, Mulgan, & Shandro, 2010). They interact in different ways with the many determinants of mental health in forging mental health throughout the life course (Kirkwood, Bond, May, McKeith, & Teh, 2008). Therefore policies aiming at improvements in mental health will have to consider these interactions.

Some policies have shown effectiveness in promoting mental health, specifically in less advantaged populations and low-income settings. Specifically, policies aiming at improving nutrition, iodine supplementation, housing, or access to education, have all shown improvements in mental health outcomes directly (Thomson & Petticrew, 2005; Jané-Llopis, Barry, Hosman, & Patel, 2005; Petticrew et al., 2005; Hosman & Jané-Llopis, 2005; World Health Organization, 2004; Herrman, Saxena, & Moodie, 2005).

Also, there is evidence of associations between many determinants of mental health and mental health outcomes, which leads to assuming plausible links between public policies aiming at those determinants and improvements in mental health.

Hence, what could be some examples of HPP-FMH? In what follows, we propose some examples which illustrate the plausible types of policy interventions that could impact some of the many determinants that have an established influence on mental health. Please note that these policy examples do not reflect the importance of one policy over the other, are not an exhaustive representation of the many potential policy impacts on mental health or of the full literature on mental health determinants, nor do they necessarily represent the most important policies in each domain.

Policies aiming at the structural and environmental determinants

Many factors at the structural and environmental levels have an established link with mental health and illness outcomes. For example:

Low early-life socioeconomic position (SEP) is a risk factor associated with an increased risk of depression in adolescence and adulthood (Harper, Lynch, Hsu, Everson, Hillemeier, Raghunathan, Salonen, & Kaplan, 2002; Kennedy, Huibert, Ormel, Huisman, Verhulst, & Oldehinkel, 2009).

For mothers, a lower level of education is associated with a higher likelihood that their children will suffer from depression in young adulthood (Park, Fuhrer, & Quesnel-Vallee, 2013). Indeed, maternal education is one of the strongest predictors of the physical and psychological health of their children (Chen & Hongbin, 2009).

Employment as another defining feature of social position is also associated with mental health outcomes. Specifically *good* employment (the nature of work and the way it is organized) has positive impacts on well-being (McDaid, 2008).

It also seems that having control over one's working conditions before retirement and being able to decide the conditions and timing of retirement are major factors in a person's mental health in retirement (Leinonen, Pietilainen, Laaksonen, Rahkonen, Lahelma, & Martikainen, 2011).

Cumulative disadvantage throughout the life course is also more likely to lead to poverty, social exclusion, and physical and mental ill health in old age (McKee & the Older Age Working Group, 2010).

Unemployment, low income, cuts in pensions and benefits, and higher prices contribute to the financial stress put on individuals and families and in many cases culminate in financial indebtedness. Debt is an important risk factor for poor mental health and disorders (Meltzer, Bebbington, Brugha, Farrell, & Jenkins, 2013).

Aboriginal acculturation and discrimination against Aboriginal people are important risk factors for mental health. Specifically, Aboriginal enculturation or cultural continuity is a protective factor associated with reduced illicit drug and prescription drug problems among Aboriginal adults in an urban setting in Canada (Currie, Wild, Schopflocher, Laing, & Veugelers, 2013).

Finally, greater income inequality in general is associated with higher prevalence of mental illness and drug misuse in rich societies (Pickett & Wilkinson, 2013). Based on these, we propose the following policies for potentially acting on mental health outcomes through structural and environmental-level determinants.

EXAMPLES OF POLICIES:

- Policies reducing poverty may be particularly valuable for mental health and for improvements in educational achievements and students' emotional well-being (Sznitman et al., 2011).
- Policies favouring fair and responsible credit, and training of staff of companies and agencies involved with giving loans and managing and recovering debts, may contribute to mental health (Meltzer et al., 2013).
- Policies helping young people obtain basic qualifications and occupational skills, and those aiming at improving employment chances and favouring control over these conditions are likely to improve mental health throughout the entire life course (Bartley, 2012). For example, some welfare-to-work policies (Ayala & Rodriguez, 2013) or local employment initiatives in deprived communities (Fone & Dunstan, 2006) may be promising for improved mental health states.
- Policies enabling cultural continuity for Aboriginals and valuing Aboriginal culture in mainstream Canadian urban settings may play an important role in increasing the Aboriginal population's mental health (Currie, 2014).
- Policies supporting women's education would plausibly be associated with increased mental health in young adulthood of future generations (Park et al., 2013; Grytten, Skau, & Sorensen, 2014).
- Policies favouring universal social pensions for all older people are often considered as basic human rights to reduce poverty and achieve greater equity in older age (HelpAge International, 2006; Cattan, 2013). They are therefore plausibly linked with improvements to mental health because staying out of poverty and maintaining buying power in older age are linked to mental health.
- Policies reducing income inequalities (for example, through income redistribution or through support for trade unions) are plausibly linked to increased mental health (Pickett & Wilkinson, 2013). Policies reducing inequalities may also reduce levels of urban violence, which has implications for mental health (Wolf, Gray, & Fazel, 2014).

Policies aiming at living conditions and life settings

Housing conditions; neighbourhood conditions, security/violence, and design; transport, etc. have a demonstrated impact on mental health and illness throughout the life course. Based on these, we propose the following policies for potentially acting on mental health outcomes through the living conditions-related determinants.

EXAMPLES OF POLICIES:

- Policies favouring neighbourhood renewal (Burke, O'Campo, Salmon, & Walker, 2009; Elliott, 2000; Truong & Ma, 2006; Ludwig, Duncan, Gennetian, Katz, Kessler, Kling, & Sanbonmatsu, 2012);
- Those specifically tackling availability of open spaces (Francis, Wood, Knuiman, & Giles-Corti, 2012);
- Policies to improve transport (Delbosc, 2012);
- Those aiming at housing improvements (Blackman, 2001) or increased housing accessibility (such as social housing under certain circumstances (Kearns, Petticrew, Mason, & Whitley, 2008), or housing first programs (Patterson, Moniruzzaman, Palepu, Zabkiewicz, Frankish, Krausz, & Somers, 2013; Gilmer, Stefancic, Ettner, Manning, & Tsemberis, 2010); and
- Policies favouring protection of natural environments (Carbonell & Gowdy, 2007), can all plausibly be linked to mental health.

The quality of settings such as daycares, schools, colleges, universities, communities or workplaces are also associated with mental health outcomes (Barry, 2009; Petticrew et al., 2005; Jané-Llopis, Anderson, & Cooper, 2012; Alegria, Perez, & Williams, 2003; Fesus, Ostlin, McKee, & Adany, 2012; Jané-Llopis et al., 2005; Bacon et al., 2010). Based on these, we propose the following policies for potentially acting on mental health outcomes through the life settings-related determinants.

EXAMPLES OF POLICIES:

- Policies favouring whole-school approaches (approaches focusing not only on academic success, but on broader aims of education such as social and emotional competencies enabling young people to flourish) which would be completely and accurately implemented (Weare & Nind, 2011) or those aiming at providing high-quality childcare can plausibly be linked to improved mental health all for children.
- Work-life policies may have good potential for improved well-being in families, and may be associated with increased mental health for *all* family members. This is because parental well-being, which is at the heart of good parenting, and hence of children's well-being, is facilitated by such policies.
- The arts, broadly considered as a domain of policy intervention in community settings, are also

increasingly recognized as a sphere to be sustained for their links to mental health. Indeed, investment and activity in arts and culture may have a significant impact on mental health and well-being of individuals and populations (Cox, Lafrenière, Brett-MacLean, Collie, Cooley, Dunbrack, & Frager, 2010; Lander & Graham-Pole, 2008).

- Policies improving work conditions not only improve workers' mental health (McDaid, 2008), but they may also have an effect on workers staying on at work and reducing early retirements (Siegrist & Wahrendorf, 2009; Siegrist, Wahrendorf, von dem Knesebeck, Jurges, & Borsch-Supan, 2007). It has been found that for some people, retiring at a later age may lessen or postpone poor health outcomes and may raise well-being later in life (Dave, Rashad, & Spasojevic, 2006).

Policies aiming at social-level determinants

Similarly, policies aiming at relationships that are formed within the community and family environments have a very plausible effect on mental health. Indeed, the quality of relationships and the networks that are forged within the family and community environments throughout the life course are closely aligned with mental health. In addition to this, the mental health benefits associated with giving support appear to exceed those associated with receiving it (Brown, Nesse, Vinokur, & Smith, 2003). Based on these, we propose the following policies for potentially acting on mental health outcomes through the social-level determinants.

EXAMPLES OF POLICIES:

- Policies that promote healthy development for children and provide safe attachments and secure relationships, through supporting, for example, positive parenting, skin to skin contact or breastfeeding (Stewart-Brown & Schrader-Mcmillan, 2011; Bartley, 2012; Barlow, 2013) could protect and favour mental health.
- Policies that facilitate contact by creating or favouring opportunities to become or remain connected (Friedli, 2009; Bacon et al., 2010), or by fostering volunteering (Binder & Freytag, 2013) can be beneficial for all, but even more so for the elderly (Von Bonsdorff & Rantanen, 2010; Cattani, Hogg, & Hardill, 2011). For similar

reasons, programs like free public transport for older people (Bartley, 2012) may have positive mental health impacts.

- Policies that enable civic and community participation, strengthen community networks and action, etc. (Jané-Llopis et al., 2005; Mathieson, Ashton, Church & Quinn, 2013; Bacon et al., 2010) can also improve mental health.

Policies aiming at individual-level determinants

Finally, some policies may, among other things, aim at certain behaviours, such as physical activity among the elderly, or adolescent drinking, for example. Indeed it has been demonstrated that mental well-being in older age may be modified through physical activity and exercise (Windle, Hughes, Linck, Russell, & Woods, 2010). Also, drinking heavily in adolescence appears to be associated with misusing alcohol in adulthood (Cable & Sacker, 2008) and alcohol misuse is a risk factor for mental health. Based on these, we propose the following policies for potentially acting on mental health outcomes through the individual-level determinants.

EXAMPLES OF POLICIES:

- Active ageing policies are promoted as one of the main policies for maintaining mental well-being in old age (Cattan, 2013; Lang, Resch, Hofer, Braddick, & Gabilondo, 2010). Yet an active ageing policy framework is much broader than the promotion of an active lifestyle, and requires action on three pillars: participation, health and security (World Health Organization, 2002).
- Policy interventions to tackle adult alcohol misuse could begin in adolescence, and promote an alcohol-free culture for young people (Bartley, 2012; Cable & Sacker, 2008), combined with taxation on alcohol products, which appears to be an effective intervention (Jané-Llopis et al., 2005; Henderson, Liu, Diez Roux, Link, & Hasin, 2004).

In the previous pages, we described the plausible effects of a series of policies, based on their impacts on the determinants of mental health, and based on the link between these determinants and mental health outcomes.

To analyze the relevance of a specific policy in a given social and historical context, one must

consider not only the plausibility of the proposed effects but the actual effectiveness in addition to a consideration of the unintended effects, equity, costs, feasibility and acceptability of this policy measure (Morestin, 2012). For some of the areas discussed above, McDaid & Park (2011) have looked at the strength of the economic evidence base which supports case for action.

The distribution of the effects of HPP-FMH

Improving the mental health of the population requires policies which aim at the least advantaged as well as more broadly with universal policies. As mental health is socially produced and there is a gradient in many manifestations of mental health problems, it is important to focus specifically on the distribution of mental health determinants across the population, just as it is important to look at the differential impacts of policies on sub-groups of the population.

Need for indicators

Finally, the goal of monitoring the impacts of policies that are intended to improve mental health means that:

- It is important to be clear about the many definitions that people have for mental health (which may vary according to context, cultures, etc.) (Littlewood, 2008); and
- It is important to identify and define appropriate multi-dimensional measures and indicators of mental health (Huppert & So, 2013).

Clarifying definitions and developing indicators are quite clearly among the key preoccupations for those who wish to study and develop HPP-FMH.

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