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A Framework to Decide 'What Works' in Prevention Policy - Key Points:

The practical meaning of 'prevention' is not clear. It can be interpreted in markedly different ways for a range of different audiences. Issues include: defining the type of prevention; identifying the root causes of problems; the ethics of early intervention in each case; the incentive to pursue incremental, as well as decisive, shifts in policy; and, the balance between aims - such as to reduce inequalities or reduce costs.

A clear definition and set of clear aims aids engagement with policymaking partners. It helps produce a common and detailed set of expectations. It helps maximise policy learning from pilot projects and international schemes. Without a clear set of aims, we have no reference point to identify projects which have a comparable experience from which to draw lessons. Nor do we have no way to gauge success and failure in comparable projects.

To a large extent, we can identify a clear Scottish Government approach to prevention, even if it does not always define it. More importantly, the National Performance Framework provides a way to define and measure the success of prevention (and other) policies. This aids a systematic search for evidence of what works.

'Prevention' describes an approach to policymaking as much as policy. Prevention policy results from Scottish Government direction, coupled with local plans produced in partnership with a range of delivery bodies and service users.

Our analysis of Single Outcome Agreements (SOAs) highlights a range of meanings of prevention, when translated from a philosophy into a series of detailed aims. SOAs demonstrate a broad commitment to the NPF and prevention, but with differences driven by each area's response to its geographical and socio-economic conditions, and its potential to give meaning to prevention in different ways. Each area appears to pursue its own projects, with minimal reference to learning from other areas – although these projects may differ more in name than aim.

Co-production is not just about the joint negotiation and delivery of policy aims. It is also about understanding what drives local policymakers and what information is relevant to them, given the constraints they face (including budget, time, and incentives) and the rules they follow. This distinctiveness may extend to policy learning based on distinctive aims, perspectives and reference points.

Consequently, the Scottish Government has a dual role in policy learning and transfer. First, it identifies what experiences and evidence are relevant, based on its own aims. Second, it

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identifies how to translate evidence into lessons that are relevant to co-producers, or aid co-producers to systematically gather evidence to suit their distinct aims.

Co-production has an important effect on the learning process because methods for evaluation-into-action vary markedly by profession, organisation and policy area. The 'implementation science' approach in healthcare, based on a hierarchy of evidence, and often a hierarchy of actors, may not be accepted in other areas. It contrasts with 'critical' approaches to evidence in education, in a field with a less hierarchical professional structure. The idea of a hierarchy of evidence may also be contested in social science.

Evaluations of prevention success are based as much on policymaking as policy. They struggle to separate the effect of (a) the intervention from (b) the delivery of the intervention by networks of public bodies. This is a fundamental issue when we seek to learn lessons from other projects: are we learning about the policy idea or the way in which the idea is understood and used, more or less competently, in particular areas?

A broad framework to identify common elements of successful prevention policies raises a fundamental issue: success, as measured from the 'top', may undermine success measured at the 'bottom'. Modern discussions still define success in terms of the aims of central government policymakers being embedded and carried out, which differ markedly from a definition based on co-production and long term outcomes. The latter should inform an initial evaluation process, which is often based on reputations and quick analysis.

We outline a specific framework encouraging a minimum standard for policy adoption, based on identifying comparable and representative experiences that could be imported, and ensuring that the production of relevant evidence and search for relevant experiences is systematic.

Not many projects live up to this minimum standard, particularly when governments don't feel they have the time to gather evidence of long term outcomes. We provide some case study narratives to identify promising projects, while noting the uncertainties that come from importing projects from other countries or scaling up from pilots. Some parts of the Scottish Government may have the resources to consider the evidence and implications of such evaluations, but practitioners and service users may rely on shorter briefings and assurances about the value of specific projects.

The idea of 'What Works' is no substitute for political choice based on limited evidence. That choice may vary markedly across 32 SOA areas. A 'bottom up' approach may involve the co-production of relevant evidence as much as the co-production of policy.

A Framework to Decide 'What Works' in Prevention Policy

We can divide the 'Scottish approach' (Scottish Government and ESRC, 2014) to policymaking into three relevant elements. First, it has a reputation for pursuing a consultative and cooperative style when it makes and implements policy. It works with voluntary groups, unions, professional bodies, the private sector, and local and health authorities to produce policy aims. Its approach allows it to gather information and foster group support for policy. Second, this approach extends to policy delivery, with the Scottish Government often willing to produce broad strategies – underpinned by the National Performance Framework - and to trust bodies such as local authorities to meet its aims. In turn, local authorities work with a wide range of bodies in the public, voluntary and private sector to produce shared aims relevant to their local areas. Single Outcome Agreements mark a symbolic shift away from 'top-down' implementation, in which local authorities and other bodies are punished if they do not meet short term targets, towards the production of longer-term shared aims and cooperation. Third, the 'Scottish approach' includes a commitment to 'achieving a decisive shift to prevention', following the Scottish Government's post-Christie agenda on reforming public services, addressing inequalities and reducing demand for reactive or acute level services by providing effective services at an earlier stage (Scottish Government, 2011).

One part of the SCCC project explores the 'payoff' from the Scottish approach to policymaking, using prevention as a timely and relevant case study. If the Scottish approach is effective, we would expect this to be reflected in the level of policy coherence across government and the degree of 'ownership' and support by key stakeholders. This paper informs that process by examining some potential barriers, including the often-vague nature of prevention, which can undermine the sense that the Scottish Government and its partners have a common understanding of policy solutions.

We relate this problem to the broad idea of an 'evidence based policymaking' (EBPM) process, in which we identify our aims and generate the best evidence to inform our decisions. The Scottish Government seeks to learn from the success of prevention projects in Scotland, the UK and abroad and needs a way to identify and interpret the available evidence before making a judgement. We examine three types of solution:

1. The production of a working definition of Scottish Government prevention policy, as a way to clarify its aims and measures of policy success.
2. A broad framework to identify the common elements to successful projects: what makes a policy successful and how much success is transferable?
3. A specific framework encouraging a minimum standard for policy adoption, based on measures to identify the most promising projects. Measures include: identifying comparable and representative experiences that could be imported; considering the policy development process as well as the policy; attention to issues of scale; identifying how well a project has been evaluated; and, ensuring that the search for relevant experiences is systematic.

What Does Prevention Mean? Can We Produce a Practical Working Definition?

'As a unifying slogan it is difficult to upstage; as a tool for action in the world of social problems it has proved decidedly inadequate' (Billis, 1981: 368).

Prevention as a vague, unifying term

We can articulate a broad meaning for the term 'prevention'. 'Preventative spending' and 'prevention' are terms used by many governments, and in many policy studies, to describe a broad aim to reduce public service costs (and 'demand') by addressing policy problems at an early stage. The argument is that too much government spending is devoted to services to address severe social problems at a late stage. The aim is for governments to address a wide range of longstanding problems - including crime and anti-social behaviour, ill health and unhealthy behaviour, low educational attainment, and unemployment (and newer problems relating to climate change and anti-environmental behaviour) – by addressing them at source, before they become too severe and relatively expensive. This aim may be timeless, and relate to previous policies directed at identifying the root causes of social problems – such as poverty, social exclusion, and poor accommodation. It may also receive more attention during an 'age of austerity' in which governments seek to reduce spending and/ or redirect spending to other areas (to address key demographic shifts, such as an ageing population, which affect service demand in other areas).

At this abstract level, prevention can generate widespread and long-term consensus – to bring together groups on the 'left', seeking to reduce poverty and inequality, and groups on the 'right', seeking to reduce economic inactivity and the costs of public services (Billis, 1981: 367). In the UK, it has been a theme pursued, at least in official reports, during Labour and Conservative governments since the 1950s (1981: 368). It can also be linked to other 'valence' issues, such as (a) the need for 'joined up' or 'holistic' government in which we foster cooperation between, and secure a common aim for, departments, public bodies and stakeholders at several levels of government; and, (b) a shift from short, often misleading, targets as proxies for policy aims, to more meaningful long term outcomes.

Prevention on a spectrum, or as three approaches

This consensus is more difficult to maintain when we examine specific ways in which people have described prevention (Freeman, 1999). We can appear to help by identifying three different kinds of prevention policy, on a notional spectrum, from successful prevention to stop problems arising, to an attempt to stop more harm occurring (Gough, 2013: 3; see also Freeman, 1999):

1. *Primary prevention* – stop a problem occurring by investing early and/or modifying the social or physical environment. Focus on the whole population.
2. *Secondary prevention* – identify a problem at a very early stage to minimise harm. Identify and focus on at-risk groups.
3. *Tertiary prevention* – stop a problem getting worse. Identify and focus on affected groups.

However, unless governments make a specific commitment to primary or secondary prevention, this spectrum may simply allow them to make a commitment to 'prevention' policies which equate to reactive policies dealing with current problems.[2] Similarly, a vague reference to prevention allows existing service providers to rebrand their activities as preventative without shifting their approach.

Prevention in different policy fields

The difficulty is compounded when we try to produce a common understanding of primary/ secondary/ tertiary in different policy fields. For example, it seems clearest when related to disease: primary relates to whole-population inoculation or behavioural programmes which prevent the spread of communicable disease; secondary relates to screening programmes focused on at-risk groups and identifying disease and at the earliest possible stage; and, tertiary relates to programmes to minimise the impact of identified diseases. Therefore, a commitment to primary over secondary over tertiary prevention has a relatively specific meaning. This is *somewhat* comparable to aspects of education, including work by Heckman (n.d.) which ties major social problems to factors such as 'low levels of skill and ability in society' and recommends 'early interventions'. In this case, prevention relates to investment in relation to age and stage: more spending on the very young, and less as they age. This is not the same as in health conditions (since, for example, one can inoculate an adult from disease), but there is scope for meaningful comparison - and one can focus on whole or target disadvantaged populations (Melhuish, 2003: 5). However, it is harder to relate to less-well-understood social problems related to crime and social work, where prevention could relate to some mix between a focus on three prevention stages and on age-related interventions.

Prevention, Causality and Predicting the Future

> 'it is possible to treat the root and long-term causes of problems, driving demand out of the system' (Commission of the Future Delivery of Public Services, 2011: 26).

A general problem with cross-cutting issues is that concepts and approaches have a different meaning and implication in different disciplines, professions and departments (Head, 2010: 80). Our approach to identifying problems and their solutions may differ markedly, even though one approach may dominate discussions on how we identify causation and 'what counts as good evidence' (Nutley et al, 2013: 7). At the heart of this difficulty is our inability to predict a significant part of the future, based on our knowledge of what causes particular problems and how universal that cause is.[3] Disease prevention may be one of the simplest examples because we know the cause of many diseases, how to screen for them, and how to prevent them in the population. Much of the scientific basis may be in methods such as randomised control trials. In many cases, we effectively assume that the causes of diseases

[2] A problem accentuated in fields such as 'flood prevention' which is often about managing floods rather than dealing with the root causes (Werritty, 2006).

[3] The identification of simple linear cause and effect is perhaps more straightforward in the physical than the social world, but it is generally problematic (Billis, 1981: 369; Freeman, 1999: 233) and the identification of complex systems, which defy linearity and prediction, is a feature of the natural and social sciences (Cairney, 2012a).

are universal, affecting people in more or less the same way, allowing preventative treatment to be universal. If the results of one or several RCTs are promising, we may work on the assumption that a 'scaled up' programme should be promising.

We can identify a modified version of this approach in public health preventative work which often treats unhealthy behaviours as epidemics to be eradicated. For example, tobacco control is a mix of:

- tertiary prevention - to minimise the harm of tobacco in the current 'developed country' population
- secondary prevention - to use the 'tobacco epidemic model' to identify and address tobacco problems at a much earlier stage in 'developing countries' (Lopez et al, 1994; Jha and Chaloupka, 1999; Thun, 2012)
- primary prevention – to use past experience to remove harm to future generations.

In each case, the strategy is based on the well-established and generally accepted scientific link between smoking and ill-health, in which there is no safe level of smoking (Cairney, Studlar and Mamudu, 2012: 2-3). Measures include: regulation (bans on tobacco advertising, sponsorship, smoking in enclosed public places, sales to children); economic (high prices, funding for smoking cessation services and tobacco control advocacy and scientific research); and education (health education, warnings on packaging) (2012: 14).

This approach can also be found, to some extent, in alcohol control, but with less certainty about the consumption-health link (there is no equivalent 'no safe level of drinking' approach in government) and therefore a greater emphasis on policies to address high risk groups (Cairney and Studlar, 2013[4]). It may also underpin nascent policies on food consumption to address widely the contribution of unhealthy behaviour to illnesses such as cancer (Stewart and Wild, 2014).

Prevention, based on identifying a root cause and predicting outcomes, is more problematic in education because we cannot assume a universal effect of an intervention. In that context, Heckman's work may be sold as something as close as possible to a universal solution: government spending produces the highest 'benefit-cost ratios and rates of return' when devoted to pre-natal and pre-school, lower returns during compulsory education and the lowest returns in post-school programmes. RCTs are less prevalent and more difficult to introduce, partly because of the less controllable nature of education intervention evaluation, and partly because the profession is less dominated by RCT-minded scientists. However, there is still scope to measure the outcomes of interventions at each stage.

It is much more difficult to identify this simple approach in other social policies in which we tend to identify complicated relationships between cause and effect. For example, Wattam (1999: 318) describes a major expansion in research on risk assessment (secondary prevention) in child abuse, accompanied by scepticism about its underlying assumption that

[4] McCulloch (2014) argues that the Scottish Government's legal case on the minimum unit price of alcohol rests on the identification of 'harmful and hazardous' drinkers.

'child abuse can be scientifically measured, its causal factors identified and the conditions that give rise to such causal factors should be the subject of intervention'. In other cases, we are dealing with 'wicked' problems that often seem intractable or, at least, too big and connected to be amenable to a solution based on the simple identification of cause and effect following limited research (Taylor, 2013; Williams and Glasby, 2010).

Prevention as an ethical dilemma and a political choice

Underpinning each discussion is an ethical dilemma about how appropriate government intervention is, and what level of government intervention is appropriate. It involves a political choice and a normative judgement based on our understanding of the policy problem, the role of the state in solving it, and the balance between state solutions and an appeal to personal responsibility (Freeman, 1999). This normative decision informs an empirical judgement - based on identifying the type of intervention, its scientific basis, the likelihood of success, and its effect on different social groups. The ethical and scientific basis for intervention can be separated analytically, but not in practice. In each case, there is a need to articulate how one deals with the trade-off between individual liberties and government intervention. So, individual prevention projects may have a narrow focus, but be underpinned by fundamental decisions and a dominant understanding about who counts as a target for public policies and how far we should go to influence their behaviour (Wattam, 1999: 323).

For example, in tobacco control, health education is less controversial than regulations on smoking behaviour because the former is more geared towards informed choice than controlling public behaviour. In public health, regulatory measures for tobacco control are often more advanced than for alcohol control because the former is backed by evidence on universal harm from smoking, and an argument on universally good outcomes from cessation, while the latter involves greater uncertainty about consumption and the varying effects on responsible and problem drinkers.

Ethical issues are magnified when public policy has the potential to produce a major effect on individual liberty (such as imprisonment or medical detention) or the guardianship of children. The identification of high risk social groups can also be particularly controversial in areas such as crime because, in practice, well-meaning/ discriminatory policies are difficult to disentangle. Examples of crime-based preventative work include 'stop and search', which may place a disproportionate burden on BME groups, and the Home Office's agenda on the preventative detention of people diagnosed with DSPD (dangerous severe personality disorder), which is based partly on the idea that you can detain mentally ill people before they commit serious crimes (Cairney, 2009).

Prevention as an upfront cost and redistribution of resources with uncertain results

These political choices have resource implications, producing winners and losers. This process is particularly visible when preventative spending policies involve a reduction in funding for reactive, acute or 'firefighting', 'frontline' services which produce immediate results, to pay for new prevention initiatives that may only produce results after a generation. A shift in resources may be designed to produce better outcomes over decades, which may be

difficult to measure, at the risk of highly visible and measurable costs in the short term. These costs may be financial (invest for the long term in the same way you would invest in capital) and/ or political[5], when existing visible services are sacrificed for longer term aims. A visible party political imperative - parties competing for office every 5 years and seeking short term measures of success or failure - may combine with visible effects on public services to disrupt long term policies. This process may be reinforced when policies involve significant redistributions between social groups, such from the relatively old to young, or from groups exhibiting intractable rather than preventable problems. Prevention may generate consensus when designed on a blank sheet of paper, but not when mapped onto an existing public service, producing profound choices about the reduction of current services for one generation to benefit the next. Ironically, while prevention in the abstract may be sold during economic crises as a way to save money, it is may also be more likely to be supported in less austere circumstances (Burnside, 2010: 4).

This problem is compounded when we interrogate the assumption that prevention necessarily saves money - this is often asserted rather than demonstrated (Early Action Task Force, 2012: 7) and many study results challenge the assumption (2012: 34; Burnside, 2010: 13). Cohen et al (2008) argue that many prevention policies in healthcare do not save money, and the OECD (2013: 10) argues that 'prevention is *often* a more cost-effective way of improving health than spending money once a disease takes root'. Prevention projects may produce non-financial benefits without saving money, which raises challenges to evaluation when there is no other commonly accepted metric. Suhrcke et al (2006) find no reliable way to measure the effect of health interventions using currently accepted measures, such as effect on GDP.

These issues may be managed differently in each sector, but with a general focus on incremental rather than radical change, with the introduction of preventative policies and budgets alongside existing services (Gough, 2013: 7; Early Action Task Force, 2012: 28). This may be what a 'decisive shift towards prevention' means in practice. For example, public health policies such as tobacco control focus on policies that have a small redistributive effect, with health education, smoking cessation services and regulation enforcement representing a small part of the government budget compared to relevant services in the NHS (Cairney et al, 2012: 101-4).

Prevention as a cross-cutting approach, but which cross-cutting approach?

An intuitive solution to the existence of separate approaches in different fields is to maintain policy area-specific boundaries - different bodies and professions deal with issues in their own way (as with public health policy separate from early years education policy). However, if prevention represents a 'cross-cutting' approach to policy problems, focusing on the interaction between multiple problems in multiple fields, and finding a comparable measure of outcomes across multiple fields, we need some way to coordinate approaches to common aims and measures.

[5] For example, Healy and Malhotra 2008 argue that US voters generally reward high profile disaster relief more than prevention.

It seems unlikely that this would come from simply identifying a core common cause of policy problems. There are studies exploring income inequality as the key cause of other inequalities, such as in illness and mortality, but their conclusions can be hard to pin down because the authors do not identify clear lines of cause and effect (see for example Crepaz and Crepaz, 2004: 280). Instead, there may be intermediate causes, and studies explore *the extent to which we can argue that* perceived inequalities produce 'psycho social stress' and potentially adverse behaviour if too large (including the UK and US), or a lack of motivation to work if too small (including Sweden, Norway, Finland) (2004: 293).

A more pragmatic approach would be assume that there is no 'one size fits all' (even though it is tempting for some to roll out a health-based approach to other fields). We would compare how prevention policies might be pursued and evaluated in different fields, and consider the effect of a combination or one approach being chosen over another (see, for example, Wattam's 1999 identification of three competing approaches to preventing child abuse). This exercise could inform discussions about the main aim of prevention, from the identification of cross-cutting issues anchored to particular areas (public health, child abuse, mental health, crime, etc.) to the idea of a single unifying approach to prevention based on public spending and/or a common measure of outcomes across sectors (Early Action Task Force, 2012: 19).

Prevention as an approach to government, as well as to policy problems and solutions

It is difficult to separate a commitment to prevention policies from a commitment to particular forms of government, policymaking and spending. For example, Ernst and Young (2013: 3) express concern about simply transferring policies from one locality to another, since delivery success may be linked strongly to each locality's history of partnership working. They highlight the importance of the 'level of maturity of cross boundary and sub regional governance structures' combined with 'leadership' and the willingness of local and national policymakers to change how they work, to produce 'systemic reform'. The Early Action Task Force's (2012) explanation for the slow rollout of prevention policies relates primarily to problematic governance – including short term thinking in government, silos in the public sector, a lack of leadership, inappropriate accountability mechanisms to facilitate prevention approaches – and the need for 'early action funds' to aid the transfer of funding from existing budgets to foster new ways of delivery (see also Melhuish 2003: 5, who links successful early years interventions largely to leadership, training and supervision; Anning et al, 2007: iv on the links between governance/ multi-agency working and Sure Start success; and Manthorpe et al 2014 on the importance of bureaucracy, leadership and funding to the implementation of self-directed support in Scotland). This is a key focus of the Christie Report (Commission of the Future Delivery of Public Services, 2011: vi) which recommends prevention policies alongside integrated service provision.

If policy and delivery are inextricably linked, it is difficult to evaluate the success of policy instruments independently of the ways in which they were used. Further, the availability and use of methods differs markedly between, say, the health sciences, using methods such as RCTs, and the policy sciences, using different methods to reflect the limitations in studying

government. Generally, the missing element from policy sciences is the requirement for 'control' in a randomised control trial, particularly when policy delivery involves bodies with multiple responsibilities and variable levels of attention to them. It is difficult to insulate pilots from the broader policymaking context in which they are introduced. Governments are responsible for a wide range of unpredictable issues which cannot be prioritised simply in terms of the severity or risks associated with problems. Policymakers are simultaneously managing acute risk (based on measures of a problem) and salient risk (based on attention to the problem). We can produce a measure of a policy problem, and a science of risk, but struggle to predict a government's response and generate a science of the 'public management of risk' (Lodge, 2009).

Prevention as a Specific Policy: defining and 'owning' the problem

Many of these problems can be addressed by a government setting out a clear and detailed policy aim, produced in partnership with relevant bodies. It would address prevention's vagueness and association with many different aims, such as to reduce service costs or increase quality of life in a population, to intervene at a primary, secondary or tertiary level, to invest in young people, and/ or to replace acute service delivery with preventative projects. A clear aim would help produce meaningful measures of success (even though government policy is one of multiple causes of outcomes). It would clarify to outside groups what they are asked to support and how realistic their aims could be, to help secure meaningful stakeholder 'ownership'.

There are two main elements to Scottish Government policy in this area: a broad policy framework, and a specific focus on prevention.

What is Scottish Government Prevention Policy? 1. The Broad Framework

The Scottish Government (2007; 2014a) has, since 2007, maintained the National Performance Framework (NPF) based on a 'ten year vision'. The NPF has a stated 'core purpose - to create a more successful country, with opportunities for all of Scotland to flourish, through increasing sustainable economic growth'. The Scottish Government seeks to turn this broad purpose into specific policies and measures of success in two main ways. First, it articulates in more depth its national approach via a 'purpose framework' - linked to targets gauging its economic growth, productivity, labour market participation, population, income inequality, regional inequality and (emissions based) sustainability - and five 'strategic objectives':

1. Wealthier and Fairer - Enabling businesses and people to increase their wealth and more people to share fairly in that wealth.
2. Healthier - Helping people to sustain and improve their health, especially in disadvantaged communities, ensuring better, local and faster access to health care.
3. Safer and Stronger - Helping communities to flourish, becoming stronger, safer places to live, offering improved opportunities and a better quality of life.
4. Smarter. Expanding opportunities to succeed from nurture through to lifelong learning ensuring higher and more widely shared achievements.

5. Greener. Improving Scotland's natural and built environment and the sustainable use and enjoyment of it.

In turn, these objectives are mapped onto sixteen 'National Outcomes' and fifty 'National Indicators'. Rather than having 'prevention' as a separate objective, it can be an approach underpinning many strategic objectives, such as in health and education as a large part of 'healthier and smarter', and contributing to many national indicators, including:

- *Health* - Increase physical activity; Improve self-assessed general health; Improve mental wellbeing; Reduce premature mortality; Reduce emergency admissions to hospital; Reduce the percentage of adults who smoke; Reduce alcohol related hospital admissions; Reduce the number of individuals with problem drug use; Reduce reconviction rates.
- *Poverty* - Reduce the proportion of individuals living in poverty; improve access to suitable housing options for those in housing need; Improve the skill profile of the population.
- *Early Years* - Increase the proportion of pre-school centres receiving positive inspection reports; Improve levels of educational attainment; Reduce children's deprivation; Increase the proportion of young people in learning, training or work; Improve children's services; Improve children's dental health; Increase the proportion of babies with a healthy birth weight; Increase the proportion of healthy weight children
- *Environment* - Reduce Scotland's carbon footprint; Increase the proportion of journeys to work made by public or active transport; Reduce waste generated

Second, the Scottish Government works with local authorities to produce 'Single Outcomes Agreements'. The SOAs are produced in line with the NPF's overall vision and strategic objectives, but local authorities have considerable discretion to decide the balance between a range of priorities and how they will meet these objectives. The spirit of the Scottish Government's Concordat with the Convention of Scottish Local authorities (COSLA) suggests that the former will not seek to micromanage local authorities or use external scrutiny and funding to produce compliance with short term, specific proxy targets (Cairney and McGarvey, 2013: 139-40). Rather, it encourages local authorities to cooperate with a range of other bodies in the public sector (including health, enterprise, police, fire and transport), via established Community Planning Partnerships (CPPs, which encourage 'community engagement' and engagement with the third and private sectors), to produce a 'shared strategic vision for an area and a statement of common purpose' and meaningful long term outcomes.

In other words, the NPF provides a framework in which prevention policies can be pursued, and used to further Scottish Government objectives, but without determining how each body operates, and without obliging bodies such as local authorities to meet particular aims in a particular way. It allows for considerable discretion for bodies to map their activity onto the NPF, and to allow them to set their own priorities (Keating, 2010: 123-4; Matthews, 2014).

2. The Christie Commission Agenda

The Christie agenda for prevention policy begins with a broad statement of intent based on four principles:

- *Reforms must aim to empower individuals and communities receiving public services by involving them in the design and delivery of the services they use.*
- *Public service providers must be required to work much more closely in partnership, to integrate service provision and thus improve the outcomes they achieve.*
- *We must prioritise expenditure on public services which prevent negative outcomes from arising.*
- *And our whole system of public services – public, third and private sectors – must become more efficient by reducing duplication and sharing services wherever possible* (Commission of the Future Delivery of Public Services, 2011: vi).

The Commission's aim is to examine how to reduce social and economic inequalities[6], improve 'social and economic wellbeing' *and* spend less money, in the context of: (a) over 10 years of high post-devolution spending producing minimal or adverse effects on inequalities (including healthy life expectancy and education attainment); (b) the likelihood of reduced budgets for over 10 years; and, (c) rising demand for many public services, resulting from a combination of demographic change, such as an ageing population, and 'failure demand' (the high cost of a public service when it treats acute problems – such as a high prison population) (2011: viii; 7; 16; 75).

To do so requires the Scottish Government to address its unintended contribution to a 'cycle of deprivation and low aspiration' by: redirecting spending towards preventative policies in a major way (it estimates that over 40% of local public spending could be redirected - 2011: viii; 6-7); change its relationship with delivery bodies; address a lack of joint working in the public sector, caused partly by distinct budgets and modes of accountability; and, engage 'communities' in the design and delivery of public services, rather than treating them as 'passive recipients of services' (the 'assets-based' approach – 2011: 27).

It gives a steer on the types of projects on which a prevention agenda can draw, including those which:

- 'personalise' service delivery by, for example, encouraging disabled service users to negotiate the details of their care (including how the budget is spent) (2011: 28-9) or encourage 'recovery' from addiction (2011: 31)
- train 'kinship' carers, to reduce the need for cared-for people to use relatively expensive public services (2011: 31)
- foster social networks to address the mental health effects of isolation (2011: 32)
- involve partnerships with specialist third sector bodies (2011: 33)

[6] Broadly defined, and in relation to housing, employment and employability, crime, education, health and wellbeing.

- involve bottom-up service delivery through organisations such as community development trusts (2011: 34)
- focus specifically on inequalities in areas such as training and work (2011: 57)
- focus specifically on 'the needs of deprived areas and populations' (2011: 59).

These projects should be underpinned by series of measures to produce the right environment for preventative work. First, inter-disciplinary professional training should help foster a 'single cross public service' (2011: 39). Second, transparent and consistent measures - 'accountability frameworks', 'performance management' and 'benchmarking', 'funding, budgeting and accounting' or 'commissioning' processes (for current and capital spending), and audit - should be introduced to support the outcomes-based approach of the National Performance Framework (2011: 42; 63-5). Third, a 'power to advance well-being' and statutory duty to provide 'Best Value' should be extended from local authorities to all public bodies (2011: 47).

It identifies 9 priorities and at least 10 recommendations, but we can identify an overall aim, based on three relevant steps: (1) make a firm and tangible commitment to prevention, backed up by a commitment to cross-cutting budgets (and, in some cases, legislation – 2011: 72); (2) use the existing evidence on prevention to identify the projects most worthy of investment; and (3) pursue a 'bottom-up' approach to policy delivery, encouraging local bodies and 'communities' to work together to turn this agenda into something relevant to local areas.

3. The Scottish Government's response to Christie

The Scottish Government (2011: 6) response was positive, signalling 'a decisive shift towards prevention' and 'a holistic approach to addressing inequalities'. It sought to turn this broad agenda into specific aims and projects, by:

- listing its existing prevention-led projects, including a focus on early years (and poverty) investment, class sizes and curriculum reform, employment training, tobacco, drug and alcohol control, 'inequalities-targeted health checks', alternatives to short-term custodial sentences, affordable housing, energy assistance and community-based carbon emissions reduction projects.
- announcing three new funds, representing £500m 'investment in preventative spending' from Scottish Government and public body funds - a 'Change Fund for older people's services' (primarily NHS budget), an 'Early Years and Early Intervention Change Fund' NHS and local authorities) and a 'Reducing Reoffending Change Fund' (with high third sector involvement) – and a 'Scottish Futures Fund' bringing together spending on youth sport, broadband, Sure Start, fuel poverty and public transport encouragement.
- Outlining its specific priorities up to 2016, to expand nursery education and reduce class sizes, roll out Getting it Right for Every Child (GIRFEC) nationwide, increase funding (£30m) on early cancer detection, introduce a minimum unit price on

alcohol and further tobacco control, regenerate 'disadvantaged communities' and support community-based renewable energy schemes (2011: 6-9).

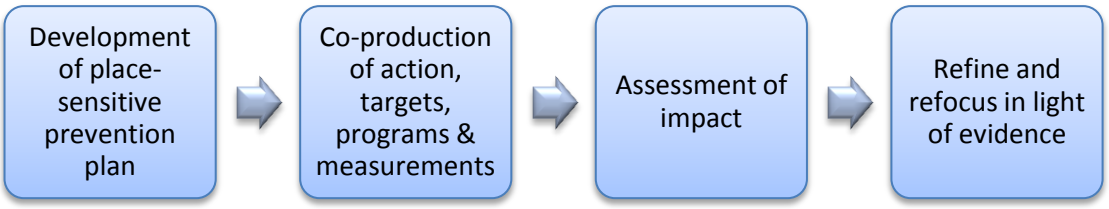
It also provides a review of its current and future activities, describing how they fit into the prevention agenda. The list is long (approximately 50 bullet points) and brief, without a detailed explanation of how each policy fits Christie's criteria (2011: 76). Generally, it shows a broad commitment to a broad prevention-style philosophy, 'mainstreamed' throughout government, accompanied by a short list of projects receiving new dedicated funding. So, Scottish Government prevention policy is a very broad definition applied across the public sector, combined with relatively-developed public health measures and a smaller number of identified priorities, including:

- Early years – a focus on investment in education at an early age (nursery, pre-school and lower class sizes in primary 1-3) combined with the GIRFEC agenda on personalising social care for individual children.
- Older people's services – a focus on keeping older people out of hospital care, in favour of supporting people living at home (free personal care, combined with fuel, transport and social network initiatives to promote mental wellbeing) or residential care.
- 'Reducing reoffending' projects based on partnership with third sector organisations and some justice system reforms.

4. The Single Outcome Agreements (SOAs)

This combination of an outcomes based approach, and a commitment to SOAs generated within local areas, has produced a mix of similarities and differences in the local response (Scottish Government, 2014b lists the 27 SOAs for 2013). The broad similarities follow close adherence to the guidance issued by the Scottish Government (2012) and COSLA. All SOAs support:

- a 'decisive shift toward prevention' and the idea of holistic action to reduce inequalities and/ or secure long-term cost-saving
- a more systematic integration of prevention into its community planning
- community planning through consultation, information sharing, co-production, and lesson-drawing based on a combination of research evidence and local knowledge.
- prevention plans for the six priority areas for 'transformational' improvement: economic recovery, development and growth; employment; early years; community safety and security, with a particular focus on the reduction of reoffending; the reduction of health inequalities, with a particular focus on increasing participation in physical activity; and the improvement of outcomes for the elderly.
- A four stage process to identify existing policy and spending, co-produce aims and targets for change and evaluate progress regularly.



There are broad differences of approach in many areas, partly because SOAs appear to draw lessons primarily from the Scottish Government or their own experience - there is minimal evidence, at least from these documents, of learning directly from neighboring areas. Many SOAs legitimately describe shifts towards preventative spend as an enhancement of existing practices. In other cases, it is more difficult to tell if existing programs are truly preventative and if the 'prevention' label is used to guarantee continued funding. The NPF metrics may help evaluate their performance, but the lack of agreement over the meaning of prevention and early intervention allows CPPs to fit much of their current services under that heading. While many SOAs follow the Scottish Government's broad definition, others construct their own definitions and concepts. Prevention projects can therefore range from the Highland focus on 'healthy and fulfilling' lives to East Lothian's 'crisis intervention'.

CPPs can share prevention as a priority but be motivated by different ideas about causality. For example, almost all drug and alcohol strategies seek to prevent risk-taking behavior through educational and diversionary programs, or provide support and rehabilitation of those in difficulties, while Shetland also has a deterrence-focused approach, based on increasing canine searches and police detection of substance and alcohol misuse. Local areas may also use different measures to define their geographical and socioeconomic properties. The most frequently cited source of information on inequality is the Scottish Index of Multiple Deprivations. To this, CPPs such East Dunbartonshire add information from their own commissioned studies. Local areas may also target populations in different ways, using different rationales for intervention and the targeted use of resources.

The more notable differences come when local areas turn broad strategies into specific projects, relevant to their geographies and socioeconomic conditions, and try to give greater meaning to 'prevention'. Some natural geographic and demographic differences produce idiosyncratic aims: the Highland SOA features action to prevent wildlife crime, mitigate the negative effects of bad weather on hard-to-reach rural communities, and prevent environmental degradation; Orkney's discussion of community safety includes actions to prevent water-related accidents through primary prevention (safety inspections) and early intervention (educational and diversionary programs for children and young people); and, Argyll and Bute argues that its geography plus an unequal, declining, and ageing population presents it with the challenge of having to implement prevention for a unique group of 'people on the fringe', facing deprivation and geographic isolation. Yet, geography is not always a predictable indicator of differences. For example, there is some variation in

discussions of the prevention of terrorism through targeted schemes and early interventions to reduce the risk of 'radicalization' – and it does not seem to relate strongly to, for example, urban/ rural areas.

The diversity between SOAs appears to be most evident at the project level, although many CPPs have a common commitment to, for example, the Early Years Collaborative (Scottish Government, 2014c). It would also take more research to know if individual projects differ more by name than aim. Examples include the:

- 'Being a Parent in Dundee' prevention and early intervention partnership to support parents
- East Ayrshire 'Nurture Framework' for secondary prevention for children and young people with emotional, social and behavioural difficulties
- East Lothian 'Support from the Start' early intervention strategy
- One Glasgow Children 0-8 work-stream aimed at preventing the escalation of behavioural and developmental problems in children
- Scottish Borders Childsmile oral health program.

Informing the Scottish Approach to Prevention through Policy Learning and Transfer

We have identified a Scottish Government position on many aspects of prevention and, through the NPF, some indicators of how it measures success. In that context, the Scottish Government may want to know how to turn this commitment into a series of specific projects that produce better outcomes in Scotland in its favoured terms. It may seek to identify good practice by learning in two broad ways:

1. From other countries or governments, based on their perceived success in relevant, comparable areas.
2. From good/ best practice within Scotland. This route may involve the identification of successful pilot projects to be 'scaled up' or encouraged elsewhere. This 'scaling up' process can vary, from the encouragement of some bodies to learn from successful bodies, to the production of policy instruments designed to be applied across Scotland as a whole.

In other words, it may seek to adopt projects if they are perceived to be *successful*. This requires us to 'operationalize' success in terms of certain criteria, perhaps relating to the cost of the programme and its outcome, and interpreted according to the aims of policymakers and their criteria for success. Our aim is to provide a framework in which to measure, describe and explain success, addressing two different aims:

Academic. To identify the many, significant problems we face when learning from other governments and projects, identifying success, and seeking to import or extend policies. To argue that policy learning and evaluation is an inherently political process, which cannot be separated from politics and treated simply as a technical matter or objective measurement.

Policymaker. To use the best evidence available to make and justify decisions. The Scottish Government is in a different position from academics. It cannot simply conclude that 'prevention' is a vague term and that the learning and policy transfer process is problematic. It must decide what programmes to fund or encourage, based on an acceptable measure of their likely success, and it must justify that decision to the public via Parliament. It must also work with its stakeholders and partners to make policy work. In that context, the identification of problems is limited unless accompanied by potential solutions.

Identifying, Learning From, and Transferring Success: Problems to Address

Learning from other countries or our own pilots?

General problems with transferring policies from other countries relate primarily to insufficient information about the original programme's aims, content and alleged success, and insufficient thought about how to learn from that experience and modify the programme to the importing government (Rose, 1993; 2005; Dolowitz and Marsh, 1996; 2000; Cairney, 2012b; Cairney and Yamazaki, 2013; see also Taylor, 2013: 20 on the effects of unclear aims). Policymakers and practitioners cannot consider all international experience, so they use short cuts to identify the most promising projects most worthy of further study (Berry and Berry, 2014). Consequently, the initial sifting exercise may be based on quickly-generated reputations of success rather than long term independent evaluations. This is a particular problem when we seek projects to secure long term outcomes. It may be complicated further if a devolved Scotland seeks to learn from independent countries who do not need to consider, in the same way, how reserved and devolved elements combine to produce outcomes. In each case, superficial analyses do not capture the 'unknowns', such as the contribution of a 'policy environment' to policy success. They are often unexamined internally, when actors don't reflect on the factors that they take for granted in their policymaking environment (such as the role of the courts in family and welfare policy in US states), and externally, when outsiders don't know what to look for when making comparisons.

We may know more about domestic pilots but still worry about generalizability: we need to know enough about the reasons for success (or failure) in that particular area before considering if it can be replicated in a much larger number of areas. Pilots can be outliers if they receive disproportionate levels of resources to make them work (including political attention and funding) and/ or if they take place in areas with particular advantages. For example, Highland projects may produce particular success based on underlying success in joint working, in an area with unusual conditions.

Separating causes of success: the instrument and the style of implementation

We can identify two very different ideas about 'scaling up', from the top-down and universal roll-out of a successful policy instrument, to the encouragement of modified instruments and bottom-up solutions. In part, the approaches represent different disciplinary traditions based on ideas about the objectivity of evidence gathering and the 'social context about its application' (Nutley et al. 2013: 5). In the former, associated largely with public health and

health sciences, the evidence relates to policy instruments; we use methods such as randomised control trials to measure their effect and we draw on implementation science to determine how best to implement (Nilsen et al, 2013). More sophisticated accounts of scaling up discuss the importance of implementation capacity and the right conditions for policy adoption, while others focus on the vague notion of a lack of 'political will' as an obstacle to evidence-based policy adoption (Mangham and Hanson, 2010; Gilson and Schneider, 2010).

In the latter, policymaking and implementation are inextricably linked: we can separate them analytically but, in practice, the success of a policy instrument is inseparable from the conditions in which the delivery is made. Consequently, the evidence-gathering process differs, since methods such as RCT are used far less frequently (partly because the 'control' element is often unattainable - Sanderson, 2002: 12), and evaluation is based on more pragmatic measures based on, for example, a historical baseline rather than a control group. The existence of these two different ideas can present problems if a government takes the evidence process and idea of scaling up from the former, but tries to adopt the governance approach of the latter.

The evidence doesn't exist, it exists in a partial form, or it is not self-evident

A common theme of reviews of prevention is that the evidence for success is patchy and unsystematic:

> Understanding what works and what doesn't needs good evidence, but this is thin on the ground. Data has been collected over many years for different funders, using different processes and indicators and making it difficult to draw comparisons and conclusions, even when considerable effort and expense has been invested in record keeping (Early Action Task Force, 2012: 34).

The EATF describes the need for 'common core evaluation', and identifies some progress towards it, but without any results so far (2012: 34). It also highlights the unavailability of evidence in many cases, particularly when the service is provided by a company 'claiming commercial confidentiality and withholding crucial information' (2012: 34). So, we are left with the identification of the economic and ideological case for primary prevention, and some positive evaluations from some projects, but without a clear sense of how the evidence ties together – that is, if there are common elements to success, and how much success can be linked to the policy instruments or the policymaking approach.

We can see some of the problems and compromises involved by looking the limitations to a successful evaluation of multiple projects. Adler-Baeder et al (2010) describe their attempts to find a common method to evaluate 200 community based programmes on 'parent education/support, home visiting, respite care, fatherhood, community awareness, school-based, non-school-based/after-school, and mentoring'. They focus on the need for a valid measurement of the demographics of the population and characteristics of the participants, a common measure of impact across the programmes, and '"user friendly" methods of data collection'. They focus on 'participants' knowledge, attitudes, and skills' before and after the programmes using a random sample of relevant populations for a broad questionnaire, then a

more detailed questionnaire for a smaller group, and an 'ethnographic' study of 'a select number of participants and facilitators'.

The study took three years to complete, and it simply says that the interventions as a whole worked. There is no discussion of the context of the programme or how transferrable it would be, including how the programmes were funded and which organisations worked together (and US-specific circumstances, such as the role of the courts in many programmes). There is no separation between the governance of the project and the policy instruments. There is no comparison across different types of projects. The focus is on the almost-immediate evaluation of perceived knowledge, not long term behaviour. There is no ability to compare with people who did not engage with the projects. In that context, consider the time and resources it would take to provide a standard measurement across policy fields and comparable across multiple countries.

A further complication is that any evidence gathered from multiple sources outside an organisation may be couched in a language not readily translatable or transferable (particularly if from another profession or unfamiliar region). In such cases, people may be sceptical about the results and/ or unable to see the practical implications. They may then rely on rules of thumb to gather and use evidence, such as 'personal experience', advice from people they trust, such as professional groups or 'people that they consider to be experts in the field', and cues from their peers or media/ social media (Nutley et al, 2013: 9; 21).

In other words, we may know a lot about how evidence is produced, but relatively little about how it is used and very little about the practical effect (2013: 20). The evidence is imperfect not self-evident: to make it work, we have to make sure that the users of evidence have a way to make sense of it and translate it into action.

Solution 1. Identifying common elements to successful projects

The first solution is to produce a short set of conclusions about the common elements, or essence, of successful projects. However, policy science-based accounts of evaluation demonstrate the role of quick, often ideologically driven, evaluations, coupled with a focus on the public service delivery environment. Success is often measured in terms of administration, rather than the instrument and its long term outcomes.

Take, for example, the Institute for Government's (Rutter et al, 2012) discussion of policy successes in the post-war UK era, derived partly from a vote by UK political scientists, including: the national minimum wage, Scottish devolution, and privatisation. The respondents' reasons for declaring success are based on a mix of their personal values and their assessment of 'process', 'political' and 'programmatic' factors. *Process* measures success in terms of its popularity among particular groups and its ease of passage through the legislature. *Political* describes its effect on the government's popularity. *Programmatic* describes its implementation in terms of original aims, its effect in terms of intended outcomes, and the extent to which it represented an 'efficient use of resources' (Marsh and McConnell, 2010; McConnell, 2010). Respondents declare success in narrow terms, as successful delivery in the short term. So, privatization is a success because the

government succeeded in raising money, boosting its popularity and international reputation. Similarly, devolution was a success because it addressed a problem (local demand for self-autonomy).

Rutter et al's (2012: 7) definition of success may differ from the respondents, but it is still a definition of administrative *process* or *politics* rather than a discussion of the properties of policy instruments: 'the most successful policies are ones which achieve or exceed their initial goals in such a way that they become embedded; able to survive a change of government; represent a starting point for subsequent policy development or remove the issue from the immediate policy agenda'. This emphasis continues with their advice to policymakers: Understand the past and learn from failure; Open up the policy process; Be rigorous in analysis and use of evidence; Take time and build in scope for iteration and adaptation; Recognize the importance of individual leadership and strong personal relationships; Create new institutions to overcome policy inertia; and, Build a wider constituency of support. Much of this approach can be traced back to traditional 'top-down' discussions of policy implementation in which we try to explain success or failure according to the extent to which policy implementation meet these criteria:

1. The policy's objectives are clear, consistent and well communicated and understood.
2. The policy will work as intended when implemented.
3. The required resources are committed to the programme.
4. Policy is implemented by skilful and compliant officials.
5. Success does not depend on cooperation from many bodies.
6. Support from influential groups is maintained.
7. Demographic and socioeconomic conditions, and unpredictable events beyond the control of policymakers, do not significantly undermine the process (Cairney, 2012b: 35-6).

This is a 'top down' measure of success, seen from the point of view of actors in central government ensuring that they are accountable to the public via ministers and Parliament. It highlights the potential tension between success as measured from the 'top' or the 'bottom'. It requires modification to make it consistent with the Scottish Government's agenda on decentralization and partnership working. In particular, it requires a move away from the idea that you need to simplify the delivery chain to minimize problems with compliance, towards the idea that prevention policy is based on shared and co-produced aims. We would also reframe 'leadership', from a single leader at the centre, to many people requiring leadership qualities to enable them to cooperate. The Scottish Government is effectively encouraging a 'bottom up approach', by setting a broad strategy and accepting that other bodies will deliver policy in their own way (which is difficult to do in Westminster systems, where government success is also measured in terms of ministerial and party manifesto aims).

This has implications for how it measures success and structures its evaluation process. If success is as much about policy process as policy instrument, and the Scottish Government favours a particular 'bottom up' process, this will structure its search for lessons from other

projects. A project which has a reputation for success based on a simple delivery chain will have less relevance than a project whose success can be traced to partnership working.

Solution 2. Produce criteria to evaluate projects

The second solution is to produce a set of simple measures to identify the most promising projects (based partly on criteria identified by Rose, 1993; 2005; see also Sanderson, 2002: 11). As a whole the measures prompt us to be sure that the project was a success, that we know why it succeeded and that we are confident we can replicate the process:

1. The project was introduced in a country or region which is sufficiently comparable to Scotland. Comparability can relate to the size and type of country, the nature of the problem, the aims of the borrowing/ lending government and their measures of success.
2. It was introduced nationwide, or in a region which is sufficiently representative of the national experience (it is not an outlier).
3. Sufficient attention is paid to the role of bottom-up policymaking and the potential risks to transferring the policy to another region without local and/ or 'community' ownership.
4. Sufficient attention is paid to the role of scale, and the different cultures and expectations in each policy field.
5. The project has been evaluated independently, subject to peer review and/ or using measures deemed acceptable to the government.[7]
6. The evaluation is of a sufficient period of time in proportion to the expected outcomes.
7. We are confident that this project has been evaluated the most favourably – i.e. that our search for relevant lessons has been systematic, based on recognisable criteria (rather than reputations).

We then consider how to evaluate the evidence and rate it as the basis for further investment. For example, Perkins (2010, in Nutley et al, 2013: 9) lists four possible categories, from 'Good practice' based on positive experience, to 'Promising approaches' based on positive but unsystematic findings, 'Research–based' based on 'sound theory informed by a growing body of empirical research', and 'Evidence–based', when 'the programme or practice has been rigorously evaluated and has consistently been shown to work'.

In each case, the "leap from 'quality of evidence' to 'decision to apply' can never be a simple technocratic choice. It will necessarily involve judgement and political considerations"

[7] In some professions, there may be dominant or widely held views about 'hierarchies of evidence', with RCTs and/ or meta-analyses/ systematic reviews at the top and 'case study reports' at the bottom, even though systems such as GRADE are used to examine in more depth the limitations of particular studies (2013: 10-12). In others, the focus may be on the complex nature of policymaking systems, which arguably makes the object of research impossible to control (there is very little prospect of sizeable RCT-based evidence in many fields) and undermines the generalizability of the results (2013: 13; Head, 2010: 85). In some fields, qualitative research is valued most highly (2013: 20) and some challenge the 'evidence-based practice movement' (Hammersley, 2005: 86; Nutley et al, 2007: 5; Williams and Glasby, 2010). Further, a hierarchy of evidence may be very different if based on, for example, service user's perceptions rather than external assessment (2013: 16-7).

(2013: 14). This statement seems particularly relevant to the Scottish agenda based on the generation of policy in partnership with public bodies and 'communities'. The co-production of policy implies the co-production of ideas about how to seek, produce and evaluate the evidence underpinning policy (Williams and Glasby, 2010: 99).

Case Studies of prevention programmes

Case Study 1: The Incredible Years parenting programme

Incredible Years Parenting (IYP) is a programme aimed at preventing conduct disorders in children. IYP deploys early-year intervention aimed at strengthening parenting skills and preventing conduct disorders in children. It is targeted at 3-4 year old children exhibiting signs of disruptive behaviour disorders and aims to address the causes of, and negative parental reactions to, challenging behaviour. It does so by developing positive parenting, improving parent-child relationships, helping parents identify, react to and manage behaviours, and improving home-school relationships.

The IYP has been extensively evaluated independently using a range of methods including randomised controlled trials, qualitative studies of parents' experiences, quasi-experimental cross-sectional studies, economic cost-effectiveness assessments and national replication comparisons. Issues of scaling-up are being addressed but are deemed manageable as long as support (technical, practical and financial) for those delivering the service is maintained.

Training and implementation of the Incredible Years Parenting (IYP) program in Scotland started in 1999 and the pilot program in a nursery school was completed in 2001. Evaluation of the pilot project was positive, with improvements in children's behaviour noted both in the school and home setting. In light of the success of the pilot, the project was to be rolled out into a larger-scale study. Due to staff change-over and shortage of funding within the Child and Adolescent Mental Health Services (CAMHS), this scaling-up was scrapped. In time, and due to the tenacity of one particular individual in CAMHS, a few staff in Scotland began to train for, and deliver, IYP services in a more piece-meal manner.

In summary, this project is supported by extensive and robust evaluation, and it has the potential to meet the aims expressed in several SOAs to introduce positive parenting programs. However, its application in Scotland has been patchy and seems to depend on the commitment of staff from one particular centre – which highlights the importance of the buy-in from, and support for, those who deliver the service – which may be difficult to replicate in some areas.

Case Study 2: The Family Nurse Partnership

In 2006, the UK Department of Health introduced Family Nurse Partnerships (FNP) in England as a series of pilot projects. The FNP is an evidence-based targeted early-years intervention programme aimed at improving the health and life-opportunities of first-time mothers and their children in deprived areas. It focuses on primary prevention of illnesses, injuries and developmental issues linked to maternal behaviour from early in the pregnancy until the child is 2 years old. This is done by providing universal point-of-access maternity

and antenatal care, and identifying individual needs, with named midwives allocated in some cases. It features elements of secondary prevention aimed at mitigating parental vulnerabilities, relational difficulties and challenging behaviours. In particular, it provides screening to determine the need for more specialised services, and can task health visitors to follow-up with families throughout the first 5 years of a child's life.

FNP was directly inspired from the Nurse-Family Partnerships (NFP) that have been increasingly implemented in the United States since the 1980s. The American cities which feature the program display similar patterns of poor birth outcomes, social exclusion and family relation problems linked with deprivation in the United Kingdom. Attention has been paid to the role of bottom-up policymaking and to the potential risks to transferring the policy to another region without local ownership. We can see the importance of buy-in from, and resocialization of, those who deliver the service, and the need to 'Anglicize' the curriculum and educational material. Issues of scaling-up were assessed and deemed manageable as long as fidelity to eligibility criteria and objectives was maintained.

The American iteration of the program has been evaluated independently using a series of randomised controlled trials spanning three decades. Preliminary evaluation in UK is being undertaken as part of the Building Blocks Trial – a partnership between the government, research, and primary and secondary care teams involved in offering the service – using randomised controlled trial and economic modelling.

In summary, this project is supported by extensive and robust evaluation, and it has the potential to meet the intention expressed in several SOAs to introduce similar programmes.

Case Study 3: 'Stepping Forth' Exercise Programme

The 'Stepping Forth' exercise programme has been offered by NHS Forth Valley and their Local Authority partners since 2009. It aims to reduce falls and risks of falls for older people, and to reduce the need for personal assistance by developing independence through physical activity. It aims to prevent injuries and dependency on personal care linked to decreased strength, flexibility and balance in older age. This is done by leading and supporting participants in undertaking an exercise regimen designed specifically to prevent falls. It is directly inspired from the Otago exercise programme developed in New Zealand – it modified the original by using existing services and resources rather than relying on entirely new ones, working in health and social care settings rather than relying entirely on home exercise interventions, and aiming to generate results in shorter amounts of time.

Attention has been paid to the potential risks to transferring the policy to another region without local ownership. In particular, buy-in from, and the support and training of those delivering the service, as well as their encouraged participation in recruiting participation, have been addressed in the Forth Valley area. Issues of scaling-up appear manageable as long as training and support for staff is made available. Attention to diffusion to other regions of Scotland has already started through professional networks.

The original iteration of the Otego programme has been extensively independently evaluated using a series of randomised controlled trials and has been credited with reducing the number of falls and related injuries by 35% in the trial populations. Preliminary evaluation of the 'Stepping Forth' programme is underway with qualitative case; the joint improvement team has noted some early positive results.

In summary, this project is supported by extensive evaluation, and it has the potential to meet the intention expressed in several SOAs to introduce similar programmes, but note that the evaluations of modified Scottish programmes are less extensive than of the original.

Case Study 4: 'One Service' HM Prison Peterborough Social Impact Bond

In 2010, the 'One Service' project at HM Prison Peterborough (HMP) became the first pilot on the use of social impact bonds (SIBs) in the UK. 'One Service' is a preventive programme aimed at reducing recidivism in adult males having served short sentences (up to 12 months). It aims to break the cycle of disadvantage, crime and imprisonment. It is delivered by charities in the form of individually-tailored pre- and post-release mentoring of participants, and assistance to help them connect with required services to facilitate their positive reentry into society. SIBs involve attracting investment from non-government bodies, perhaps transfer risk from government to private investors, who are rewarded by the government if the intervention succeeds.

SIBs are currently used to further the idea that improving the health, social inclusion and life-prospects of prisoners may be most successful in preventing reoffending. There is some data on the effectiveness of the program, but insufficient independent data, as of yet, on its cost-effectiveness. Independent assessment will be conducted in 2014 in view of determining the impact of the bonds and, therefore, whether a payment is due. This will be a crucial determinant of effectiveness.

As of yet, there has not been sufficient attention paid to the role of bottom-up policymaking and to the potential risks transferring the policy to another region without local ownership. On the other hand, social impact bonds are already successfully being in Scotland in the area of support in education, employment and training for vulnerable young people. Further, the use of SIB falls well within the remit of the preventive Scottish Government Reducing Reoffending Change Fund launched in 2012

In summary, this project is supported by preliminary evaluation, it has the potential to meet the intention expressed in several SOAs to introduce similar programmes, and SIBs appear to have wider applications than in reoffending – but note the lack of long term, independent evaluation.

Conclusion

Policymaking is about turning broad aims into specific policies. In our paper, we set out a framework to think this process through, from identifying an aim, to using evidence to inform the selection of projects to fund and support.

A clear definition of prevention and a set of detailed aims aids engagement with the public and the government's policymaking partners. It helps produce a common set of expectations. It helps maximise the ability of a government to identify the most relevant evidence, when it seeks to learn from pilot projects and international experience. This is difficult to do with 'prevention', which can mean anything from inoculating a whole population against a virus, to providing 'crisis intervention' to a small group. It can mean providing education and support or regulating behaviour. It is about identifying the root causes of problems, which is easier for many diseases than 'wicked' social problems. It is about how 'decisive' you want to be in a short space of time, and how you want to balance aims, such as between reducing inequalities or costs.

The Scottish Government addresses this problem through the National Performance Framework and Single Outcome Agreements. It has *two* broad aims: to pursue prevention projects and to co-production policy. These aims can reinforce each other, when cooperation produces a high commitment to co-produced objectives, and/or undermine each other, when a proliferation of plans produces a wide range of meanings of prevention.

We seek evidence to help clarify our aims and inform our decisions. Evidence can be drawn from past experience, pilot projects in our own country or policies pursued in others. The Scottish Government has an interesting double-role: to identify what evidence is relevant, based on its own aims; and, to translate evidence into lessons that are relevant to other participants. A commitment to co-production creates a commitment to understand what drives local policymakers and what information is relevant to them, given the constraints they face and what drives them to act. It also prompts us to focus as much on the evidence of successful delivery arrangements as successful policy interventions. This is a fundamental issue when we seek to learn lessons from other projects: are we learning about the policy solution or the way in which the solution is understood and used, more or less competently, in particular areas?

The identification of 'success' is a political judgement based on our aims and beliefs. Many projects quickly develop good reputations based on these, rather than 'scientific', criteria. We outline a framework to ensure that a sufficient amount of relevant evidence is gathered before a project is deemed successful. However, many projects may not live up to this minimum standard, particularly if we want to learn quickly to address pressing problems. Our case study discussion reflects this problem, describing projects and their evaluations, but stopping short of recommending they be 'scaled up'. Evidence-gathering is no substitute for political choice based on limited evidence.

References

Adler-Baeder, F., Kerpelman, J.,Griffin, M. and Schramm, D. (2010) 'Evaluating Multiple Prevention Programs: Methods, Results, and Lessons Learned', Journal of Extension, 48, 6, 6FEA1 http://www.joe.org/joe/2010december/a1.php

Anning, A et al. (2007) *Understanding Variations in Effectiveness amongst Sure Start Local Programmes* (London: Department for Children, Schools and Families)

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/222371/NESS2007FR024.pdf

Berry, F. and Berry, W. (2014) 'Innovation and Diffusion Models in Policy Research' in Sabatier, P. and Weible, C. (eds.) *Theories of the Policy Process 3rd edition* (Chicago: Westview Press)

Billis, D. (1981) 'At risk of prevention', *Journal of Social Policy*, 10, 3, 367-379

Burnside, R. (2010) 'Preventative spend – literature review', SPICe Financial Scrutiny Unit Briefing 10/57 (Edinburgh: Scottish Parliament) http://www.scottish.parliament.uk/Research%20briefings%20and%20fact%20sheets/SB10-57.pdf

Cairney, P. (2009b) "The 'British Policy Style' and Mental Health: Beyond the Headlines", *Journal of Social Policy*, 38, 4: 1–18

Cairney, P. (2012a) *Understanding Public Policy* (Basingstoke: Palgrave)

Cairney, P. (2012b) 'Complexity theory in political science and public policy', *Political Studies Review*, 10 (3): 346–58

Cairney, P. and McGarvey, N. (2013) *Scottish Politics 2nd ed* (Basingstoke: Palgrave)

Cairney, P. and Studlar, D. (2013) 'How and Why are Public Health Ideas Accepted by Policymakers? Comparing Tobacco and Alcohol Control', paper to ICPP conference, Grenoble, June http://www.icpublicpolicy.org/IMG/pdf/panel19_s2_cairneystudlar.pdf

Cairney, P. and Yamazaki, M. (2013) "Policy Transfer in Theory and Practice: What Can Japan Learn from 'Regionalism' and Devolution in the UK?" paper to National Diet Library, Tokyo, November http://paulcairney.files.wordpress.com/2013/10/cairney-yamazaki-what-can-japan-learn-from-uk-23-10-13.pdf

Cairney, P., Studlar, D. and Mamudu, H. (2012) Global Tobacco Control (Basingstoke: Palgrave)

Cohen, J., Neumann, P., and Weinstein, M. (2008) 'Does Preventive Care Save Money? Health Economics and the Presidential Candidates', *The New England Journal of Medicine*, 358(7): 661-663

Commission of the Future Delivery of Public Services (2011) *Report* (Edinburgh: Scottish Government) http://www.scotland.gov.uk/Resource/Doc/352649/0118638.pdf

Crepaz, M. and Crepaz, N. (2004) 'Is Equality Good Medicine? Determinants of Life Expectancy in Industrialised Democracies', *Journal of Public Policy*, 24(3): 275-298

Dolowitz, D. and Marsh, D. (1996) 'Who Learns What From Whom: A Review of the Policy Transfer Literature', *Political Studies*, XLIV: 343–57.

Dolowitz, D. and Marsh, D (2000) 'Learning from Abroad: The Role of Policy Transfer in Contemporary Policy-Making', *Governance*, 13, 1: 5–24

Early Action Task Force (2012) The Deciding Time (London: Community Links) http://www.community-links.org/uploads/documents/Deciding_Timefinal.pdf

Ernst & Young (2013) *Whole Place for Community Budget: A Review of the Potential for Aggregation* (London: Local Government Association) http://www.lgcplus.com/Journals/2013/01/10/c/l/x/LGA-and-EY-Community-Budgets-Report-.pdf

Freeman, R. (1999) 'Recursive politics: Prevention, modernity and social systems', *Children & Society*, 13(4), 232-241

Gilson, L. and Schneider, H. (2010) 'Managing scaling up: What are the key issues?', *Health Policy and Planning*, 25: 97-98

Gough, I. (2013) 'Understanding prevention policy: a theoretical approach' (London: NEF) http://eprints.lse.ac.uk/47951/1/Understanding%20prevention%20policy%20(lsero).pdf

Hammersley, M. (2005) 'Is the evidence-based practice movement doing more good than harm? Reflections on Iain Chalmers' case for research-based policy making and practice', *Evidence and Policy*, 1, 1, 85-100

Head, B. (2010) 'Reconsidering evidence-based policy: Key issues and challenges', *Policy and Society*, 29, 77-94

Healy, A. and Malhotra, N. (2008) 'Mass and elite preferences for disaster relief and prevention spending', paper presented at the Midwest Political Science Association annual conference http://www.stanford.edu/~neilm/disasters.pdf

Heckman, J. (n.d.) 'Presenting The Heckman Equation' http://heckmanequation.org/content/resource/presenting-heckman-equation

Jha, P. and Chaloupka, F. (eds) (1999) *Curbing the Epidemic: Government and the Economics of Tobacco Control* (Washington: World Bank).

Keating, M. (2010) The Government of Scotland (Edinburgh: Edinburgh University Press)

Lodge, M. (2009) 'The public management of risk: The case for deliberating among worldviews', *Review of Policy Research*, 26(4): 395-408

Lopez, A., Collishaw, N. and Piha, T. (1994) 'A Descriptive Model of the Cigarette Epidemic in Developed Countries', *Tobacco Control*, 3(2): 242–7

Mangham, L. and Hanson, K. (2010) 'Scaling up in international health: what are the key issues?' *Health Policy and Planning*, 25: 85–96

Manthorpe, J., Martineau, S., Ridley, J., Cornes, M., Rosengard, A., and Hunter, S. (2014) 'Embarking on self-directed support in Scotland: a focused scoping review of the literature' *European Journal of Social Work* (ahead-of-print), 1-15 http://www.tandfonline.com/doi/abs/10.1080/13691457.2014.885883#.UwY0MsZFCUk

Matthews, P. (2014) 'Being Strategic in Partnership – Interpreting Local Knowledge of Modern Local Government', *Local Government Studies* (ahead of print http://www.tandfonline.com/doi/abs/10.1080/03003930.2013.859141#.Uv433cZFCUk)

Marsh, D. and McConnell, A. (2010) 'Towards a Framework for Establishing Policy Success', *Public Administration*, 88, 2: 564–83

McConnell, A. (2010) *Understanding Policy Success: Rethinking Public Policy* (Basingstoke: Palgrave Macmillan)

McCulloch, A. (2014) 'Scottish Minimum Alcohol Pricing and EU Law' http://papers.ssrn.com/sol3/papers.cfm?abstract_id=2394018

Melhuish, E. (2003) A literature Review of the impact of early years provision on young children (London: National Audit Office) http://www.nao.org.uk/wp-content/uploads/2004/02/268_literaturereview.pdf

Nilsen, P., Ståhl, C., Roback, K., & Cairney, P. (2013). Never the twain shall meet? A comparison of implementation science and policy implementation research. *Implementation Science*, 8 (1), 63 http://www.biomedcentral.com/content/pdf/1748-5908-8-63.pdf

OECD (2013) *Health at a Glance: 2013 OECD Indicators* (Paris: OECD) http://www.oecd.org/els/health-systems/Health-at-a-Glance-2013.pdf

Nutley, S., Walter, I. and Davies, H. (2007) *Using evidence: how research can inform public services* (Bristol: The Policy Press)

Nutley, S., Powell, A. and Davies, H. (2013) *What Counts as Good Evidence* (London: Alliance for Useful Evidence) http://www.alliance4usefulevidence.org/assets/What-Counts-as-Good-Evidence-WEB.pdf

Rose, R. (1993) *Lesson-Drawing in Public Policy* (New York, NY: Chatham House).

Rose, R. (2005) *Learning From Comparative Public Policy: A Practical Guide* (London: Routledge)

Rutter, J., Marshall, E. and Sims, S. (2012) The 'S' Factors: Lessons from IFG's policy success reunions (London: Institute for Government) http://www.instituteforgovernment.org.uk/sites/default/files/publications/The%20S%20Factors.pdf

Sanderson, I. (2002) Evaluation, Policy Learning and Evidence-Based Policy Making', *Public Administration*, 80, 1, 1-22

Scottish Government (2011) *Renewing Scotland's Public Services* (Edinburgh: Scottish Government) http://www.scotland.gov.uk/Publications/2011/09/21104740/0

Scottish Government (2012) *Single Outcome Agreements: Guidance to Community Planning Partnerships* (Edinburgh: Scottish Government)

Scottish Government (2007; 2014a) *Performance* (Edinburgh: Scottish Government) http://www.scotland.gov.uk/About/Performance

Scottish Government (2014b) Final Single Outcome Agreements 2013 (Edinburgh: Scottish Government) http://www.scotland.gov.uk/Topics/Government/PublicServiceReform/CP/finalsoas

Scottish Government (2014c) *Early years collaborative* (Edinburgh: Scottish Government) http://www.scotland.gov.uk/Topics/People/Young-People/early-years/early-years-collaborative

Scottish Government and ESRC (2014) 'What Works Scotland (WWS): improving public service delivery and reform, Call for proposals' http://www.esrc.ac.uk/_images/WWS%20Call%20spec%20FINAL%2006%20Jan%202014_tcm8-29575.pdf

Stewart, B. and Wild, C (2014) *World Cancer Report 2014* (Geneva: World Health Organization)

Suhrcke, M., McKee, M., Stuckler, D. Arce, R., Tsolova, S. and Mortensen, J. (2006) 'The contribution of health to the economy in the European Union', *Public Health*, 120(11): 994-1001

Taylor, B. (2013) 'Evidence-Based Policy and Systemic Change: Conflicting Trends?' *Springfield Working Paper Series* (1) (Durham: The Springfield Centre)

Thun, M., Peto, R., Boreham, J. and Lopez, A. (2012) 'Stages of the cigarette epidemic on entering its second century', *Tobacco Control*, 21(2): 96-101.

Wattam, C. (1999) 'The Prevention of Child Abuse', *Children and Society*, 13, 317-29

Werritty, A. (2006) 'Sustainable flood management: Oxymoron or new paradigm?', *Area*, 38(1): 16-23

Williams, I. and Glasby, J. (2010) 'Making 'what works' work: The use of knowledge in UK health and social care decision-making', *Policy and Society*, 29, 95–102