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A Window of Opportunity for Preventive Policymaking? Comparing policies by the UK and Scottish Governments

Chapter 6 – Prevention and health: the cases of public and mental health

Health policy is the traditional home of preventive policies. Public health is at the heart of policies designed to improve population health, and potentially reduce health inequalities, through changes in behaviour at an early age. However, it also demonstrates the tensions between preventive and reactive policies, and the tendency for the latter to be higher on the agenda and receive more resources.

In the post-war period there have been several instances in which government bodies have signalled the need for major socio-economic and public health reforms to reduce health inequalities, but most have been built on the identification of past policy failures. Over time, these efforts give the impression of unfulfilled expectations, as policymakers go through a cycle of enthusiasm, frustration, partial failure, and finally a rediscovery of the importance of preventive policy. Yet, we can also identify long term policy change in some areas, such as tobacco control, in which policy is aimed at a combination of laws to regulate behaviour, combined with individual support, public exhortation and economic incentives to change it. In such cases, the overall health of the population often rises without reducing inequalities within it.

Debates on health and prevention play out in different ways: in social and economic debates focused on poverty and redistribution; on the extent to which governments should intervene to regulate unhealthy behaviour; and, in relation to calls for public health to receive the same priority as healthcare policy. At the same time, we can identify calls for greater attention and resources to mental health policy: to pursue parity between mental and physical health, and to stress the need for mental health to play a larger part in the public health agenda.

Consequently, in this chapter, we summarise the relatively extensive literature which compares public health policies in relation to healthcare, then fill a gap in the literature by identifying the less-well researched developments specific to mental health policy in general and ‘public mental health’ in particular. We base the latter on a combination of documentary analysis and approximately 40 semi-structured interviews conducted in 2006-7 and 2014-5. We also supplement the larger published literature on health policy for England with new empirical research in Scotland.

‘Mental health policy’ refers to issues such as wellbeing, depression, dementia, severe and enduring illness, and mental illness related to crime. Policies include legislation to deprive people of their liberty, crisis intervention, suicide prevention, the prescription of medication, the provision of cognitive behavioural therapy (CBT), policies to address drug and alcohol dependence, the funding of public mental health, and the broad commitment to ‘parity’ between mental and physical health. It intersects with other policy agendas, including preventive health policy, post-war ‘deinstitutionalisation’, the UK Labour Government’s

focus on crime and anti-social behaviour, the UK Coalition government's 'localism' agenda, its welfare and employability reforms, its increasing attention to the concept of 'wellbeing', and the Scottish Government's 'decisive shift to prevention'.

Consequently, mental health highlights an analytical irony: we may use case studies to simplify our focus on prevention, only to find that they *amplify* a sense of complexity. Mental health policy is delivered at multiple levels and by many types of government. Some policies address mental health specifically, while others relate more broadly to, for example, healthcare, social policy, crime, or employability, with the potential for unintended consequences on mental health policy. Some policies are high profile and directed at acute problems specific to one government department, while others refer to less salient, broader, cross-sectoral approaches to policy that are difficult to define and for specific government units to 'own'. Further, mental health has traditionally been far lower on the policy agenda than physical health – which suggests that the problems identified with progress in prevention could be magnified when public health meets mental health.

To examine these issues, we use the concepts outlined in chapter 2. First, we apply our theoretical argument to a broad examination of health policy and the role of prevention within it, considering what a 'window of opportunity for prevention policy', a 'complex system', and the 'social construction of target populations', means in relation to physical and mental health, how mental health intersects with broader policies on health - including the relationship between health care and public health policies - and what makes mental health distinctive when situated within such a broader discussion of health policy.

We use this discussion as context, to help describe long term trends in mental health policy and the specific case study of public mental health. We identify a greater propensity of governments to 'think preventively' – or, at least, about more than acute residential care or mental illness – in the modern era. This trend has operated in tandem with shifts in how policymakers frame the issue of mental health and treat target populations, including an important (albeit limited) shift of emphasis from a broadly paternalistic focus on in-patients treated by psychiatrists to a new focus on the inclusion of service users in the design of services often delivered in the 'community'. This inclusion of service users is a key plank of the prevention policy agenda, but has also developed independently in mental health, often in the absence of a focus on prevention.

Second, in the case study of public mental health, we engage with the concepts, common to policy theories, used to identify which actors are involved, their ways of thinking, the rules they follow, the networks in which they participate, the socioeconomic context in which they operate, and their use of knowledge to underpin decisions. In particular, it is important to understand how this new, or rediscovered, way of preventive thinking interacts with well-established ways of doing things – particularly within the non-departmental public bodies that enjoy new forms of responsibility to control mental health spending and deliver policy.

Overall, we find that policymaking systems produce outcomes that only partially reflect, and can often seem contradictory to, initial policy choices: governments express a commitment to

prevention, but routinely produce something rather different. This implementation or ‘expectations gap’ has been a regular feature of policy studies for decades, but has a new element in this case: the willingness by central government to devolve authority and *accept* a gap. Consequently, in the conclusion, we return to the broader question of accountability in complex policymaking systems: if our understanding of health policy and policymaking is so limited, so many actors are involved in a complex and unpredictable system, and there is a sizeable gap between central government policymaker aims and actual outcomes, how can we identify the extent to which policy is ‘coherent’ and hold policymakers to account for the outcomes of their choices?

What is the window of opportunity for prevention in health and mental health policy?

In chapter 1, our starting point is that a ‘window of opportunity’ has opened for the introduction of a policy solution, prevention, which is vague and difficult to operationalise – at least beyond a set of simple aims (such as to intervene as early as possible in people’s lives) and governance principles (such as to include service users in public service design). Prevention can be primary, secondary and tertiary - and tertiary measures may often resemble reactive or acute services. As a philosophy of government, prevention has the ability to become a focal point for government action, based on the promise that preventive measures can help reduce inequalities and/ or public service costs or social security spending. However, it may also represent the ultimate example of the unclear links between policy philosophies and detailed policies and outcomes, since it is difficult to know what policy is, who is responsible for outcomes and how we would measure their success. As such, it may suffer in comparison with issues that are high profile and appear to have simpler, quicker, and more measurable solutions. This same basic problem, outlined in chapter 3, plays out in each policy area in different ways.

In health, despite a very high rhetorical commitment to prevention policies, four issues remain:

1. Terminological confusion persists, as policymakers commit to reducing health inequalities but struggle to ‘operationalize’ them before selecting specific interventions.
2. Preventive policies suffer in comparison with well-funded acute services, or may act merely as cover for a cut in services.
3. Policy solutions based on ‘social determinants’, or reducing health inequalities via measures such as income redistribution (Acheson, 1998), enjoy insufficient UK government support (Baggott, 2011: 73; 389) and the Scottish Government has relatively few powers to go its own way.
4. Policy solutions based on regulation, exhortation or individual incentives to improve health enjoy more sustained attention and political success (Blackman et al, 2009: 769).

Broad trends in health policy and prevention: missed opportunities?

The language of prevention is now used regularly by the Scottish Government, and key public bodies, committed to a general cross-government ‘decisive shift’. The UK government demonstrates a similarly high commitment – broadly in relation to health policy, and specifically when linking the health of the population to economic activity – for example, the Department of Health (2010: 46) makes reference to ‘working-age ill health ...costing England £100 billion a year’, while the Chief Medical Officer (2014: 12) describes mental illness as the ‘leading cause of sickness absence’ and a cost to the UK economy of ‘4.5% of Gross Domestic Product’. The Department of Health delegates responsibility for much of this agenda to key public bodies such as NHS England.

NHS England’s (2014: 3) *Forward View* argues that, ‘the future health of millions of children, the sustainability of the NHS, and the economic prosperity of Britain all now depend on a **radical upgrade in prevention and public health**’ (original emphasis). However, its next sentence sums up the propensity for governments and public bodies to go through a cycle of identifying failure and promising change: ‘Twelve years ago Derek Wanless’ health review warned that unless the country took prevention seriously we would be faced with a sharply rising burden of avoidable illness. That warning has not been heeded – and the NHS is on the hook for the consequences’ (2014: 3).

In other words, NHS England suggests that there has been more than one window of opportunity for preventive health policy, and several possibilities emerge: Baggott (2011: 35) traces ‘preventive medicine’ and early public health initiatives (on issues such as sanitation and safer working conditions) from the Victorian era; and, Billis (1981) suggests that prevention has been on the agenda for most of the post-war period. However, most notably, Bartley (2004: 1-8; 14-15; see also Acheson, 1998: 10) highlights the importance of the *Black Report* (Department of Health and Social Security, 1980) in putting health inequality ‘firmly on the map’ of public policy, by (a) gathering statistics to highlight stark differences in male mortality, and susceptibility to illness and disease, according to social class (measured largely in terms of occupation), (b) refuting the idea that the introduction of the NHS and welfare state would reduce health inequalities; and (c) highlighting the role of ‘preventive measures extending over many years, such as protection from hazardous environments and lifestyles’.

At least from 1980, there have been instances when stakeholder attention has risen to the cost of inequalities and ill health, preventive or public health solutions have existed, and key policymakers have had *some* opportunity to adopt the principle of preventive measures. However, the health inequalities agenda generally represents a *missed* opportunity. Past experience suggests that policymakers have often lacked the willingness to make fundamental changes or the ability to make sense of prevention, at least enough to produce and deliver a specific agenda and set of objectives. Indeed, Acheson (1998: 10) suggests that the UK Government did not act on the Black report until the 1990s, Exworthy and Oliver, (2012: 293) argue that the Thatcher government ‘attempted to suppress its dissemination’, and Baggot (2011: 382-4; 62-7) notes that the Thatcher government’s economic policies from 1979 *widened* economic and exacerbated health inequalities, while the Major government’s *Health of the Nation* strategy from 1991 had a minimal impact on policymaking and deliberately *ignored* health inequalities and the ‘social determinants of health’ agenda.

A previous window: limited progress?

A more meaningful window of opportunity did not open until the election of a Labour government in the late 1990s (prompting the ‘second Black Report’ chaired by Acheson in 1998 - Exworthy and Powell, 2002: 82). Harrington et al (2009) suggest that ‘The election of a Labour government in 1997 brought the issue of health inequalities firmly back on to the policy agenda’. The UK shared with several countries, ‘a growing awareness of the existence and preventability of these inequalities as well as the financial cost of treatment if they were not addressed’ (Blackman et al, 2012: 49; see also Exworthy et al, 2002: 80; WHO Regional Office for Europe, 2002). Greater attention to the scale of the problem was made possible by advances in data gathering, with a new and committed Labour government (supported by trade unions and campaign groups) providing the motive and opportunity for action, coupled with a solution built on:

1. the use of targets and performance management to ensure progress
2. ‘joined up government’ in central government, to address issues that require cross-departmental cooperation, and
3. health and local authority partnerships built on some pooled resources and jointly-delivered services (Blackman et al, 2012: 50; Exworthy et al, 2002: 82-3; Baggott, 2011: 384; 66-7).

Then, although devolution in 1999 gave the Scottish and Welsh governments the responsibility for key aspects of this problem, the three governments produced a similar language to describe the causes of inequalities. Their differences related more to the ways in which they would *deliver* policies (Harrington et al, 2009: 25). Though this may seem like a minor point, it highlights the ways in which policymakers make sense of the problem and preventive solution, and how the solution relates to existing policies.

For example, the UK government’s reputation for pursuing targets and a relatively punitive form of performance management (Greer and Jarman, 2008) is reflected to some extent in post-devolution differences (although Exworthy et al, 2002: 82 note an initially greater focus in 1999 on targets in the White Paper on public health for Scotland, not England). England had two high level ‘quantifiable national targets’ by 2001, on reducing inequalities in infant mortality (measured in relation to occupation) and life expectancy (deprivation), accompanied by targets on specific illnesses, including cancer, and behaviours such as smoking (as well as a separate agenda on fair access to healthcare – Exworthy et al, 2002: 81). Scotland followed in 2004 and 2006 with broader, and perhaps less enforceable, ‘health improvement targets’ combined with a commitment to ‘continuous improvement’, as well as a commitment in 2004 to improve health in ‘deprived areas’ (Baggott, 2011: 402), and the development of relevant ‘national indicators’ (such as child deprivation) of Scottish Government performance from 2007 (chapter 5). Wales maintained ‘aspirational statements’ with no element of quantification (Harrington et al, 2009: 25; Blackman et al, 2012: 56; Blackman et al, 2009).

Harrington et al (2009: 25) detect the same shift among all three governments, from an initial focus on the ‘social determinants’ of health inequalities (focusing on poverty, housing and social exclusion/ inclusion), followed by government and parliamentary frustration with policy progress, then a movement from 2003-5 towards a restatement of the central role of the NHS in health improvement and the identification of plans to address unhealthy behaviour and individual lifestyle choices in relation to smoking, drinking and eating. This marked, in the space of approximately five years: (a) the waning of government enthusiasm to deal with the *structural* ‘root causes’ of inequalities, which are notoriously hard to address with policy, partly since they relate to a wide range of socio-economic problems and policies that can’t be contained in one government; and, (b) a rise in enthusiasm for a set of more concrete measures to regulate or encourage *individual* or lifestyle choices - with the potential to *widen* health inequalities (2009: 769; Baggott, 2011: 71-3; 391-5).

It is in this field of policy, to address individual or public behaviour, that we can detect the most visible kinds of commitment and activity. For example, the UK has, since the mid-to-late 2000s, maintained the most extensive tobacco control regime in Europe (Joossens and Raw, 2011). Measures include the: widespread ban on tobacco advertising in 2002; raising of the legal smoking age from 16-18 in 2009; a ban on smoking in public places in 2006; raising of tobacco taxes to approximately 77% of the cost of cigarettes; high spending on smoking cessation clinics and nicotine-substitute products (Cairney et al, 2012: 101-3; Cairney, 2008) and, most recently, plans to introduce plain (unbranded) packaging on tobacco products.

Stronger tobacco control was sold in England partly as a response to the health inequalities agenda, set by the Wanless (2002; 2004) reports, and coordinated by the Treasury, which described smoking as ‘the single most significant causal factor for the socio-economic differences in the incidence of cancer and heart disease’ (HM Treasury and Department of Health, 2002; Cairney, 2007a).

Although their tobacco policies are almost identical, the Scottish Government has made many policies separately, and banned smoking in public places one year earlier. The need to address health inequalities through such measures was pushed by its Chief Medical Officer, but the smoking ban also represented a ‘big idea’ to justify Scottish devolution (Cairney, 2007b).

Tobacco has become a model for several other public health policies, although policy measures have been less extensive in areas such as alcohol and obesity, and tobacco remains the only area in which the industry is excluded from policymaking (Cairney and Studlar, 2014; Baggott, 2011: 75). The Scottish Government has been willing to challenge the alcohol industry and pursue measures to help reduce alcohol consumption – and passed legislation, to introduce a minimum price for a unit of alcohol, which is currently subject to court challenge (Holden and Hawkins, 2013).

A window of opportunity for healthy behaviour policy?

‘Window of opportunity’ does not *quite* sum up these developments as a whole. Instead, we can detect the adoption of a broad policy agenda but still the need for additional processes to

introduce specific policy instruments – particularly when they involve additional funding and regulation. This point takes us back to our initial concern in chapter 1 about ‘what happens next’. Broad preventive ideas meet well-established ways of doing things, or specific policy debates in particular fields – suggesting that it makes sense to discuss a *series* of ‘couplings’ during windows of opportunity, to explain the adoption of some policy instruments and not others, as well as different solutions adopted by UK and devolved governments.

For example, Cairney (2009) argues that each ban on smoking in public places across the UK involved separate windows of opportunity, in which policymaker attention to the problem – and a relatively new possible solution, which had only been implemented in Ireland – varied, and each government had different motives and opportunities to adopt new legislation. Such experiences suggest that the idea of prevention and public health may be broadly accepted in government, but that specific measures will only be adopted under particular circumstances, and that policy change is not inevitable. They also highlight the timescale involved in major shifts in policy. The tobacco experience suggests that ‘comprehensive’ change took two to three decades to occur (Cairney et al, 2012; Studlar and Cairney, 2014).

Further, unlike in the social determinants agenda, policies on healthy behaviour have a relatively clear set of objectives, often involving a combination of individual policy instruments that can, to a large extent, be coordinated by a single government department and implemented by one key organization. In the broader field of health inequalities policy, involving the alignment of joined up government initiatives at central and local levels of government, the operationalisation of unclear aims and evidence, and the need to sustain political support for a decade, the task is far more complicated and less conducive to success – to the extent that Exworthy and Powell (2004: 269) struggle to adapt the multiple streams metaphor to describe what is going on. It is also difficult to identify progress – in Scotland and England – in relation to individual aspects of that task, such as joining up government, or the use of evidence to address the ‘social determinants’ of inequalities (Smith and Joyce, 2012: 63).

In other words, greater attention to health inequalities in the late 1990s helped open up a window of opportunity, but for the chance to pursue individual policy initiatives – such as specific targets in England to reduce gaps between the health of the most worse-off and the average, the Sure Start UK programme to coordinate health, education, social security, and social work action for disadvantaged children, and some efforts to address variations in health outcomes and access to healthcare according to ethnicity, gender, sexuality, age and disability – rather than the wholesale adoption of a coherent set of policies (Baggott, 2011: 385-6; 396-7). Further, many of those initiatives, such as Health Action Zones in England (to coordinate health and social care) did not last long enough to prove effective (Baggott, 2011: 135; 388).

A perennial problem of prevention in health?

Such examples from public health reflect or reinforce the idea that preventive policy solutions face a range of ever-present obstacles (Exworthy, 2008) in UK and Scottish government:

Uncertainty about how to 'operationalise' broad aims. Major reports on health inequalities struggle to present recommendations that can be readily implemented by governments. For example, Acheson (1998) and its successor, the WHO Commission on Social Determinants of Health (2008), presented dozens of recommendations which were not ranked or linked well to measurable outcomes or targets (Baggott, 2011: 385; 399-400). Or, those recommendations can be so far-reaching or vague that governments can already claim to be acting upon them (Exworthy and Oliver, 2012: 297-9).

Vagueness can help cover inactivity or rebrand programmes. The unintended consequence of vagueness is that policymakers can adopt public health measures, in the name of prevention, without expecting them to reduce costs or health inequalities (Blackman et al, 2012: 58). Policy solutions can be attached to a range of problems under a general inequalities banner, from the link between social class and life expectancy, to variations in access to healthcare (Exworthy et al, 2002: 81-2). It is difficult, if not impossible, to identify and measure the government resources devoted to prevention and reducing inequalities (Health Committee, 2009: 124). If policies are not well defined, ill-evidenced interventions can be promoted alongside the well-evidenced (Chief Medical Officer, 2014: 14).

The size of the task. Prevention is the ultimate cross-cutting issue, and reducing health inequalities involves addressing, 'poverty, income, tax and benefits; education; employment; housing and environment; mobility, transport and pollution; and nutrition' (Acheson, 1998: 8). Prevention policy involves long-term aims, and fundamental public sector reforms, which will last longer than a current government can expect to stay in office.

Competition for attention and money. Preventive policies compete with reactive services that are generally more salient and better funded. A key aim of prevention is to redirect resources from tertiary or reactive services, but governments periodically do the opposite, using public health budgets to address short-term hospital crises (Chief Medical Officer, 2005; Baggott, 2011: 73; Health Committee, 2009: 123). Public health may only receive sustained attention and funding when key healthcare indicators are under control (Blackman et al, 2012: 52).

Measurement and evidence. Policymakers favour interventions if their impact can be easily understood – such as in relation to an improvement per pound spent in a financial year (although the economic language of 'value for money' is often expressed less strongly in Scotland). In prevention, it is difficult to measure the short-term impact of an intervention or demonstrate clearly that it caused favourable long-term outcomes (Blackman et al, 2012: 57-60; Burnside, 2010: 4; Early Action Task Force, 2012: 7; Cohen et al, 2008; OECD, 2013: 10; Suhrcke et al, 2006). Further, if a large number of interventions are used to address an unclear and cross-cutting problem, it becomes near-impossible to produce evidence on their individual effects (Exworthy and Oliver, 2012: 298-9). Recommendations and policies on health inequalities tend to be based on extensive evidence of the problem, but not of the effectiveness of the proposed solutions (Bartley, 2004: 169; Acheson, 1998: 91; Baggott, 2011: 70-3; Exworthy and Oliver, 2012: 300). Moreover, this problem is exacerbated when policymaking takes place without sufficient evaluation (Health Committee, 2009: 122-3) and

when health inequalities scholars do not appreciate how to sell their findings to policymakers (Hunter, 2009: 283).

This problem has been addressed, to some extent, by: the production of evidence on early intervention programmes, and parenting programmes in particular (albeit which are generally not specific to health); the demonstration of successful outcomes in ways that may appeal to policymakers, by bodies such as the Early Intervention Foundation, whose online guidebook gives top ratings to programmes such as Family Nurse Partnership, Incredible Years, Multi-Systemic Therapy, and Trauma-Focused Cognitive Behavioural Therapy (see also the cross-party *1001 Critical Days Manifesto*); and, the adoption of economic language to support preventive efforts, such as the Chief Medical Officer's (2014: 15) identification of the major economic impact of mental illness. However, the Treasury remains sceptical of programmes that promise major but vague 'returns' from investment, partly because no programme can guarantee a tangible reduction in service provision in other areas. Further, reactive policies generally address more visible and urgent problems, and have a more immediate and measurable impact – such as funding for acute healthcare to meet short-term targets on hospital waiting times (Embrett and Randall, 2014: 151; Smith and Joyce, 2012: 63; Hobin et al, 2012: 102; Smith and Joyce, 2012: 65; Petticrew et al, 2004: 813; Chalkidou et al, 2009: 352; Blackman et al, 2012: 52-5; 58; 60).

Performance management. Performance management systems encourage public services managers to focus on short-term and measurable targets within their own service more than their shared aims with public service partners or the wellbeing of their local populations (Hunter and Marks, 2005; Exworthy and Powell, 2004: 272). Performance management is about *setting priorities when governments have too many aims to fulfil*. Central governments encourage local bodies to form long-term partnerships to address health inequalities *and* meet short-term healthcare targets, but the latter take precedence (Exworthy et al, 2002: 87). Although performance management for the English NHS may be more target-oriented and punitive than for Scotland, acute healthcare targets still tend to trump less measurable health inequalities aspirations in both countries (Blackman et al, 2009: 776).

Problems are 'wicked' and seem to defy cause and effect. Prevention policies often focus on problems described as 'wicked' or intractable, with no clear sense of the cause of problems and effect of solutions (Taylor, 2013; Williams and Glasby, 2010; Exworthy and Oliver, 2012: 291; Hannigan and Coffet, 2010: 222). Public health comes relatively close to a clear-cut solution when it involves, for example, the generally accepted scientific link between smoking and ill-health and the cumulative knowledge of policy solutions to encourage smoking cessation (Cairney, Studlar and Mamudu, 2012: 2-3). It is less clear when health intersects with issues of poverty and inequality, and the need to join up services to address health, education, housing and crime. There also remain unresolved problems about how to define inequality as a policy problem, combining relatively easily measured divisions such as occupation, gender, and ethnicity, with vaguer notions of status, resilience, and access to social networks and opportunities (Bartley, 2004: 23).

Further, policymakers know much more about the size of class-based health inequalities than their cause – and, historically, have entertained many explanations based on income, working class culture, ‘natural selection’, a ‘psycho-social’ focus on the emotional and physical effects of work and social status, ‘life course’ studies tracking adult behaviour to childhood circumstances (including problems relating to ‘early attachment’), ‘materialist’ studies of the effects of hazardous occupations, and ‘neo materialist’ studies of the ability of states to reduce inequalities via benefits, housing and public services (Bartley, 2004: 9-15). Consequently, they often perform the policymaking equivalent of a ‘leap of faith’: acting without being clear on cause and effect or knowing if an intervention will cause good outcomes; and, accepting that the evidence of success will be limited and could take years to produce (Blackman et al, 2009: 773; 2012: 59; Exworthy and Oliver, 2012: 294; Chief Medical Officer, 2014: 14).

Ethical dilemmas and the ‘nanny state’. Prevention involves fundamental political choices regarding: the balance between state solutions and an appeal to personal responsibility (Freeman, 1999); which kinds of inequality (including class, gender, race and disability) are the most worthy targets for public policies; and, how far we should go to influence behaviour or restrict liberties (Wattam, 1999: 323; Cairney, 2009a).

Consequently, we can identify a far greater tendency for policymakers and the public to accept the *principle* and *logic* of prevention policy than specific measures designed to achieve broad aims. Policymakers pursue incremental changes that encourage prevention but do not have major implications for existing budgets or services (Gough, 2013: 7; Early Action Task Force, 2012: 28; Cairney et al, 2012: 101-4). This strategy may be effective over the long term if budgets are always rising, but be ill-suited to an ‘austerity’ agenda in which prevention policy is expected to save money, or in which it is relatively easy for governments to find money from long-term investment budgets to fund short-term shortfalls. Governments may ‘cherry pick’ policy agendas to claim ‘quick wins’ (Blackman et al, 2009: 762). Or, they may charge other public bodies and groups with the task of making sense of prevention – by encouraging ‘localism’ and putting service users at the heart of service design – as a cover for tough funding decisions.

On that basis, the objectives articulated in *Forward View*, albeit in a stronger language than previous strategy documents – to advance public health, involve service users more in service delivery, reorganise health and social care, and provide leadership – signal an as-yet-unfulfilled potential for meaningful policy change (Hunter, 2015 describes England’s NHS chief executive, Simon Stevens, as a ‘true convert to the cause’ but suggests that elected politicians do not share his commitment). It shares this unfulfilled potential with the Scottish Government’s ‘decisive shift’ (chapter 5). This is not to say that nothing changes when governments make a strong commitment to preventive health policy – but that (a) UK and Scottish governments have recognised their limited progress to reduce inequalities and public service costs so far (Scottish Government, 2011); and (b) no government has yet broken the cycle of enthusiasm, limited progress, criticisms of progress, and rediscovery (Baggott, 2011: 77).

Complexity and social construction in health and public health

The literature on complexity and health informs such discussions in two main ways: to help identify ‘the complexity of determinants of health’ and the ways in which health-specific policy behaviour emerges from complex systems (Tenbenschel, 2015: 370). It can be used to help explain why policy initiatives seem to fail (and prompt debates about the extent to which we can control health systems), and describes a process of ‘sense making’ used by policymakers and practitioners trying to deal with a complex world by constructing simple rules to guide their behaviour (2015: 371; Kernick, 2006; Plsek and Greenhalgh, 2010; Paley, 2010). It is this process of sense making on which we focus. As we discuss in chapter 2, policymakers adopt the principle of prevention, but as a broad policy solution to an ill-defined problem. At the same time, they seek ways to manage complexity; in particular, they adopt simple rules to manage government and maintain the popularity of the elected party.

Our discussion of public health suggests that many of these rules favour acute healthcare policies rather than longer term preventive policies. In the language of complexity, policymakers contribute to positive and negative feedback, as they respond disproportionately to what they perceive to be immediate health crises, at the expense of attention to longer-term prevention aims. Strange attractors develop, as the public bodies responsible for service delivery reproduce rules that reinforce inattention to prevention. Further, there is path dependence in the NHS system that makes it difficult to shift resources from tertiary services, dealing with immediate demand, to primary or preventive services to reduce demand. Finally, new solutions may ‘emerge’ from local areas, particularly when central governments are serious about supporting localism as the best route to collaboration, but are not the inevitable consequence of a ‘decisive shift to prevention’ by central government.

Social construction theory suggests that such outcomes may vary by target population, but it is difficult to produce a clear picture on government responses. For example, policies to deal with health inequalities may be linked to deprivation and the sense that individuals or communities in poverty deserve extra attention, particularly if they are children with limited abilities to take responsibility for their healthy behaviour (see also chapters 4 and 5 on the importance of parenting programmes to the UK and Scottish Governments). However, for example, the uptake of Family Nurse Partnerships, aimed specifically at improving the life chances of teenage mothers and their children, may have had as much to do with the demonstrable evidence on their success as the desire to target a specific population (Cairney, 2015c). Or, there are specific initiatives for older people (such as the prevention of falls), focused largely on keeping them out of a hospital system that proves difficult to leave when you enter.

More generally, the most sustained policy development is based on regulation and individual exhortation, often accompanied by attempts to ‘empower’ people to make good choices (Woodall, 2012). There is also a tension within public health policies regarding the extent to which policies are aimed generally at societal health improvement or specifically at certain populations such as ‘trouble drinkers’ (Cairney and Studlar, 2014). More generally, it may be

relatively difficult to mobilize public or policymaker support for particular target populations because prevention is often about the relatively abstract improvement in community outcomes, or programmes to improve the life chances of people in the distant future; it does not compete well with attention to the immediate fate of specific populations in the present.

What does a ‘window of opportunity for prevention policy’ mean in relation to mental health?

Although rising government attention to mental health coincided with attention to public health in the 1990s (Hannigan and Coffet, 2010: 223), the nature of their respective ‘windows of opportunity’ are distinctive. In mental health, the idiom ‘prevention is better than cure’ is relatively problematic. Although a focus on population wellbeing may represent primary prevention, it is unlikely to diminish the need for tertiary services, in some cases, and secondary prevention to address ill-health, in others. On the other hand, key governance principles, associated with the prevention agenda, are *particularly* relevant to mental health – including a focus on involving service users in the design of public services, which is a grass roots and voluntary group agenda that developed in mental health almost independently of prevention (6 et al, 2007: 31; Rogers and Pilgrim, 2001).

Mental health policy also highlights distinctive layers of complexity: people with complex needs engage with a complex National Health Service (NHS) system (Kernick, 2006) overseen by actors within a complex policymaking system. Indeed, Hannigan and Coffet (2010: 221) argue that in mental health:

- policymakers have generally been engaging with problems that they do not understand when they try to solve them;
- their policy solutions have produced major long term unintended consequences; and,
- there remain unusually high levels of path dependence in mental health, relating in particular to the shift from acute/ institutional to preventive/ community based policies.

Further, the role of social construction is particularly important in mental health. Although there may be a similar sense that a bio-medical model dominates our understanding of physical *and* mental health, the latter involves (a) greater debate on the nature of mental illness and the extent to which it relates to contested notions of socially deviant behaviour (and ‘moral panic’ in relation to mental health and violence); and (b) greater involvement by other professions, such as the legal profession in relation to human rights and the deprivation of liberty without trial (Kelly, 2008: 62-3; Pilgrim, 2005; 2007; Cutcliffe and Hannigan, 2001; Anderson, 2003; Paterson and Stark, 2001; Cairney, 2009).

Actors compete to make sense of such complexity, produce rules for healthcare institutions to follow, and socially construct target populations to influence how they receive government benefits and burdens. This can include a range of agendas, including the need to deprive some people of their liberty, the insufficient status and funding for mental health services, the pursuit of parity of esteem for mental and physical health, a shift from institutional to

community services, public service reform (including health and social care integration), and the inclusion of mental health in public health initiatives (Hannigan and Coffet, 2010: 224).

Long term (pre-devolution) trends in policy and policymaking

Pre- and post-WW2 trends in UK policy and policymaking (before devolution in 1999) can be linked somewhat to long-term changes in the broad philosophies underpinning policymakers' understanding of mental illness – at least from the days of institutional segregation, towards modern psychiatry, the rise of psychological alternatives, and modern ideas such as treatment based on 'recovery', trauma, or wellbeing (Phillips et al, 2012; although 6 et al identify major continuities in the beliefs of many groups and professions).

While it still remains a medicalised issue, we may identify shifts away from a focus on acute mental illness to be treated solely in institutional settings by psychiatrists, towards: a major push to deinstitutionalize much mental health care, in line with wider trends towards care in the community for older people and people with learning difficulties (Baldock et al, 2012: 299); debates about social definitions of normal/ deviant behaviour; and, attempts to broaden the scope of mental health to issues such as depression and wellbeing, and pursue greater parity between mental and physical health. This has helped produce some broad trends, including:

- Rogers and Pilgrim (2001: 41-53) describe a general move away from the 'Victorian asylums' (which demonstrated minimal ability to treat people for illness), the identification of environmental contributors to mental illness (such as 'shellshock' following WW1), and growing interest in out-patient treatment. They track the post-WW2 reduction of in-patient capacity in England, from 150000 beds (almost half of all NHS beds) in 1954 to 50000 in 1992 (2001: 61-74; Baldock et al, 2012: 295), prompted partly by a mix of cost-saving imperatives, hospital scandals in the 1970s regarding poor institutional care, the rise in pharmacological prescribing, and the development of community care alternatives (although most of it happened from the 1980s). The current figure for England is little over 20000, prompting the Royal College of Psychiatrists to commission a review into capacity (Smith et al, 2015). There have been similar shifts in Scotland, although it has more per capita bed capacity (Cairney, 2009: 686).
- The development of legislation built, to an increasing extent, on the need to protect human rights when depriving people of their liberty without trial (Rogers and Pilgrim, 2001: 55).
- Post-war technological development, leading to the expansion of prescription drugs.
- More recently, an expansion of psychological therapies (such as cognitive behavioural therapy, CBT) to address depression, and potentially preventative measures based on the promotion of good health (as part of a broad attempt to shift the focus from mental illness to wellbeing).
- Attempts to challenge mental health's low status within the NHS.

This shift went largely in tandem with shifts in policymaking, and consultation in particular, in which the government has widened its consultation net, acted as a referee between often-competing groups, overseen a shift towards greater user involvement, and reduced medical dominance of consultation. This is no mean feat, given the unusually wide range of views in mental health, from “the ‘medical model’ at one end to the belief that mental illness is a social construct at the other” (Cairney, 2009a: 675-6; Spandler et al, 2015), the intense post-war struggle of voluntary and user groups to challenge psychiatric dominance in consultation and service delivery, the divisions within each lobby (Pilgrim, 2007: 90), and the fact that, in many areas, there is no natural point of consensus between two fundamentally different aims, to protect the rights to liberty of individuals or detain (and treat) individuals for the public good (Pilgrim, 2005: 440).

A clear trend from institutional to community services, from psychiatric to social ideas?

However, we should not exaggerate this shift, and treat it as a binary move from psychiatric to social and preventive notions of mental health. For example, Rogers and Pilgrim (2001: 63) describe continuity in the ways in which policymakers thought about mental illness when processing post-WW2 legislation – that psychiatrists could identify real mental conditions, inevitably requiring treatment, which often justified the deprivation of liberty for treatment, and that patients could be treated effectively by a profession with undoubted integrity – which contributed to successive mental health acts, helped maintain a still-substantial role for hospital treatment, and perhaps hindered the meaningful development of community based alternatives (which were also constrained by limited funding). A shift towards greater third sector and user involvement should also be seen within this broadened medical understanding of mental illness. So too should the study of devolved policy from 1999, in which territorial governments were free to develop policy and policymaking approaches, but in the context of a medical model shared across the UK.

We should also not overestimate the coherence of a number of mental health policy changes. For example, mental health legislation began to identify the importance of individual patient rights without being accompanied by the provision of adequate services (2001: 79), leading to classic problems about: depriving people of their liberty, insisting in legislation that this had to be accompanied by a *right* to therapeutic care while detained, but not providing *actual* levels of adequate therapeutic care. Further, mental health legislation from 1983 referred to a ‘duty of aftercare for discharged patients’ without ensuring adequate services, while bodies such as the Mental Health Act Commission, charged with the oversight of services, were often under-resourced and had limited impact (2001: 79-80). Similarly, a shift towards greater community care (following the NHS and Community Care Act 1990) was patchy, to partly reflect: the difficulties of joined up working between NHS, local authority, third and private sector services; a slow shift in resources from hospitals to community settings; and, some perverse incentives to set up community ‘institutions’ rather than at-home treatment (2001: 84). This all took place in the context, facing politicians, in which:

- ‘segregation’ on the basis of mental illness ‘is both wanted’ (to separate people from the general public) and ‘distrusted by the general public’ (or by people fearing that they could be subject to this policy) (Rogers and Pilgrim, 2001: 76).
- The smallest group of people receiving (‘forensic’) mental health-related services receive the highest level of media and public attention, compared to broad issues of depression in the population (the most populous group) and the adequacy of NHS, community and ‘preventive’ services.

The Mental Health Act 2007: a major blip in long-term trends?

Cairney (2009: 676) describes the process, begun in the late 1990s, to develop a new Mental Health Act, primarily for England and Wales, as a major break in policy and policymaking trends, and a partial shift in the social construction of mental health populations, from *vulnerable people with rights to services* to *people potentially dangerous to the public*. It shifted the rhetorical balance from individual rights to liberty and adequate services to public safety, including a major focus on preventing crimes by ‘dangerous people with severe personality disorder’ (DSPD). It also produced a major stand-off (lasting almost ten years) between the UK Government and almost all relevant professional and third sector groups in the ‘Mental Health Alliance’. Previous approaches, when processing the 1959 and 1983 Acts, were based more on a ‘broad commitment to service modernisation and patients’ rights’ (2009: 676), and involved extensive efforts by governments to generate a degree of agreement, between psychiatric and third sector groups, on the balance between the deprivation of liberty to oblige treatment and the pursuit of a rights-based approach to secure appropriate services.

The government’s new policy went through several iterations, and received substantive pre-legislative scrutiny, but did not change in a way that satisfied the Mental Health Alliance. Instead, the positions of government and groups became entrenched, they never produced a negotiated settlement, and the government produced a much smaller Mental Health Act 2007, which focused largely on modernisation to meet new ECHR requirements. Many issues remain unresolved, and the 1983 and 2007 Acts are still in need of further reform to deal with issues regarding, for example: the relationship between police detention to provide a ‘place of safety’ (under s136 of the 1983 Act) and low hospital capacity to provide follow-up treatment; the inappropriate use of the 1983 Act to secure access to in-patient hospital services; the negligible effect of community treatment orders (CTOs) on hospital admissions; the greater use of CTOs for black patients; and, the role of preventive detention for public protection (Health Committee, 2013a; 2013b; Annison, 2014).

This experience of UK government policymaking is all the more significant when we see, from the experience of Scotland, what could have happened; that governments can secure consent for controversial aspects of policy which address similar issues on public safety and individual rights. The first Act passed by the Scottish Parliament was emergency legislation to close a loophole in mental health law, to help detain a patient on the basis of public safety and override concerns about his lack of treatability. This produced concerns that the bill would produce the wrong message, exacerbating mental health stigma and ‘diverting funds

from more positive representations of mental health' (Cairney, 2009: 682). Scotland's Mental Health Act 2003 (amended in primary legislation in 2015) also contained the same controversial measures on community treatment orders, producing the potential to use the Act more extensively without being constrained by hospital capacity. Yet, the Scottish Parliament passed the bill four years before Westminster, even though it began far later. It had built up a reputation for progressive policy and inclusive policymaking, in areas such as mental capacity, and it engaged in a two year process to generate sufficient consensus for the Act by responding and adapting to concerns (2009: 683).

The pursuit of parity between mental and physical health

One reason to treat the UK government's legislative reforms as a blip is that they played out while the Department of Health was setting a new agenda on mental health governance using the language of service user involvement and accountability that we now associate with prevention (chapter 1).

In 1999, the National Service Framework (NSF), became a vehicle to generate far greater levels of consensus on key principles, suggesting that: policy should help destigmatise mental health, most mental health patients are 'vulnerable rather than dangerous'; and, there should be parity between attention to, and services for, mental and physical health (Cairney, 2009: 685). It stated that people with 'mental health problems can expect that services will:

- involve service users and their carers in planning and delivery of care
- deliver high quality treatment and care which is known to be effective and acceptable
- be well suited to those who use them and non-discriminatory
- be accessible so that help can be obtained when and where it is needed
- promote their safety and that of their carers, staff and the wider public
- offer choices which promote independence
- be well co-ordinated between all staff and agencies
- deliver continuity of care for as long as this is needed
- empower and support their staff
- be properly accountable to the public, service users and carers' (Department of Health, 1999: 4).

The NSF's pursuit of 'parity' between mental and physical health services was based on a combination of arguments (Department of Health, 1999; see also Scottish Government, 2012: 1):

- A large part of the population is affected by mental illness, to the extent that it is as normal as physical ill health. The NSF suggests that one in six people are affected 'at any one time' by mental illness (primarily anxiety or depression) in their lives, and tries to relate this to as-common physical conditions (such as asthma). It recommends whole-population health promotion, based on risk factors for depression (focusing on healthy behaviour), combined with mechanisms to identify high risk to aid early intervention.

- Mental health should receive more attention, and be better understood, to help reduce stigma and encourage people to seek treatment.
- Mental health ‘should have the same priority as coronary heart disease’.
- Funding for mental health services should rise substantially (an extra £233m per year over three years).
- Addressing mental health should go hand in hand with addressing other sources of inequality, relating ‘the special needs of women, men, and different ethnic groups’ (foreword by Secretary of State for Health, Department of Health, 1999: 1).

However, it also adds a strong note of caution, highlighting, for example, the initial need to fill ‘gaps’ in (often-institutional) care for severe and enduring mental illness, and the prospect of a ten year plan to recruit and train specialist staff (1999: 7). This caution was reflected in practice, in which most investment went to institutional care and almost none to, for example, mental health promotion or stigma campaigns.

This discussion raises a fundamental question about the time it take to produce major transformations in health service and community care policies, and how we might evaluate the nature and speed of policy change – since one might expect the pursuit of parity to occur over many years, to account for new training and service design, or decades, as the attitudes of one generation are replaced by another. This may require short and long term milestones, to help us measure progress or question the extent to which there is any. In that respect, the NSF provides an eclectic mix of measures, including of: the population’s psychological health (via the National Psychiatric Morbidity Survey); rates of suicide; the extent to which NHS Direct and psychological therapies are ‘rolled out’; the level of prescribing for mental health (in relation to clinical guidelines); levels of psychiatric emergency readmission; service user and carer experiences; and, many ‘local milestones’ on information about, and access to, specialist and emergency services (1999: 39-40; 99).

Even if we accept that major change takes time, the more recent pursuit of parity for England – the ‘cross government’ mental health strategy *No Health Without Mental Health* (2011a: 2) – symbolises uncertainty about long-term change and the centrality of government to it. On the one hand, it reinforces many NSF themes. It contains a major principle – ‘We are clear that we expect parity of esteem between mental and physical health services’ – and a set of aims on improving mental health in the population, including helping people ‘recover’ from mental health illnesses, improving the physical health of people with mental health problems, improving care and support, enhancing services to prevent the development of some mental health problems, and reduce the stigma associated with mental illness (2011a: 6; the latter is pursued via the *Time to Change* campaign).

On the other, it provides little assurance regarding successful implementation. Instead, it highlights a *dual process of policymaking*. First, it consults widely to generate widespread consensus behind vague valence statements to encourage mental health parity – and the promotion of ambiguous policies such as ‘recovery’ (Pilgrim and McCranie, 2013) and ‘wellbeing’ (criticised heavily by the Chief Medical Officer, 2014: 14) – and to generate a sense of ownership across government departments and with ‘employers, schools, local

authorities and the voluntary and community sector’ (2011a: 3). Second, its governance style highlights the limited ability of central government ministers to ensure this agenda has a practical difference within health and community care services, because: (a) power is ‘moving away from the centre’ and, in line with the ‘Big Society’ theme, ‘We want more decisions about mental health taken locally, with more flexibility for local people to make decisions based on local needs’ (2011: 3); and, (b) many of the indicators of success, used for this mental health strategy, relate to long-term outcomes, nascent measures of wellbeing, and a wide range of broad socio-economic indicators of public health. Only some aims, such as a commitment to waiting times for cognitive behavioural therapy, come with ‘hard’ measures of success (Department of Health, 2013; 2014) but, even in such cases, people wait much longer for mental than physical health services (Chief Medical Officer, 2014: 207). .

While these overall measures may be welcome – a focus on outcomes, wellbeing and self-directed care is generally well received – the unintended consequence is that parity of service is difficult to secure if mental health relates to broad aims and long-term outcomes but physical health relates to short-term high-stakes targets – as described in comments in 2014 by the Chief Medical Officer (Triggle, 2014), director of the Centre of Public Health at the National Institute for Health and Care Excellence (Mason, 2014), and the British Medical Association (2014). In this sense, mental health resembles public health – both struggle to compete with physical health in terms of day-to-day performance management.

Further, recent funding decisions by bodies such as NHS England undermined this parity strategy, and the Health Committee (2013a: 3-4) reports that local ‘commissioners find it easier to cut mainstream mental health services because of the way in which they are commissioned through block contracts’ (see also Siddique and Meikle, 2015; McNicoll, 2014). In some cases, NHS England and GP commissioners cannot agree on who should fund services, producing major gaps (which vary markedly by region) in relation to services for children or adolescents with complex needs, and reinforcing problems in relation to mental health (when services fail to prevent conditions from worsening) and services (when patients are held in adult wards or police cells, or staff morale falls to the extent that people leave the service) (Royal College of Psychiatrists, 2015: 6; Chief Medical Officer, 2014: 12; 100).

One major new development regards how ministers now deal with the problem. In the past, we may have expected them to intervene directly in the running of the NHS. The phrase ‘command and control’ was a feature of the previous Labour government. Now, they criticise the decisions of public bodies without intervening to change them. For example, Norman Lamb, care services minister 2012-15, criticized an NHS England decision as ‘flawed and unacceptable’ (Campbell, 2014) but ministers did not intervene to make such decisions more consistent with their aims (similar criticisms, rather than interventions, can be found in Department of Health, 2011: 8-9).

This kind of outcome also produces consequences for group-government relations. In the past, groups may have focused successfully on ministers and civil servants in government departments. Now, ministers take a ‘hands off’ strategy and many civil servants have moved on to public bodies like NHS England, prompting groups to engage in complicated strategies

to ensure influence throughout the public sector – or, at least, highlight the inconsistencies between ministerial policies and public body practices (see, for example, several letters to the Guardian, including by a group of mental health charities (Duggan et al, 2014) and practitioner groups (Carter et al, 2014)). In that sense, policymaking for Scotland and England are very similar: ministers form alliances with groups to produce broad strategies, but (in effect) expect groups to pursue specific policy outcomes with local public bodies (Cairney et al, 2015; Cairney, 2013).

Public mental health as the ultimate cross-cutting issue

Mental health is a major source of health inequality - for example, ‘people with mental illness die on average 15–20 years earlier than those without’ and are more likely to engage in unhealthy behaviour (Chief Medical Officer, 2014: 12; 217) – and a clear candidate for public health activity. Yet, in the context of our discussion of the constraints to public and mental health policies, public mental health takes our analysis one stage further, to represent the ‘highest bar’ of preventive policymaking. At the very least, most of the problems we discuss in relation to public health are more marked, particularly in relation to its low salience, inability to compete for attention and resources with physical healthcare, and poor links to the priorities of public bodies. Policymakers may perceive public mental health aims to be too broad and responsibilities too cross-cutting to make sense of them, a problem compounded by the nature of many aspects of mental illness which are not preventable in the same way as unhealthy behaviour. Further, if a key measure of the success of early intervention is a long-term shift from acute to primary or early intervention services, mental health presents unusual problems, since it is difficult to imagine that preventative policies will reduce the need for, or cost of, acute and ‘crisis intervention’ care.

Scotland’s ‘decisive shift to prevention’

On the other hand, the governance principles associated with prevention relate strongly to those in public mental health. Prevention can be linked to a wide range of initiatives associated with improving wellbeing, including a focus on: person-centred care and an ‘assets based’ approach (focusing on the assets people have, not their problems or limitations) to help design services, or ‘recover’ from addiction; social networks to address the mental health effects of isolation; and, community-wide initiatives to focus specifically on ‘the needs of deprived areas and populations’ (Commission of the Future Delivery of Public Services, 2011: 28-32; 59).

Prevention and service reform themes also tie closely to the Scottish Government’s (2012) mental health strategy for 2012-15: ‘Self-help, self referral, self-directed, self management and peer to peer are all concepts that will only grow in importance and which demand a different mindset and approach to service design’. There is a strong focus on early intervention, linked to the Scottish Government’s Early Years Framework which focuses on child development from pregnancy to 3 years old, and initiatives such as the Family Nurse Partnership (2012: 19), and its programme of early detection, built on the idea that the ‘risk of long-term negative personal and social outcomes, including school disruption, family stress

and dysfunction, mental health problems, loss of employment productivity, social isolation, drug and alcohol problems, as well as crime and antisocial behaviour' can be 'predicted by externalising behaviour at age three', and addressed through intensive parenting programmes such as 'Triple P and Incredible Years' (2012: 20). There is also some focus on inequality of access based on gender, sexuality and ethnicity (2012: 30), on examining the underlying causes of behaviour such as self-harm and eating disorders, linked to the broad theme of 'distress' (2012: 34-5), and developing a framework to support 'wellbeing in later life' (2012: 36).

In cases of severe and enduring illness, the distinctiveness of this focus is often less clear. The pursuit of parity between mental and physical health services suggests a focus on secondary (to identify risk groups and focus resources) and tertiary prevention (to stop a condition or its effect from worsening), producing targets on measures such as: reducing psychiatric in-patient re-admissions (2012: 6); reducing the suicide rate (2012: 7); introducing a target of receiving CBT within 18 weeks of referral, and to align the prescribing of antidepressants with clinical guidelines (2012: 8); rolling out 'alcohol brief interventions' (2012: 32); and, reducing the wait for Child and Adolescent Mental Health Services (CAMHS) treatment from '26 weeks by March 2013' to '18 weeks by December 2014', partly by growing the workforce (with further commitments related to looked after children and learning disability) (2012: 8; 23; although see Ward, 2015). The Scottish Government (2012: 11) also seeks to incorporate a focus on 'prevention, anticipation and supported self management' by directing resources to early detection, seeking a notional hierarchy of treatment, from community treatment and home treatment for crisis prevention, to 'day case treatment' in hospitals and then in-patient care (2012: 11; 39), and seeking to improve the physical health and employability of people with severe and enduring mental illness (2012: 43-6).

England's Healthy Lives, Healthy People

These themes are as central to the UK Government's public health strategy. In its White Paper (Department of Health, 2010a: 20; 32), it highlights several links between mental and physical health (for example, people with mental illness die younger and are more likely to engage in unhealthy behaviour), and the need to help people improve their 'wellbeing' and 'resilience'. It also makes a commitment to 'localism': identifying the need to address public health and inequalities, but delegating policy to Public Health England and identifying the main driver of policy coordination in Directors of Public Health at the local authority level (2010: 7). This public mental health strategy:

Complements A Vision for Adult Social Care: Capable Communities and Active Citizens in emphasising more personalised, preventive services that are focused on delivering the best outcomes for citizens and that help to build the Big Society ... The Government is radically shifting power to local communities, enabling them to improve health throughout people's lives, reduce inequalities and focus on the needs of the local population ... There has not been enough focus on the root causes of ill

health. Mental and physical health and wellbeing interact, and are affected by a wide range of influences throughout life' (2010a: 4; 7; 21; 23; see also 2010b).

There is a strong emphasis on the rejection of 'top-down initiatives and lectures from central government' in favour of a 'new approach' which: 'gets to the root causes of people's circumstances and behaviour, and integrates mental and physical health'; links wider factors 'such as education, employment and the environment' to health inequalities; focuses on environmental (rather than biological or genetic) causes of many mental illnesses, such as domestic violence and the effect on children of witnessing violence; and, signifies a shift of policy responsibility, 'to be shared right across society – between individuals, families, communities, local government, business, the NHS, voluntary and community organisations, the wider public sector and central government' (2010a: 36). Further, as in Scotland, local authorities, in charge of the health and wellbeing of their populations since 2013, must state how they are addressing this agenda in strategy documents (Learmonth, 2015).

Discussion: with this new long-term agenda, when can you expect to see new outcomes?

An enduring theme in prevention policy is that interventions take a long time to produce positive outcomes – particularly early years interventions designed to improve the life chances of children. Yet, much of our analysis of health policy suggests that it would be a mistake to simply wait for a broad commitment to prevention to pay off. Rather, if we draw on key policy concepts, we can identify the potential barriers to policy implementation that are generally not time-specific:

- *The diffusion of actors.* Policy strategies are made by central governments but delivered by public bodies in partnership with each other and stakeholders. The adoption of localism by both governments ensures not only the potential for a gap between expectations and outcomes, but also an acceptance by government of that gap. This is particularly true in English public health, where healthcare commissioning bodies had considerable control over the direction of services before powers were transferred to local authorities.
- *Institutions and path dependence.* In general, preventive policies involve incremental changes to reduce acute or reactive services, punctuated in public health by healthcare crises that have the opposite effect. In mental health, preventive policies generally act to improve the use of, rather than reduce, more reactive services.
- *Bounded rationality, ways of thinking, and short-cuts to action.* Public and mental health both demonstrate the ways of thinking among policymakers which can undermine preventive policies: broad, long-term, and low salience policy aims struggle to compete with specific short-term high-salience health care issues, in many ways, including in relation to how one identifies value for money and supports policy delivery through performance management. Further, these ways of thinking also influence the uptake of interventions *within* mental health, such as CBT which is supported very heavily by governments (and the UK in particular) largely because they accept the evidence on its value for money, particularly as a tool to enable people to stay in or return to work ('alcohol brief interventions' are also well supported in

Scotland and England, largely because they can be rolled across the population and demonstrate low cost and positive outcomes).

- *Ideas and the role of knowledge and evidence.* Compared to physical health, the evidence on the social determinants of poor physical and mental health is less clear and more contested, and the evidence on the success of interventions is more difficult to demonstrate (particularly when policymakers seek evidence of value for money and/ or ‘cashable savings’).
- *Policy networks.* Central government relations are generally consensual, as ministers, civil servants and groups agree broad principles and strategies. These relationships are not as well developed between key public bodies and groups such as mental health charities, which generally describe poor access to NHS England (until the arrival of Simon Stephens) and Public Health England. Groups also face the need to form relationships with local public bodies – a problem that is more manageable in Scotland than England.
- *Socioeconomic context and events.* The advent of ‘austerity’ provides a double-edged sword: it has prompted attention to prevention as a way to reduce public spending; but, in practice, central governments delegate responsibility to local public bodies and cut their budgets, which tends to undermine their incentives to produce preventive policies. This strategy may be reinforced by public and mental health strategies which promote the development of individual social and emotional skills – summed up in terms such as ‘resilience’, ‘character’, ‘empowerment’, ‘recovery’, and ‘assets’ – in part to emphasise the role of personal responsibility (and often as a cover for reduced investment).

Putting public and mental health together therefore produces the impression that the outcomes of a prevention agenda are unpredictable. Many worthwhile ‘preventive’ measures often exacerbate inequalities and do not reduce costs. The latter may be a particular problem in mental health acute services, as described by the British Association of Social Work: ‘The government’s mental health strategy says intervene early, intervene with communities, and intervene with children. That’s laudable and absolutely right. But with no additional resources? Amid all the cuts, how do you balance early intervention while still intervening at the top end?’ (Community Care, 2012). Or, a combination of prevention and localism can be a tempting solution for governments, since they can reduce budgets at the same time as delegating responsibility for policy outcomes to local authorities and their partners, knowing that they can exhort local public bodies to shift to preventative policies to reduce long-term costs even though long-term policymaking suffers during periods of austerity (Parsonage, 2010).

Further, these policy aims are so broad that, to all intents and purposes, we may not know how they play out, in terms of practices and outcomes, unless we get a sense of policy and policymaking in multiple government departments, and examine how partnerships and strategies emerge across multiple levels and types of government. This could produce the potential for the diffusion of good practice, with some organisations or local areas innovating

and others emulating, but the willingness and ability of public bodies to learn from each other is unclear.

The combination of policies for mental health, public health, and prevention becomes so broad that everything is connected, prompting the possibility that preventive public mental health means everything and nothing. Or, when policy aims are so broad and cross-cutting, the potential for policy to become incoherent rises, as each department pursues aims that either seem to contradict others, or a group-government consensus reached by one department is undermined by another.

Perhaps the starkest examples come from UK Government policy, in which a focus on prevention can involve positive frames, relating to ‘wellbeing’ and the production of new measures of happiness to compete with GDP as a measure of a country’s progress (Bache and Reardon, 2013), or rather negative frames about anti-social behaviour, when a focus on ‘prevention’ and an appeal to the root causes of inequalities is used to describe its new agenda on ‘Troubled Families’ (chapter 7), in which the government seeks to identify a core group of families with intergenerational problems (regarding unemployment, chaotic lifestyles and low education attainment) and ‘turn them around’ in a relatively short space of time (Department for Communities and Local Government, 2012).

Or, public mental health and an ‘assets based approach’, can be combined with the UK Government’s framing of economic inactivity and excessive welfare dependence (chapter 8), to describe its controversial reframing of social security policy, beginning with Dame Carol Black’s (2008) review which recommended a major reform in the way that people are assessed for unemployment related benefits: ‘The paper-based sick note should be replaced with an electronic fit note, switching the focus to what people can do and improving communication between employers, employees and GPs ... Government should pilot a new Fit for Work service based on case-managed, multidisciplinary support for patients in the early stages of sickness absence, with the aim of making access to work-related health support available to all’. The implementation of this idea is now the most criticised aspect of government policy by the mental health third sector, even though it can be framed as preventive public health (BBC News, 2012).

Scotland is not immune from these problems, since any way to give meaning to a broad strategy will produce winners and losers, as some initiatives catch fire and others are rejected according to new criteria. In mental health, the effect may be on particular ‘categories’ of illness or service, since a focus on recovery, early intervention or prevention may relate primarily to depression, the most common and understood condition which is relatively straightforward to destigmatise, prevent (or address early) and roll out (by encouraging people to recognise a problem and seek services). It contrasts with severe and enduring medically defined conditions, such as bipolar disorder or schizophrenia, which are more difficult to understand and address, provide less-recognised benefits (preventing the worsening of conditions), and are more likely to involve relatively expensive services which are less conducive to personalised delivery (many people reject the idea that they have a problem and will refuse to commission services). There remains great potential to exacerbate

inequalities driven by mental illness while improving mental wellbeing within the population as a whole, while a large number of local authorities and their partners are simultaneously trying to make sense of a new policy agenda and reduce the costs to deliver it.

Conclusion

Public mental health is the ultimate case study of prevention. First, it demonstrates the unfolding effects of a new governance agenda in the UK and Scottish governments, to combine localism and local community partnerships with a shift to long-term outcome-based measures of success. Second, it accentuates the problems evident in both public and mental health, including a struggle to compete with healthcare policy when policymakers seek quick ways to address simply defined problems with solutions that have a visible impact in the short term, or use performance and accountability measures that reinforce a focus on healthcare. These factors combine to shift our understanding of a ‘window of opportunity’ for prevention. There may be a ‘decisive shift’ among both governments, but only to promote a new agenda – not to design, deliver and prioritise a new collection of specific policy interventions. The ‘tools’ (Hood and Margetts, 2007: 5-6) used to further preventive policies, largely relate to ‘nodality’, in which central government represents a hub for policy strategy and learning, rather than a major new source of ‘authority’, ‘treasure’ or ‘organisation’ (although not exclusively – for example, Westminster’s *Care Act 2014* places a broad legal duty on local authorities to prevent or delay the development of adult needs for care and support).

There have now been at least three phases of UK government prevention policy in relation to health inequalities: a period from the 1980s, in which governments became aware of but downplayed or ignored them; a late 1990s surge of attention, but with limited effects on the social determinants of health; and, an emphatic restatement of priorities in the last five years, but accompanied by a sense of unpredictability based on acknowledged failures of the past. There is more evidence of general progress in mental health policy during this period, including a modern focus on mental and physical health policy parity, but also a ‘hands-off’ policy style which can contribute to the sense that highly lauded policy choices are not delivered. This experience also contrasts with public mental health in which policymakers struggle to articulate a role for mental health and interest groups struggle to gain access to policymaking.

The latter is indicative of the properties of policymaking when issues cross-cut government departments and are addressed increasingly by non-departmental public bodies at central and local levels: groups find that the stable and privileged relationships they enjoy with single departments, to produce consensual strategies, are replaced by unpredictable and often peripheral contact with other departments and bodies which have their own ways of thinking about policy issues, and rules of policymaking and engagement.

We focus on these issues in chapters 7-9, expanding on the idea that, in a complex system, policymaker attention can lurch dramatically from one issue to another, and they may draw on quick, emotional judgements to treat different social groups as deserving of government

benefits or sanctions. Different rules develop in many parts of government, producing unpredictable outcomes when, for example, well-established rules and relationships within the Department of Health cross-cut with criminal justice agendas in the Home Office, and welfare and employability reforms in the Department of Work and Pensions. There has often been a strong events-driven agenda, based on high profile cases of mental health related violent crimes or employability and disability reforms, combined with responses from other government departments that have been criticised by mental health groups. We can also see long-term ‘paradigm’ shifts in health departments, such as from a focus on institutionalisation towards community and personalised care, but without a sense that it is always based on the development of a new way of thinking about mental health (the endurability of the ‘medical model’ is still significant) rather than an economic imperative.

Each of these elements could contribute to a sense of complexity: policymakers juggle anti-stigma and stigmatising judgements about how to treat mental health; policy is processed in multiple institutional settings which often seem inconsistent with each other; group-government relations exhibit long-term shifts but short-term instability; there is no clear picture on paradigm change; and, the reaction of policymakers to events can knock well-established strategies and relationships off course. When combined, they suggest that the world of policymaking is too complex to predict or fully understand. They expose slogans such as ‘joined up’ or ‘holistic’ government as attempts to give the appearance of order to policymaking when we know that: policymakers can only pay attention to a small portion of the issues for which they are responsible; they delegate or devolve most decisions; different understandings of policy problems, and the rules used to solve them, develop across government; and, policy outcomes ‘emerge’ at local levels.

The idea of ‘complex government’ can also be used to reject the idea – associated with the ‘Westminster model’ - that power is concentrated in the hands of a small number of people in central government (Cairney, 2015). Instead, governments develop strategies to deal with the fact that their powers are rather limited in practice. Consequently, there is a profoundly important tension between the reality of complex government and the assertion of government control and accountability. Policymakers have to justify their activities with regard to the idea of accountability to the public via ministers and Parliament. We expect ministers to deliver on their promises, and few are brave enough to admit their limitations. Yet, the reality of government is that they cannot take meaningful responsibility for decisions and outcomes that appear to be out of their control – so, instead, they look for new ways to share responsibility with other actors. This has a reinforcing effect on the difficulties of understanding the system, since localism agendas produce a large number and wide range of ‘policymakers’ using short-cuts to make decisions, developing their own institutions, networks and ways of thinking, and reacting to policy conditions that vary markedly across the UK.

This conclusion presents a major problem for traditional notions of democratic accountability: if our understanding of mental health policy and policymaking is so limited, how can we identify the extent to which policy is ‘coherent’ and hold elected and unelected policymakers to account for the outcomes of their choices? This is a particular problem when

we consider the broad aim of governments to shift resources towards early intervention and preventative policies, from acute to primary care, or from physical to mental health: how can we generate a broad sense of perspective to assess the extent to which these changes are happening?

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