Conceptualisations of Public Mental Health: The Role of Primary Prevention and the Social Determinants of Mental Health

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ABSTRACT

Background: Within the area of public mental health there is a lack of consensus regarding how best to deliver a preventative and population-level approach to mental health. There has been increased interest in how psychologists can contribute towards developing a public mental health approach that focuses on the prevention of mental health problems, as opposed to treatment. A study that explores how psychologists think about, and engage with, public mental health and prevention has not been carried out before.

Aims: This study aimed to explore how practitioner psychologists understand the concept of mental health prevention, how this informs their practice, and how they engage with the evidence on the social determinants of mental health as part of this.

Method: Eleven semi-structured interviews were conducted with clinical and community psychologists involved in the area of public health and prevention. Interview transcripts were analysed using thematic analysis.

Results: Participants' understanding and use of public mental health and prevention approaches were captured in five themes. A description of these themes and associated sub-themes is presented.

Conclusion: The findings indicate that there are a range of understandings regarding the concept of mental health prevention and that this relates to beliefs and values about mental health and where change should occur. The psychologists in this study had employed a variety of skills, models and theories in their prevention work. Most participants felt that prevention ought to address the social determinants of poor mental health, and some had found ways to do this through multi-sector work and influencing key decision makers. The implications for the theory and practice of applied psychologists involved in prevention, and for decision making in public mental health are discussed.

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1. INTRODUCTION

1.1. Chapter Introduction

As early as the 1970s it was evident to health researchers that providing free access to the National Health Service (NHS) was not enough to reduce widening inequalities in health outcomes (Black, 1980; Smith et al., 2016). Current mental health provision in the United Kingdom (UK) is oriented towards 'mopping up the flood', whilst paying little attention to 'turning off the taps' (Cooke, 2014, p.24). However, there is growing policy consensus regarding the need for a preventative and population-level approach to mental health (Department of Health, 2020; NHS England, 2019). The area of public mental health, which spans mental health prevention, promotion and treatment, has been historically overlooked, but is now a priority area for Public Health England (Campion, 2019; Walker et al., 2019). There has also been more interest in how clinical psychologists can contribute towards the development of a public health and prevention approach to mental health (British Psychological Society, 2018; Harper, 2017; Jenkins & Ronald, 2015).

This chapter will begin by outlining the emerging field of public mental health and will describe some of the challenges for the area that have been identified within the literature. In particular, the chapter will outline the challenges associated with the concept of 'prevention', which has been described as a complicated and contested term when applied to the area of mental health (Cowen, 1998; Radden, 2018). Debates related to use of the term, the classifications used to define prevention interventions, and the concept's relationship to mental health promotion will be outlined. Discussion surrounding how best to translate the evidence-base and policy regarding the social determinants of mental health into the practice of prevention, and models relevant to this, will also be described. Finally, the growing interest in how applied psychologists can contribute to the development of a public health and preventative approach to mental health will be considered. The limited research into clinical psychologists' involvement in this area will be highlighted. The rationale for this study, which aims to explore how

clinical psychologists understand and practice mental health prevention, will then be presented.

1.2. Literature Review Strategy

The aims of the literature review were to identify publications on 1) public mental health and mental health prevention 2) social determinants and prevention 3) the involvement of clinical psychologists working in this area. The broad nature of the research topic, which includes a number of intersecting areas, means that there is a large amount of literature that could inform the review. Therefore, a number of literature review strategies were considered. Systematic review was considered, however this approach is recommended when the aim is to assess the methodological status of an evidence base and typically privileges empirical studies, such as randomised control trials (Greenhalgh et al., 2018). This study is interested in the ways that researchers have conceptualised prevention, when it is applied to mental health, and the related challenges associated with translating this understanding to practice. Research relevant to this is primarily theoretical in nature and would therefore have been excluded in a systematic review of peer-reviewed publications (Greenhalgh et al., 2018). In addition, the majority of publications regarding the role of clinical psychologists in public health and prevention are journal articles, which also would have been excluded. A scoping review was considered in order to include a broader range of publications. However, a scoping review would not have permitted the inclusion of relevant grey literature produced outside of academic publishing, such as government reports and polices on public mental health and prevention (Arksey & O'Malley, 2005).

Therefore, a narrative review was selected as the most appropriate for meeting the stated aims of the literature review. Narrative reviews are preferred when different types of research methodologies are of interest (Ferrari, 2015). This allows for the inclusion of a range of publication types, including literature that is theoretical nature, as well as government reports and policy (Greenhalgh et al., 2018). The emphasis within a narrative review is on synthesis and critical interpretation of broad areas of knowledge (Greenhalgh et al., 2018).

Furthermore, this type of review is recommended for providing a comprehensive account of the development of a clinical or scientific concept, such as mental health prevention (Ferrari, 2015).

The literature search strategies will now be described. Initial searches identified key documents outlining a public mental health and prevention approach (Public Health England, 2017a; Walker et al., 2019). This informed the selection of relevant search terms: public mental health, prevent*, primary prevent*, population, mental health, wellbeing and psychosocial. Given the emphasis, within UK policy, on addressing mental health inequalities using prevention methods, the following search terms were also selected: mental health inequal*, social determinant, upstream. A database search was conducted using PsychInfo, Academic Search Complete, CINAHL, Science Direct, Scopus and Google Scholar. The search was carried out using combinations of the following terms: public mental health, prevent*, primary prevent*, population, mental health, wellbeing, upstream, health inequal*, clinical psycholog*, and psychosocial. All databases were searched from their start date to January 2021. References of retrieved meta-analyses were also reviewed to identify further publications. Due to resource limitations regarding translation the search was restricted to those written in English. Relevant grey literature was identified by searching the websites of organisations such as the Royal Society for Public Health, Public Health England, the Department of Health and the World Health Organisation (Adams et al., 2016). The following section presents a narrative review of the relevant literature.

1.3. The Development of a Public Health Approach to Mental Health

The underlying principle of public health is to improve the health and wellbeing of the population by improving health services, promoting healthy lifestyles and preventing ill health (Walker et al., 2019). Until recently, the field of public health has focused almost exclusively on chronic health problems and infectious diseases (Campion, 2019). The majority of resources for mental health provision within the UK are allocated to the treatment of individuals diagnosed with psychiatric disorders (Public Health England, 2017). Despite this, evidence

shows that rates of mental health problems have continued to rise since the 1940s and that even with optimal service delivery and treatment, prevalence rates would remain high (Andrews et al., 2004; Smith et al., 2016). Recent UK policy has set out proposals to change this, with the aim of effective treatment delivery to be paralleled by a focus on preventing the development of mental health difficulties, through public health and population-level approaches (Public Health England, 2017; Department of Health and Social Care, 2019). The term 'public mental health' has been used to refer to the practice of taking a population-level approach to the prevention of mental health problems and the improvement of wellbeing (Walker et al., 2019).

The World Health Organization (1996) considers public mental health to be a triad encompassing the areas of prevention, promotion, and effective care. Within the UK, Public Health England, along with equivalent agencies in Scotland, Wales, and Northern Ireland, is the executive body responsible for delivering national policy to improve mental health and wellbeing. It's aims are taken forward by public health professionals working at the level of local government (Walker et al., 2019). The three overarching goals of Public Health England's mental health programme are 1) the prevention of mental health problems and suicide, 2) the promotion of mental health and wellbeing amongst the general population, and 3) improving the treatment of people experiencing mental health problems (Walker et al., 2019). However, despite policy-level commitment to achieving parity of esteem between physical and mental health, the area of public mental health has received far less attention and expenditure in the UK (Naylor, 2017).

A recent analysis of current delivery of mental health prevention in thirty five local authorities in England identified that there was wide variation in the level of priority given to a prevention and public mental health agenda (Public Health England, 2017b). Campion (2019) has described this situation as the 'public mental health implementation gap' (p.1). This highlights the disparity between the aspirations of policies aimed at the prevention of mental health problems and the operational plans carried out by professionals at a local level. The author attributes this to a number of factors, including inadequate resource allocation

and a lack of public mental health knowledge and relevant skills within public health, social care and NHS settings (Campion, 2019). Most public health departments do not have a mental health specialist and public health training programs teach population-level associations, but not the application of practical skills relevant to mental health (Campion, 2019). Furthermore, professional mental health training is not typically grounded in public health research and models. A number of authors have argued that there is a need to combine the contribution of different disciplines, including, but also extending beyond, public health professionals (Davies, 2014; Public Health England, 2019).

An additional difficulty faced by researchers and practitioners in this area is the challenges related to applying traditional public health concepts and methods to the area of mental health (Cowen, 1998; Radden, 2018). Whilst consensus exists regarding certain core aspects, the field of public mental health has been described as an area "characterised by a lack of clarity over its boundaries and terminology" (Davies, 2014, p.29). This presents challenges for establishing a shared understanding of public mental health that can be applied in everyday practice within health services, commissioning bodies, public health and government departments (Davies, 2014). The concept of prevention has been described as central to any discussion of the issues that occur when public health methods are applied to mental health (Radden, 2018). The challenges related to this are further discussed in the following section.

1.4. Challenges Related to the Concept of Mental Health Prevention

The term 'prevention' is used to refer to interventions that aim to prevent the onset of health-related problems occurring (Bloom & Gullotta, 2003). Preventative approaches to physical health have reduced the incidence of some diseases, for example through immunisations programmes or the introduction of hygiene measures (Campion, 2019). Despite being employed regularly in research and policy, prevention has been described as an 'ambiguous' and 'complicated' category when applied to mental health (Jané-Llopis, 2006). Prevention can take place in a variety of settings, such as health services, schools, the workplace and at a whole population-level (Arango et al., 2018). Interventions can vary widely, examples include stress management, nutrition, parenting support, employment

programmes, legislation and mental health campaigns (Jané-Llopis, 2006). Prevention is a term that can be used to refer to reducing the likelihood of poor mental health, reducing the severity, or preventing subsequent episodes (Radden, 2018). Given the scope of work that could be considered preventative, a number of frameworks have been developed to classify different kinds of prevention (e.g., Caplan, 1964; Gordon, 1987). These were originally developed for physical health but are routinely applied to mental health prevention. The issues related to this are described below.

1.4.1. Conceptual Frameworks for Prevention

There have been a number of theoretical advances in the conceptual frameworks that are used within prevention. The most widely used was proposed by Caplan (1964). This framework delineates between three types of prevention - primary, secondary and tertiary. Primary prevention aims to decrease the number of new cases of a disorder within the population, secondary prevention aims to lower the rate of established cases and tertiary prevention aims to limit the impact of problems that have already occurred. Caplan's (1964) classifications provided an early and influential framework, however some authors have debated how usefully they can be applied to mental health (Blair, 1992; Cowen, 2000).

The area of primary prevention is particularly contested, and definitions vary within the literature (Rappaport, 1992). Rappaport (1992) suggests that understandings of primary prevention have varied depending on socioeconomic and political contexts. During the 1960s civil rights movement, the term became associated with a community mental health perspective which sought to improve population mental health by changing social and economic conditions (Rappaport, 1992). However, since the 1980s efforts were made to 'remake' primary prevention as a scientific endeavour, concerned with risk detection and the prevention of diagnosable disorders (Mrazek & Haggerty, 1994; Murray et al., 2020; Rappaport, 1992). Orford (2008) argues that this approach is based on a medicalised 'disease-prevention' strategy, which led to a narrowing of the concept. Furthermore, the pathways linking risk factors and mental health are complex, with numerous causal influences operating contingently in ways that are often difficult to predict (Cromby et al., 2013; Merlo, 2014).

Until the 1990s, biomedical and behavioural models dominated thinking about mental health prevention, emphasising individual risk-factors and tending to underestimate the effects of social and environmental context (Blair, 1992). However, within the UK, the relocation of public health functions into local government, in 2013, has been associated with an increased focus on health determinants such as housing conditions and local economic development (Conrad, 2014). Baum (2016) argues that this has necessitated the integration of biomedical and psychosocial approaches to prevention. 'Primary prevention' has become associated with public health policies that aim to reduce health inequalities and address the 'upstream' determinants of mental health within the whole population (Public Health England, 2017). There has also been increased interest in alternative approaches to prevention, such as 'wellness enhancing' and 'asset based' approaches, discussed further in Section 1.4.2.

Whilst there are common themes across definitions of primary prevention, namely the intention to prevent the onset of problems within the population, definitions vary depending on the selected population and the methods being used (Blair, 1992). This may account for some of the confusion within the evidence base on primary prevention. Papworth and Milne (2001) found that the majority of studies in this area did not meet the criteria of being population focused and were designed to treat early indicators rather than prevent the onset of problems. Similarly, Cowen (2000) found that much of what was labelled as primary prevention in the literature did not meet criteria or standards for such definition.

Furthermore, several authors have argued that the secondary and tertiary components of Caplan's (1964) framework constitute remediation and treatment, rather than prevention (Baker & Shaw, 1987; Albee, 1982; Cowen, 1983). Gordon proposed that the term 'prevention' should be reserved for individuals not yet "suffering from any discomfort or disability from disease or disorder", therefore excluding the category of tertiary prevention (Gordon, 1983, p.108). The author put forward the following alternative classifications: universal, selective, and indicated prevention. Universal prevention targets an entire population or group, selective prevention targets groups identified as being at increased risk and

indicated prevention includes strategies targeted towards individuals experiencing minimal but detectable signs of distress. The defining feature for determining interventions was therefore the targeted population, rather than the stage of disorder. Both Caplan's (1964) and Gordon's (1987) definitions for prevention are shown in Table 1.

Table 1 – Prevention Frameworks

Author	Aims
Caplan (1964)	**Primary:** aimed at reducing the incidence of mental health disorders within the population. **Secondary**: aimed at reducing the prevalence of disorders by reducing duration. **Tertiary:** aimed at reducing the impairments resulting from disorders.
Gordon (1987)	**Universal:** targets the whole population, groups, or settings e.g., schools or workplaces. **Selective:** targets groups, demographics, or communities with higher prevalence of mental health problems **Indicated:** targets individuals with early detectable signs of mental health stress or distress

To date, the majority of mental health prevention research has been selective or indicated in nature (Orford, 2008; Mrazek & Haggerty, 1994). Efforts are largely focused on the prevention of 'single-issues' e.g., loneliness, suicide prevention and postnatal depression, rather than structural and multilevel social factors (Kessler & Albee, 1975; Orford, 2008). Programs are often targeted towards mothers, infants or school-aged children, as these are critical periods for determining later mental health (Durlak & Wells, 1997; Jané-Llopis, 2006; Public Health England, 2017). For example, parent-child interaction programmes for children who have been identified as having behavioural difficulties. Parenting skills programmes such as these often focus on the prevalence of mental health problems among specific subgroups (e.g., parents with lower incomes or women with a history of depression). However, a number of authors have suggested that interventions targeting higher-risk populations, based on factors such as social

class and unemployment, may not address what individuals need or want and may be experienced as stigmatising (Albee, 1986; Nelson & Prilleltensky, 2020; Orford, 2008).

Both Caplan's (1964) and Gordon's (1987) classifications were originally intended to classify prevention interventions for physical health but have since been routinely applied to the prevention of mental health difficulties. As discussed, a number of authors have argued that the application of these terms to mental health is not straightforward (Cowen, 2000; Mrazek & Haggerty, 1994). Furthermore, Caplan's (1964) and Gordon's (1987) frameworks are often used interchangeably, adding to the confusion regarding definitions within the literature (Bloom & Gullotta, 2003). Despite there being considerable debate regarding the use of these terms, no research has been undertaken to ascertain how prevention practitioners understand and manage these tensions in practice.

1.4.2. The Relationship between Mental Health Prevention and Promotion

The conceptual difficulties with the risk detection and prevention model have led to an interest in mental health promotion (Cowen, 1997; Wells et al., 2003). This is based on a 'salutogenic' perspective which theorises that improving psychological wellbeing protects against the likelihood of mental health difficulties (Barry et al., 2019). Whilst most prevention models focus on the avoidance of risk factors, mental health promotion seeks to enhance psychological factors, such as self-efficacy and resilience. Perspectives on the concept of mental health promotion and its relationship to mental health prevention vary. Durlak and Wells (1997) expanded the definition of primary prevention to include promotion strategies as a way to achieve prevention aims, arguing that mental health promotion has the secondary outcome of reducing mental health problems. Prevention and promotion methods are often present within the same programmes and can involve similar activities (Cowen, 1997; Blair, 1992). However, Davies (2014) argues that this has led to an inconsistent blurring of concepts that are informed by distinct principles and intended outcomes. Another area of concern is that concepts associated with mental health promotion such as 'wellbeing', 'resilience' and 'empowerment' are vague, difficult to define and therefore difficult to integrate into a public mental health approach (Detels et al.,

2009). A focus on wellbeing enhancement has also been critiqued for neglecting the early determinants of wellbeing, such as adverse life events, which can lead to variations in psychological resilience (Friedli, 2020). Therefore, whilst research into mental health promotion has sought to respond to some of the conceptual issues related to the area of prevention, there are several challenges identified within the literature regarding use of the term.

1.5. Preventative Action on The Social Determinants of Mental Health

Health inequalities research has demonstrated the relationship between the social determinants of physical and mental health and the need for preventative action to take place at a population-level. This section describes how health policy in the UK has responded to this and outlines some of the challenges with researching and implementing interventions in this area.

1.5.1. Policy Context within the United Kingdom

Action on the social determinants of health has been identified as having the greatest potential for preventing the development of mental health problems and improving population mental health (Walker et al., 2019; Compton & Shim, 2020). This has been described as a priority area for Public Health England (2017) and within the NHS Long Term Plan (2019). The major causes of both physical and mental health problems are known to arise from the conditions in which people are born, grow, live, work and age (World Health Organisation, 2010). These conditions are referred to as the 'social determinants of health', a term used to encompass the environmental, political and social influences on health, such as income, housing, employment and community conditions (Marmot, 2005). A broad definition of social determinants has been described as necessary, in order to account for the complexity of the social factors influencing health (Graham, 2004). However, distinctions are often made between 'upstream' (e.g., economic conditions) and 'downstream' (e.g., living conditions) determinants (Public Health England, 2017). 'Health inequalities' are the result of the unequal distribution of social determinants across groups (Marmot, 2005). Within the UK, health

inequalities have been observed across a number of areas including employment status, income, ethnicity and gender (Mackenbach, 2011; Wohland et al., 2015).

Whilst the evidence-base on social determinants has tended to focus on physical health outcomes, there are important implications for mental health. The term 'social determinants of mental health' refers to the various social factors that shape poor mental health, such as income inequality, unemployment, housing instability, lack of access to mental health care and adverse life events (WHO, 2014). A consistently observed, inverse relationship, between social determinants and higher rates of mental health problems has been shown across many countries (Murali & Oyebode, 2004; Fell & Hewstone, 2015; Lorant et al., 2003). Although the strength of the relationship varies, this appears to hold across numerous measures, including class, income, housing conditions, education, and employment (Wilkinson & Pickett, 2009; Burns, 2015; Rogers & Pilgrim, 2002). For example, income disparity, unemployment and poorer standard of living are all associated with an increased likelihood of a range of psychiatric diagnoses including depression, anxiety, post-traumatic stress disorder and schizophrenia (Burns, 2015). Across Europe, the global financial crisis of 2008 was associated with worsening mental health and an increase in suicides, especially among men, demonstrating how macro-level factors, and governmental responses, influence population health outcomes (Parmar et al., 2016). Within the UK, austerity measures and reduced government investment in public infrastructure has coincided with increased levels of debt, food poverty, homelessness, and insecure employment (Barr et al., 2015).

Given the well-established relationship between a range of social inequalities and poorer health outcomes, action on social determinants has assumed a prominent position in health policy in the UK and internationally (Marmot et al., 2012; World Health Organisation, 2008). In 2008, an independent review led by Sir Michael Marmot proposed a number of recommendations for reducing health inequalities in England (Marmot, 2010). The review laid out six policy objectives needed to reduce the social determinants of health. This included giving every child the best start in life, fair employment, healthy communities and strengthening the role and impact of ill-health prevention. In response, the government adopted a 'Fair

Society, Healthy Lives' public health strategy in England, which involved a life-course framework for tackling the wider social determinants of health. Marmot's policy objectives remain highly influential in shaping national policy and action on improving and reducing health inequalities (Marmot, 2020).

More recently, NHS England's *Five Year Forward View* (2014) explicitly linked physical and mental health inequalities and the need for developing a prevention approach: "If the nation fails to get serious about prevention, then health inequalities will widen, and our ability to fund beneficial new treatments will be crowded-out by the need to spend billions of pounds on avoidable illness" (p.7). An outcome of The Five-Year Forward View on Mental Health (NHS England, 2016) was the establishment of the *Prevention Concordat for Better Mental Health* (Public Health England, 2017). This document outlines national and local priorities for delivering a prevention agenda, emphasising that action to "promote good mental health and prevent mental health problems involves addressing the social determinants of health" (Public Health England, 2017, p.16). It outlined a national program of work for the prevention of mental health problems and aims to unify cross-sector commitment to increase the use of public mental health approaches across health services and local authorities. Building on this, all NHS health systems are expected to set out plans for reducing population-level mental health inequalities by 2024 (The NHS Long Term Plan, 2019).

Disciplines such as behavioural science, clinical and health psychology, have been critiqued for focusing efforts on individual factors involved in poor health and therefore neglecting the influence of social context on people's lives (Smail,1987, Pilgrim, 1991). However, advancement in the evidence-base on the causal role of social factors, as well as growing health divides, has led to an increased interest in a social determinants framework in these fields (e.g., MacKay & Quigley, 2018; Hepworth, 2004; Barr et al., 2015). Within clinical psychology, a number of authors have argued for greater emphasis on the impact of material conditions and the integration of a social inequalities perspective within psychological interventions (e.g., Smail, 2001; McClelland, 2013). The term 'social inequalities' is used to refer to inequalities in wealth or social status, and to include a broader meaning of inequities in power and privilege (McClelland, 2013;

Johnson and Boyle, 2018). Such authors argue that psychologists should make explicit links between immediate (e.g., work, housing, relationships), more distal circumstances (e.g., economics, politics, and culture) and the development of psychological distress (Smail, 2001). Johnson and Boyle (2018) argue that the logical implications of the policy and evidence-base on social determinants is that psychologists "need to work much more at a preventative, political and community action level" (p.63).

The recent announcement that Public Health England will be replaced by the National Institute for Health Protection has raised questions regarding where responsibility for action on social determinants will be held (Kings Fund, 2020). The establishment of a new agency, the Office for Health Promotion, located within the Department of Health and Social Care, has been described as a potential catalyst for cross-sector action (The Kings Fund, 2021). However, a number of policy commentators have argued that there is a need for cogent detail on investment, implementation strategies and workforce planning. The recent policy document *Advancing Our Health: Prevention in the 2020s* has been criticised for seeming to neglect previous commitment to address childhood poverty and widening health inequalities (British Psychological Society, 2019; The King's Fund, 2019). Furthermore, despite apparent government commitments, health inequalities have continued to widen on numerous measures since 2010 (Marmot, 2020). Challenges related to the implementation of action on social determinants are described in the following section.

1.5.2. Challenges with Researching and Implementing Interventions for Social Determinants

A number of policy analysts have identified how government commitments to addressing health inequalities have often reverted to modifying lifestyle factors, such as exercise and diet (Hunter et al., 2010; Katikireddi et al., 2013). This has been termed 'lifestyle drift' whereby an initial focus on social determinants gives way to a narrower focus on changing individual behaviour (Williams & Fullagar, 2019; Smith et al., 2016). More advantaged groups are better resourced to make healthier lifestyle choices, therefore interventions focusing on promoting

individual health behaviours, without changing their social and economic context, may inadvertently widen inequalities (Katikireddi et al., 2013). There are a number of challenges related to developing and implementing effective interventions on social determinants. The evidence-base on social determinants relies on large scale empirical data and the field of epidemiology has played an important role in highlighting population-level health inequalities (Smith et al., 2016). However, epidemiological studies, through demonstrating population-level associations, can only indicate possible areas for intervention (Burns, 2015). Interventions can include initiatives to decrease unemployment, improve working conditions, labour market policies, transport, housing and living. The range of approaches and interventions that this potentially includes can make it difficult to prioritise interventions or develop comprehensive evidence-based strategies for improving health equalities (Petticrew et al., 2004).

The current evidence-base for the effectiveness of interventions addressing the social determinants has been described as limited (Bambra et al., 2010; Ogilvie et al., 2005). Population-level interventions are less likely to have been studied and assessing the quality of large-scale interventions within systematic reviews is difficult (Bambra et al., 2010). Many public health interventions cannot be studied using randomised control trials due to the characteristics of the interventions, study populations, outcomes and other methodological issues (Smith et al., 2016). However, there is some evidence that certain categories of intervention may have a positive impact on health (Bambra et al., 2010; World Health Organisation, 2010). The most developed evidence-base is on the health effects of housing initiatives, such as rent-assistance programs and changes to physical infrastructure (Bambra et al., 2010). This included improvements in self-reported physical and mental health, as well as other factors, such as perceptions of safety and community participation. However, Bambra et al., (2010) concluded that it is difficult to know what works in terms of addressing social determinants, as few relevant studies within the UK have been conducted. The authors attributed this to practical, scientific, and political reasons (Bambra et al., 2010).

In addition, there may be a disparity between what is known about evidence-based prevention programmes and what is being implemented (Campion, 2019).

Mrazek and Haggerty (1994) argue that research findings that are relevant to the prevention of mental health problems often do not have an impact because they are not known to practitioners, stakeholders, or policy makers. Overall, surveyed researchers, policymakers and practitioners within the UK have reported that efforts to address health inequalities had been less successful than hoped for (Smith et al., 2016). Smith and Kandlik Eltanani (2015) suggest that more could be done to improve the relationship between health inequalities researchers, policy makers and practitioners. There is a lack of consensus regarding the type of work that needs to be undertaken in order to improve the relationship between social determinants and mental health. The wide range of factors affecting health inequalities suggests that a range of approaches may be needed to improve population health (Ogilvie et al., 2005). Related to this are the debates regarding the models that inform public health and prevention work. This is described in the following section.

1.6. Debates Regarding Public Health and Prevention Models

Approaches to mental health prevention have emerged from a range of disciplines, including behavioural science, public health, psychiatry, community and health psychology (Arango et al., 2018; Bloom, 1988; Hepworth, 2004). Blair (1992) argues that mental health prevention has tended to vary along a dimension between medical and social approaches, depending on the discipline of the practitioner or researcher. There are a broad set of approaches to prevention, informed by different explanatory models of mental health and divergent views on the best way to prevent the occurrence of mental health problems. The main public mental health and prevention models are discussed in this chapter, along with relevant debates.

1.6.1. Epidemiology and Public Health Models

A number of public health models describing the relationship between social determinants and a range of health outcomes have been developed (e.g. Galea et al., 2010; Whitehead et al., 2006; World Health Organisation, 2010). These models tend to focus on the development of physical health conditions and pay

less attention to the processes determining mental health. Whilst they differ in format and complexity, most models show health inequalities as the outcome of a number of interacting social influences, at play at different levels of society (Graham, 2004). Graham (2004) argues that the similarities between these models suggests that they can be combined into a composite model in order to describe core factors and processes. Health is described as the outcome of complex and interacting causal influences which originate in the social structure in which people live (Graham, 2004). At the most distal level are economic, cultural, and structural conditions, which shape factors at an intermediate level through social hierarchies, working and living conditions. These intermediate factors influence individuals by shaping access to material resources and determining health-related behaviours, such as smoking, alcohol use, healthy eating, and physical activity. At the most proximal level, epigenetic and biological processes are emphasised as factors mediating the effects of social determinants (Graham, 2004).

Explanatory models for the relationship between social determinants and mental health tend to expand on this by including psychosocial factors such as reduced autonomy and sense of control, effort–reward imbalance, discrimination, low sense of belonging, support and trust (Stansfield & Bell, 2019). This is thought to produce prolonged stress responses that have long-term consequences for physical and mental health (Siegrist & Marmot, 2004). Psychosocial explanations have been criticised for focusing on individual attributes and subjective perceptions of status, rather than examining material and structural causes of health inequalities (Aldabe et al., 2011; Coburn, 2004). Friedli (2016) describes this as a process of 'psychologising' poverty, something that risks shifting policy attention away from underlying issues of equity, power, and injustice.

Another critique of epidemiological models is that socioeconomic position is generally considered to be the primary driver of health inequalities (Orford, 2008). There is less consideration regarding the processes related to other areas such as ethnicity, gender, age and sexual orientation and how experiences of exclusion or disadvantage can intersect (Orford, 2008). The concept of intersectionality, which recognises that a person has multiple and simultaneously

held identities, has been used to argue for a more complex understanding of the various intersecting aspects of 'social position' (Evans, 2019). However, these inequalities in power and privilege, and their relationship to physical and mental health, have been examined less within public health. Johnstone and Boyle (2018) argues that the constant and dynamic interaction between political and social influences and individual distress is missing from epidemiological models. Furthermore, epidemiological research is medically led and much of the research into social determinants makes use of diagnostic categories, which Johnstone and Boyle (2018) argue risks obscuring the relationship between social conditions and mental health, even as it is being discussed.

1.6.2. The Risk Factor Model

The dominant prevention model involves the identification of risk factors associated with psychiatric disorders in order to develop interventions (Coie et al., 1993; Mrazek & Haggerty, 1994; Murray et al., 2020). Developing interventions is therefore seen to involve a number of sequential steps: 1) identify a psychiatric disorder, 2) review evidence regarding risk factors related to onset, 3) develop, implement and evaluate interventions, 4) extend effective interventions to larger-scale research and 5) disseminate community level applications of effective models. The full process of this has been termed the Preventive Intervention Research Cycle (Mrazek & Haggerty, 1994). Interventions usually involve behaviour change programmes, using a group format, with individuals deemed to be at risk for mental health disorders (Mrazek & Haggerty, 1994).

This largely reflects the traditional physical health model of identifying risk factors for poor health and developing interventions aimed at reducing exposure (e.g., anti-smoking campaigns for lung cancer). This approach relies on the assumption that, if interventions to prevent specific disorders can be identified, then the intervention will become a mainstream activity (Orford, 2008). However, the knowledge of risk factors for mental health is derived from regression analyses, which are best suited to singling out a primary determinant for diseases. This approach has limitations when applied to mental health prevention for a number

of reasons (Merlo, 2014). Most psychological problems are numerously determined, with multiple factors playing a role in causation. The causal relationship between risk factors and diagnosis is complex, intersecting, and often impossible to predict (Merlo, 2014). For example, sexual abuse and experiences of deprivation are both considered to be predictors of poor mental health, but together their effects may be synergistic (Cromby et al., 2013). Furthermore, not everyone exposed to the same circumstances will end up experiencing clinical levels of distress (Johnstone & Boyle, 2018). Therefore, the risk factor model for prevention has been critiqued for not accounting for complex contextual, relational, and social influences on mental health.

1.6.3. Social Change Model

Alternative approaches to the risk factor model of prevention have emerged from the fields of critical public health and community psychology (Campbell & Murray, 2004; Hepworth, 2004; Mykhalovskiy et al., 2019). Social change and justice as a foundation for prevention gained increased attention within community psychology during the 1960s and 1970s (Nelson & Prilleltensky, 2020). Community psychologists and critical public health practitioners aim to understand and facilitate "health-enabling contexts" (Hepworth, 2004, p.41). Advocates of this approach argue for social change to be at the core of public health, with prevention understood as "an instrument of social justice" (Hage & Kenny, 2009, p.1). Orford (2008) argues that selective approaches within prevention tend to be professionally driven, focusing on individual deficits, and largely ignoring social context. Instead, improvements in mental health require real changes to the distribution of power and resources and the use of strategies at community, social and structural levels (Hage & Kenny, 2009). Improvements to the social determinants of mental health are understood to result from access to economic resources, socially inclusive communities, and changes to the practices of organisations and institutions.

The ecological systems model (Bronfenbrenner, 1979) has provided a conceptualisation of the relationship between individual level, community, economic and structural factors. Bronfenbrenner (1979) outlined a number of

nested systems moving from the micro (i.e. a family or social network), meso (i.e. relationship between micro-systems, such as home and work) and macro levels (i.e. economic systems and policies). Behaviour is therefore influenced by numerous interacting systems operating at individual, community and structural levels. This model has been used to conceptualise how different settings, such work, schools, and communities can provide contexts for social and preventive interventions (Nelson & Prilleltensky, 2020; Orford, 2008). However, movement from micro to meso- to macro- level systems can lead to issues of health and behaviour becoming more complex and diffuse, meaning that there is a risk of slipping back into individualised explanations (Orford, 2008). A number of authors have also suggested that most community psychology approaches have remained primarily focused at the meso-level (Cromby et al., 2013).

The way that mental health is understood within public health and prevention models has implications for the types of interventions and strategies selected (Blair, 1992). Understandings of mental health as essentially an individual phenomenon legitimises investigation into biomarkers, risk factors and modifying behaviours, rather than addressing social influences such as socioeconomic disadvantage. There has been greater interest in how psychologists can contribute to the development of a public mental health and prevention approach, but it is not known what models and theories inform work in this area. This is discussed within the following section.

1.7. Developing a Psychological Approach to Public Mental Health and Prevention

A briefing paper from the British Psychological Society stated a commitment to the prevention of both physical and mental health problems and recommended that prevention be a key focus within the practice and training of applied psychologists (BPS, 2018). The field of applied psychology has been defined as the professional application of “psychological knowledge to the solution of problems associated with human behaviour” (Davey, 2011, p.2). It encompasses a number of disciplines, including clinical, health, education, occupational, forensic, and community psychology. These fields can be distinguished by

several features, including the employment setting, the nature of the problems of focus, and the competencies required. A number of authors from the area of applied psychology have argued for the involvement of psychologists in public health and prevention. These have primarily come from the fields of health (e.g., Chater & McManus, 2016), clinical (e.g., Harper, 2017) and community psychology (e.g., Rappaport, 1992; Trickett & Rowe, 2012). Health psychologists typically focus on the psychological and behavioural aspects of physical health and illness and have been involved in population-level approaches to areas such as physical activity, anti-smoking, and nutrition (e.g., Abraham & Michie, 2005). In comparison, community psychologists emphasise the influence of wider societal contexts on health and are interested in collaborative, strengths-based, community action (Orford, 2008). Within the UK, community psychology is a theoretical approach, rather than a formal qualification, and community psychologists typically commence their careers as clinical psychologists (Orford, 2008). The discipline of clinical psychology is the largest applied psychology profession at present (HCPC, 2019, BPS, 2015). Furthermore, due to their training in psychologically informed interventions for a range of mental health difficulties, clinical psychologists are arguably well placed to contribute to the field of public mental health. The following section, therefore, provides a brief overview of the profession of clinical psychology within the UK, with a particular focus on the models and theories that inform the profession. This does not aim to provide a comprehensive account but highlights the relevant implications for the development of public mental health.

1.7.1. Clinical Psychology Within the United Kingdom

Clinical psychology within the UK emerged following the Second World War (Pilgrim, 2010). The profession has undergone a number of developments since that time, from behaviourism to therapeutic pluralism and more recently a focus on consultation and leadership (Hall et al., 2015). The majority of clinical psychologists in the UK are employed by the NHS, where there is an emphasis on providing therapeutic treatment to individuals (British Psychological Society, 2012). Pilgrim (2010) argues that the profession has been greatly influenced by starting out in settings influenced by the discipline of psychiatry. Despite

subsequent attempts to differentiate itself from psychiatry, both disciplines have tended to explain the development of psychological distress using somatogenic (i.e. brain chemistry) or psychogenic (i.e. dysfunctional thinking) models (Cromby et al., 2013). A number of authors have argued that the profession of clinical psychology does not engage sufficiently with social context, which has led to individualism within the profession's theory and practice (Boyle, 2011; Johnstone & Boyle, 2018).

However, there have been a number of shifts towards re-conceptualising the nature of psychological distress and offering alternatives models within the profession. In the UK, community psychology grew out of clinical psychology in the 1960s, prompted by dissatisfaction with the dominance of individualistic approaches, which arguably do little to alter the social sources of people's distress (Orford, 2008). Community psychology emphasises the importance of community development and social action through developing alliances with marginalised groups. Many clinical psychologists within the UK work in traditional clinical settings but engage with the theory and practice of community psychology (Orford, 2008). Recently, the Power Threat Meaning Framework aimed to provide an alternative conceptual framework for mental health which is not based on diagnosis, as part of a 'paradigm shift' away from a 'disease' model (Johnstone & Boyle, 2018). Trauma-informed organisational change has also gained influence within the NHS, based on the recognition of the high rates of trauma and adversity in the lives of people accessing mental health services (Sweeney et al., 2016).

There has also been a diversification in how clinical psychologists work with service users, for example, through consultancy or building psychological skills within other professional groups (British Psychological Society, 2012). Hall et al., (2015) describe the profession of clinical psychology as defined by its eclecticism and diverse methodology. In their historical analysis, the authors highlight a recurring theme centred around the 'true identity' of the profession (Hall et al., 2015). This referred to the professions' relationship to science, versus therapeutic practice, and the question of whether clinical psychologists should intervene with individuals, families, organisations, or communities. Recently, there has been

increased interest in widening the remit of clinical psychologists to include public health and prevention approaches to mental health (Harper, 2017; Jenkins & Ronald, 2015).

1.7.2. Clinical Psychologists Involvement in Public Health and Prevention

Within the UK, clinical psychologists make up the majority of registered practitioner psychologists, and could therefore play an important role in the development of a psychologically informed approach to public mental health. Albee (1986) was one of the first clinical psychologists to suggest a social justice approach to prevention, arguing that no disease or problem was eliminated by treating one person at a time. More recently, Harper (2016) advocated for clinical psychologists establishing a 'psychosocially' informed approach to public mental health, that is population-based and preventative. The Division of Clinical Psychology, within the BPS, has recently established the Public Health and Prevention Sub-Committee to facilitate co-ordination of action in this area. There are examples of practice which suggest that clinical psychologists are becoming more involved in public health settings (e.g., Jenkins & Ronald, 2015). Jenkins and Ronald (2015) argued that clinical psychologists are in a unique position to draw on psychological theory and knowledge at a population-level, as part of consultation with public health professionals, policy work and service development (Jenkins & Ronald, 2015).

Further examples of practice have been provided by clinical psychologists within the United States, which appear to be informed by a range of theoretical models. Holden and Black (1999) argue that the discipline's scientist-practitioner foundation and skills in academic research mean that clinical psychologists are in a key position to contribute to the application of the Prevention Intervention Research Cycle Selection (described in section 1.6.2). Rogers (1983) explains how behavioural theory and biopsychosocial understandings of health can be used to target attitudes and beliefs about health behaviours, such as smoking, alcohol use, nutrition, and exercise. Alternatively, a number of authors locate prevention work within an ecological systems perspective, which recognises that health is determined by multiple factors beyond the individual (Murphy & Frank,

1979; Woods-Jaeger et al., 2020). These examples offer promising accounts of how clinical psychologists can work in this area. However, no empirical investigation into the involvement of clinical psychologists in public health and prevention has taken place. The most relevant study explored the involvement of clinical psychologists involved in macro-level policy level work, which included individuals working in the area of public health (Browne et al., 2020). Browne et al., (2020) found that clinical psychologists possess core knowledge and skills which are transferable to policy work. Despite this, not all the work described by the study's participants appeared to be preventative in its aims. Furthermore, the term prevention encompasses a broad range of interventions, in addition to policy-level work.

Harper (2016) has argued that, when preventative approaches are developed within clinical psychology, interventions tend to remain within the domain of secondary or tertiary prevention, often involving earlier intervention with individuals showing first signs of difficulties. It is unclear to what extent clinical psychologists are involved in primary prevention, work that is population-focused and aims to prevent the onset of problems. Clinical psychology is composed of numerous specialities and practitioners will take different positions in relation to theory and practice. Therefore, there is a need for further research on the particular experiences of psychologists involved in public mental health and prevention work and what models and theories inform their work.

1.8. Research Rationale

Mental health prevention, as opposed to treatment, is a recent government priority (NHS Long Term Plan, 2019; Department of Health, 2020). Interest in the involvement of applied psychologists in public mental health and prevention work is growing (Harper, 2017; Jenkins & Ronald, 2015; Cooke, 2014). However, the UK lacks a systematic and integrated approach to public mental health at present and the evidence base on the role of clinical psychologists, in particular, is limited. A review of the literature suggests that research on mental health prevention is characterised by a lack of clarity around the concept of prevention when applied to mental health (Radden, 2018). 'To prevent' means 'to stop something from happening', however different perspectives regarding what that

'something' is, and how best to achieve this, remain a source of contention (Bloom & Gullotta, 2003). The prevention literature is informed by a number of different disciplines, which has resulted in a variety of definitions and models for prevention. These are based on differing theories and assumptions about the nature of mental health, which has resulted in some conceptual confusion (Cowen, 1998).

There is also a lack of consensus as to how best to translate the evidence on the social determinants of mental health into preventative solutions (Bambra et al., 2010). There is a need to move from descriptive population-level studies towards research that aims to provide a better understanding of how to address the social influences on mental health. This study aims to explore what 'mental health prevention' means to practitioner psychologists, primarily clinical psychologists, in both theory and practice. It aims to address the gaps in the literature by enhancing understanding about the kinds of prevention activities these psychologists are involved in, and the theories and models that inform their work. Dissemination of this information would strengthen the knowledge base for mental health prevention, enhance coordination of public mental practices and inform guidance for psychologists working in this area.

1.8.1. Research Questions

- How do applied psychologists, primarily clinical psychologists, involved in prevention work understand the concept of 'mental health prevention'?
- What kinds of mental health prevention work are they involved in?
- What models and theories inform the work of applied psychologists, primarily clinical psychologists, involved in this area?
- How do they understand and respond to the social determinants of mental health?

2. METHODOLOGY

This chapter describes the methodology underlying the research. The ontological assumptions and epistemological position of the researcher are outlined, as well as the reasons for taking a critical realist position. The section will describe the choice of qualitative methodology, using interview data analysed by thematic analysis. The methods that were carried out, including ethical considerations, the recruitment process, use of individual interviews and thematic analysis procedures are described. Finally, research reflexivity and principles for evaluating the quality of the research are briefly discussed.

2.1. Epistemological and Ontological Position

Epistemology is the area of philosophy concerning the nature of knowledge and the methods that are available for learning and knowing about the world (Willig, 2013). Epistemology is concerned with the question of 'how we know what we know' and the extent to which knowledge of reality can be obtained and considered to be reliable and valid (Willig, 2013). In comparison, ontology is the study of the nature of reality – what there is to know and the extent to which 'reality' exists outside of our interpretations of it (Pilgrim, 2019). Different philosophical traditions have sought to answer these questions in different ways and qualitative researchers can adopt a range of epistemological approaches to knowledge generation, for example, realism, phenomenology and social constructionism (Harper & Thompson, 2011). This has implications for the methodology used to research and understand the phenomena being studied (Willig, 2008). Therefore, the epistemological and ontological stance of the researcher must be clarified and the selected research processes should be consistent with this position (Harper & Thompson, 2011). There are a number of dimensions which differentiate epistemological and ontological approaches, a key one is the extent to which data can be considered to mirror and reflect reality. This is often conceptualised along a continuum between realism and relativism (Willig, 2013). A realist position presupposes that the world is made up of structures and processes which can be understood, and that research data collected more or less reflects these realities, provided that the methods used are

skilled enough. Relativism is the position that there can be multiple interpretations of the same observation and competing forms of understanding across individuals, time and context. Therefore, data cannot be thought of as constituting a true reflection of what is going on in the world.

This research took a critical realist stance in its perspective on epistemology and ontology (Pilgrim, 2012). Critical realism has developed as an alternative to positivist and constructionist thinking, drawing on aspects of both, whilst providing a middle way between direct (i.e. naïve) realism and strong relativism (Pilgrim, 2019). The realist perspective on ontology is primary in critical realism (Pilgrim, 2012). Ontological realism is the premise that a reality does exist independently of what we know or think about it; not all realities are constructed by language and discourse (Willig, 2008). However, critical realism's epistemological relativism maintains that, whilst enduring entities do exist, they can only be accessed via observation and empirical processes that are subject to human error and biases (Guba & Lincoln, 1994). Any understanding of the phenomena being studied is mediated by the researcher's particular personal, social and historical context, meaning we can never be in direct contact with it. This means that ontological realism is balanced by epistemic relativism (Pilgrim, 2019).

A critical realist approach would hold that, whilst straightforward access to reality is not possible, the practice of psychologists can be assumed to be 'real' and independent of the research (Pilgrim, 2019). The researcher can therefore take participants' descriptions at face value and accept that their accounts constitute true depictions of how they understand and practice mental health prevention, whilst also acknowledging that this does not constitute a reflection of a 'true' underlying concept (Pilgrim, 2019). Critical realism also permits the researcher to go beyond participants' descriptions, by considering the ways that participant's understanding of mental health prevention is shaped by personal context, beliefs about mental health, preferred models and theoretical interests (Harper & Thompson, 2011). Critical realism is also a framework that can accommodate and 'bridge the gap' between quantitative and qualitative methodology (Harper & Thompson, 2011). The majority of the existing research on social determinants and mental health prevention has been quantitative and takes a realist

perspective. While methodologically this research uses a qualitative approach, critical realist use of thematic analysis offers a way of providing new findings, which can be situated alongside previous empirical research (Willig, 2008).

2.2. Qualitative Methodology

The use of qualitative methodology enables the researcher to obtain rich data regarding participants' understanding and experiences (Willig, 2013). Mental health prevention is a contested area and there is a lack of consensus regarding how best to translate evidence regarding the social determinants of mental health into practical interventions (Bambra, 2010). Qualitative methodology enables participants to respond to questions by drawing on their own understanding and experiences, facilitating exploration and the emergence of new or unanticipated ideas and meaning (Willig, 2013). As the research is interested in how mental health prevention is conceptualised and put into practice by participants, I concluded that qualitative methodology was the most appropriate research methodology for this study.

2.2.1. Choice of Analysis

There are many different qualitative methodologies, each emerging from a distinct ontological and epistemological tradition (Willig, 2013). Thematic analysis was selected as the most appropriate qualitative method for the study. Thematic analysis is a qualitative method that can be used to systematically identify and analyse patterns of meaning in order to develop themes that summarise major features of the data (Braun & Clarke, 2006). In the process of selecting a method of analysis, a number of alternatives were considered, including grounded theory, interpretative phenomenological analysis and discourse analysis. Grounded theory is a method that enables the development of new theories that are grounded in the research data (Green & Thorogood, 2010). The research questions aimed to explore how participants make use of existing theories, concepts and models related to prevention, rather than the emergence of a new theory or model. Therefore, it was decided that grounded theory was not an appropriate method for this study. Interpretive phenomenological analysis

focuses on developing rich accounts of the subjective experience of each participant (Smith & Osborn, 2007). This study aimed to gain an understanding of how participants make sense of, and engage with, the concept of prevention, however the research questions required exploration of more than the participants' unique lived experience. Thematic analysis allows for the identification of themes and patterns across participant's accounts and was therefore deemed to be a more appropriate choice of analysis (Braun & Clarke, 2006).

Discourse analysis examines the ways in which power structures and discourses construct and reproduce versions of reality, society, and personhood, through the use of language and dominant practices (Willig, 2013). This form of analysis could potentially elucidate how discourses and theories about the nature of mental health produce and legitimise certain public health interventions and preventative solutions, whilst also marginalising alternative knowledge and actions. However, it has been argued that the ways in which social and material realities impact upon and constrain discourse requires further elaboration (Pilgrim, 2019). This risks idealising language and neglecting the ways in which material factors influence action on mental health and prevention. As the research questions were not aimed at examining the discursive construction of prevention through language, it was decided that discourse analysis was not an appropriate method.

Thematic analysis is considered to be most appropriate when the intention is to elucidate the nature of participants' understandings and conceptualisations of an area (Willig, 2013). It is an exploratory method of data analysis which can be used to capture the extent and content of participants' knowledge about an area and to make sense of shared meanings and experiences (Willig, 2013). There are certain types of research questions which thematic analysis is particularly suited to addressing. These include questions on how people think about certain areas or concepts and how people make sense of the practices they engage in (Willig, 2013). It was therefore concluded that thematic analysis was the most appropriate method for this research.

In contrast to other qualitative methods, thematic analysis is not tied to a particular epistemological orientation e.g., social constructionist or realist (Braun & Clarke, 2020). This flexibility allows thematic analysis to accommodate a range of epistemological positions, including both relativist and realist positions. It is essential, however, that the researcher is explicit about their assumptions and epistemological position (Willig, 2013). This study was carried out using thematic analysis in accordance with a critical realist position, described previously. Thematic analysis, based in critical realism, is understood to be a method of analysis that aims to reflect reality, whilst also seeking to "unpick" or "look beyond the surface" of reality (Braun & Clarke, 2006, p.9). Through its assumption that a version of reality is evident in participants' responses, the use of a critical realist perspective for thematic analysis permits focus on the content of participant's thoughts and feelings regarding prevention. Consideration is paid to the meaning participants attach to the concept of prevention, and the consequences of this for practitioners, rather than the 'reality' or accuracy of representation of these issues (Willig, 2013). As such, the ways in which participants make sense of their engagement with prevention, as well as the ways that social context influence such meanings, can be explored.

2.4. Ethical Considerations

This section details the processes of obtaining ethical approval, informed consent and data security.

2.4.1. Ethical Approval

Ethical approval for the commencement of this study was given by the University of East London's School of Psychology Research and Ethics Committee, following submission of an application outlining the proposed research (Appendix A). Participants were not recruited via any NHS trusts or services; therefore, it was not necessary to seek ethical approval from the Health Research Authority. Confirmation of ethical approval from the School of Psychology Research and Ethics Committee is shown in Appendix B. Ethical approval was sought in May 2020 when it was apparent that the UK government's response to the Covid-19

pandemic would prohibit use of face-to-face interviews. Therefore, ethical approval was gained for the use of the online communication platform Microsoft Teams, for the purpose of interviews.

2.4.2. Informed Consent and Debrief

Informed consent was obtained from all participants who took part in the research. Participants were provided with an information sheet about the study (shown in Appendix C) via email prior to the interview taking place. The information sheet outlined the research aims, what participation would involve, data security and how anonymity would be ensured in the research process as well as any dissemination of the findings. Participants were invited to raise any concerns or questions they had about the research process via email, prior to the interview, and then again at the start of each interview. Participants were also reminded that they were free to take a break or withdraw from the interview at any time.

Confirmation of consent to participate in the research was obtained using a signed consent form (Appendix D), which participants were asked to sign and return by email before the interview. This confirmed that participants had been given sufficient information about the study, understood what participation would entail, and how the research data would be used. Following the interview, participants were provided with a debrief sheet (shown in Appendix E), with further information about the research, a reminder about what would happen to their data, and their right to withdraw their data from the study up to three weeks after the interview, after which data analysis would begin. Whilst there were no anticipated risks or adverse effects from taking part in the research, participants were signposted to support services and advised to contact their supervisor or occupational health department, in the event that they experienced any concerns about their wellbeing.

2.4.3. Data Security

A digital audio recorder and the record function on Microsoft Teams was used to record the interviews. Following the interviews, the data files were transferred from the audio recorder and from Microsoft Stream to a secure password-protected computer hardware. Following this, the data files were deleted from the audio recorder and from Microsoft Stream. The audio-recordings were transcribed and stored on the password-protected computer separately from the sound files. All identifying information was removed or anonymised. The data was backed up using separate secure servers, provided by the university. The recordings will be deleted following examination and the transcripts deleted three years after completion of the study, to allow for the process of research publication. Participants were made aware of this in the information sheet (Appendix C) and were informed that the research supervisor and examiners could have access to the anonymised transcripts.

2.5. Data Collection

This section describes the recruitment process, participant characteristics, interview procedure and analysis.

2.5.1. Interview Schedule

A semi-structured interview schedule was developed for the purpose of the interviews and can be found in Appendix F. The interview schedule was developed based on the research questions and the literature on public mental health and prevention. The schedule began broadly by asking participants about their understanding of the term ‘mental health prevention’ before moving on to ask about the work that they were involved in, what skills, theories and models they drew on, as well as any challenges or barriers to their work. Prompts were used to enquire about participants’ understanding and engagement with the research on the social determinants of mental health and how, if at all, this featured in their work.

2.5.2. Recruitment

The research was primarily, but not exclusively, interested in recruiting clinical psychologists working in the area of public mental health and prevention. Within the UK, clinical psychologists make up the majority of applied psychologists, yet there is a lack of research on the involvement of clinical psychologists in this area. However, at the start of the recruitment process, it was unclear how many clinical psychologists were involved in this area of work. Furthermore, the commencement of the recruitment process took place during the early stages of the coronavirus pandemic; it was not clear to what extent these circumstances would prevent participants from taking part in the study. It was known to the researcher that there were a number of applied psychologists, such as health and community psychologists, writing about their involvement in public health and prevention work. Therefore, whilst the research primarily aimed to recruit clinical psychologists, at the beginning of the recruitment process it was decided that other applied psychologists would be sought if it was not possible to recruit a sufficient number of clinical psychologists. Due to this, two stages of recruitment occurred and are described here.

2.5.2.1. Stage One

The first stage aimed at recruiting clinical psychologists only. Recruitment was carried out through the use of an online survey conducted by The Division of Clinical Psychology (DCP) Public Health and Prevention sub-committee. The survey was developed by the DCP in order to obtain brief information on clinical psychologists' engagement in prevention and public health work. The survey included questions regarding the kind of public health and prevention activities respondents were undertaking, the settings this took place in (e.g., NHS, local authority, third sector) and groups they worked with (e.g., adult, child, learning disabilities). The research supervisor is a member of the sub-committee, therefore, it was agreed with the committee that a question would be included in the survey which allowed respondents to indicate if they were willing to be interviewed by the researcher. Brief information was provided at this stage informing survey respondents that the research was being undertaken by a

trainee clinical psychologist, on the area of public health and prevention, as part of partial completion of doctoral training. The survey was advertised on the DCP's social media pages and the BPS website between July and September 2020. A summary of the survey's findings can be found on the British Psychological Society website (BPS, 2020).

At the end of September 2020, the results of the survey were sent to the researcher by a member of the sub-committee and were reviewed by the researcher. A total of twenty-one individuals completed the survey and all respondents apart from one indicated that they were willing to be contacted by email. The following criteria was used to identify individuals to contact:

- The respondent was a qualified clinical psychologist.
- The activities described focused on mental health, rather than physical health.
- The work described appeared to be at a stage that meant in-depth information could be elicited.
- The work described involved primary or secondary prevention (outlined in Section 1.4.1).

Six respondents were contacted via email and invited to take part in the research. Participants were sent further information regarding the study (Appendix C) and informed that the aim of the interview was to deepen understanding of their experience and understanding of mental health prevention, beyond what was elicited in the survey. Of the six respondents, five individuals were subsequently interviewed. One individual was not able to be interviewed within the timescales of the research submission.

2.5.2.2. Stage Two

During stage two, several avenues were pursued concurrently. Further clinical psychologists were sought for interviewing by other means. Information about the research (shown in Appendix G) was shared online in clinical psychology forums, such as the 'UK based Clinical Psychologists Network' and 'Psychologists for Social Change' on Facebook. Two participants were recruited this way. One participant was recruited through contacts known to the research supervisor.

Once interviewing commenced, a snowballing procedure was used in which initial participants were asked to identify other clinical psychologists who met the study's inclusion criteria. Two further participants were recruited this way.

Concurrent to this, the inclusion criteria was broadened to include applied psychologists, on the basis of having previously written about this area. Two health psychologists working in senior management positions in a public health department were contacted, however due to the increased pressures associated with the coronavirus pandemic, they were not able to be interviewed. One academic community psychologist who had written about their involvement in prevention work was contacted and agreed to be interviewed. At this point, a sufficient number of interviews with clinical psychologists had taken place and therefore no further community or health psychologists were recruited.

The decision to not recruit further community psychologists was informed by several factors. As the interviews progressed it became apparent that four of the participants were qualified clinical psychologists who also identified as community psychologists. In the UK, community psychology is an approach, rather than a formal qualification, therefore this was determined by participants' self-described association with the field, and engagement with the theory and practice of community psychology. This meant that community psychologists were sufficiently represented within the sample for meaningful themes, related to this, to be identified during analysis (Braun & Clarke, 2013). When using thematic analysis, sample size is dependent on the quality of the data obtained and the saturation of themes (Braun & Clarke, 2013). A range of six to twelve participants is generally considered to be optimal in qualitive research (Willig, 2013). The researcher discussed the issue of data saturation with the research supervisor, and it was agreed that the data that had been collected was sufficient for theme development and for the purposes of the study, meaning that no further participants needed to be sought.

2.5.3 Description of Sample

Participants filled in a demographics form prior to the interview (shown in

Appendix H). In total, eleven interviews were carried out. Ten participants were qualified clinical psychologists. One individual was an academic community psychologist who also worked in local government as a town councillor. Four of the participants who were qualified clinical psychologists also described themselves as community psychologists. Participants worked in a range of settings including public health departments, child and adolescent mental health services, local authorities, the third sector and academia. Participants worked in locations in Wales and the South and North of England. Information about participants' gender and the kind of prevention activities they were involved in can be found in Table 2, along with their assigned pseudonym.

Table 2 - *Participants' characteristics*

Pseudonym	Gender	Clinical or Community	Setting(s)	Prevention Target Group
Amy	Female	Clinical	Primary Care	Adults
Liz	Female	Both	NHS	Young people
Caitlin	Female	Both	Third Sector	Young people
John	Male	Clinical	Government, Public Health England	Whole population
Alex	Male	Community	Academia, Local Government	Whole Population
Paul	Male	Both	Health and Wellbeing Board	Local Population
Adam	Male	Clinical	Health and Wellbeing Board	Local Population
Sandra	Female	Clinical	Public Health Department	Local Population
Anna	Female	Clinical	Public Health Department	Local Population
Eve	Female	Clinical	NHS, Local Authority	Looked after Children
Julia	Female	Both	Third Sector, Local Authority	Young people, Local Population

2.5.4. Interview Procedure

All individual interviews were conducted over Microsoft Teams due to the restrictions placed on face-to-face contact during the coronavirus pandemic. Interviews were conducted at a time that was suitable to participants. Participants were sent the information sheet (Appendix C) via email prior to the interview. Confirmation of consent to participate in the research was obtained via a signed consent form (Appendix D), that was returned to the researcher via email prior to the interview. At the start of the interview participants were asked whether they had any additional questions, which were responded to. The interview was semi-structured and guided by the use of the interview schedule, described in Section 2.5.1. Interviews varied in length, lasting between 50 and 70 minutes in total. Directly after the interview, participants were sent the debrief sheet (Appendix E) via email.

2.6. Data analysis

This section described the process of data transcription and thematic analysis, using Braun & Clarke's (2012) recommendations.

2.6.1. Transcription

The 'teams captions' function on Microsoft Teams, which produces text captions for audio data, was used to provide an initial transcript. This was checked for accuracy by listening to the audio and manually editing the transcript. The data was transcribed verbatim, using an orthographic style, meaning that the original spoken words of participants were captured, as well as occurrences such as utterances, repetitions and pauses. This is recommended for thematic analysis in preparation for inductive analysis (Braun & Clarke, 2012). All identifiable information was removed from the transcripts and participants were allocated a pseudonym, for the purposes of anonymity.

2.6.2. Thematic Analysis Procedure

Braun and Clarke (2006) suggest that thematic analysis moves through six phases: a process of data familiarisation, generating initial codes, searching for themes, defining and labelling themes, and report writing. Whilst described here as a linear process, in practice this involved going backwards and forwards between the different stages in order to strengthen theme development. The six-phases included:

2.6.2.1. Phase 1: Familiarisation with the Data

Familiarisation with the data occurred in the process of transcription and repeated readings of the transcripts. This involved making notes regarding thoughts and initial observations after each interview, during the transcription process, and after multiple re-readings of the transcripts.

2.6.2.2. Phase 2: Generating Initial Codes

Codes are “the most basic segment, or element, of raw data or information that can be assessed in a meaningful way” (Boyatzis, 1998, p. 63). Codes were generated by reading the transcripts multiple times, writing notes, annotating features of the data and identifying potentially relevant segments of data as codes (Braun & Clarke, 2006). An example of a coded transcript page is shown in Appendix H. Both descriptive and interpretive codes were identified from the data, through consideration of the data in relation to the research questions and wider literature (Braun & Clarke, 2006). Multiple codes were assigned to the same excerpt, where appropriate. An example of three codes with associated extracts is shown in Appendix I. As the process progressed, codes were reviewed, modified or collapsed depending on the similarities or differences between them. A list of the final codes is shown in Appendix J.

2.6.2.3. Phase 3: Searching for Themes

Codes were used to generate initial themes and subthemes that represented "patterned responses or meaning" in order to capture important aspects of the dataset, in relation to the research questions (Braun and Clarke, 2006, p. 82). Themes were built by collating and comparing codes and grouping any which appeared to share a unifying feature. Emerging themes were considered in relation to the relevant research literature and the research questions. A thematic map was developed to provide a visual representation of initial themes and subthemes and their relationship to one another (Appendix K).

2.6.2.4. Phase 4: Reviewing Potential Themes

The researcher and research supervisor reviewed these initial themes and sub-themes together. On reflection, the themes were considered to be too numerous, not specific enough, and therefore did not provide a coherent narrative to the data set. This resulted in further refining and renaming of themes so that a coherent narrative was developed. This process resulted in five main themes which are shown in the final thematic map in Appendix L.

2.6.2.5. Phase 5: Defining and Naming Themes

This phase involved ensuring names of themes were informative and concise. It also involved developing a refined and a more detailed analysis of each theme and the connections between them. This involved consideration of the unique 'essence' of each theme and interpretation of how it related to the research literature and questions (Braun & Clarke, 2012).

2.6.2.6. Phase 6. Producing the Report

This phase occurred as the final result of the iterative and immersive process of interpreting and making sense of the data. It involved the process of developing a detailed and coherent narrative to the data set and interpretation of the emergent themes, in relation to existing research literature and the research questions. This

process and the findings from the data are reported in the results and discussion sections.

2.7. Reflexivity

Due to the central role of the researcher in the way that data is collated and interpreted, reflexively driven qualitative research is essential (Stratton, 1997). This is thought be especially important when taking a critical realist position, which holds that there can be multiple perspectives on any given phenomenon (Bhaskar, 1978, Willig, 2013). How the researcher and their interest in the area might influence the research process should therefore be considered. As part of this reflexive process, the researcher used a reflective journal to make notes of their relevant thoughts and observations as the research progressed. Extracts from the research journal are shown in Appendix M. A reflexive review of the research is presented in the critical review section.

2.9. Evaluation

There is no consensus on a set of standards for evaluating qualitative research, but a number of recommendations for assessing quality have been put forward. In evaluating this research Spencer and Ritchie's (2012) principles for quality in qualitative research were used. The principles the authors set out are rigour, credibility, and contribution. Rigour refers to the extent to which the research processes of data collection, analysis, and interpretation have been conducted in a thorough and systematic way. Credibility relates to the extent to which conclusions about the findings are convincingly supported by evidence grounded in the data. Contribution relates to whether the study advances knowledge or understanding of the topic of focus. These principles were held in mind throughout the completion of the study. A critical evaluation of the research based on these principles can be found in the discussion section. Braun and Clarke's (2020) guidelines for quality in thematic analysis were also held in mind throughout the analytic process and are discussed in Section 4.2.4.

3. Results

This section presents the themes identified following thematic analysis of the coded transcripts. Five main themes were identified, with corresponding sub-themes. An outline of the themes and sub-themes can be found in Table 3. Each theme is expanded on below and supported using selected exemplar extracts from the interviews. Minor changes were made to extracts, such as removing repeated words and hesitations, for readability. The use of three dots (…) indicates that words have been removed.

Table 3 - *Themes and sub-themes*

Theme	Sub-theme
Understandings of Mental Health Prevention - 'It's Different Things to Different People'	Prevention Compared to Early Intervention Prevention Compared to Promotion Social, Rather Than Individual, Level Change Debates about the Classifications of Prevention
Understandings of the Influence of Social Determinants - 'Looking Both Upstream and Downstream'	Informed by Epidemiological Models Informed by Psychological Theory Informed by Practical Experience
Psychological Skills for Prevention - 'Formulating, Not Just With One Person in the Room'	Assessing Social Context Formulating Psychosocial Problems Translating Prevention Research and Policy to Practice
Prevention Activities and Interventions - 'Fitting in Where You Can Bring About Change'	Collaborating with Community Groups Influencing Decision Makers Sharing Psychological Skills Working Across Sectors Changing Narratives About Mental Health
Barriers to Preventative Work - 'It's Difficult, from a Service Perspective, to Justify'	Barriers to Prevention Within Psychology Barriers to Prevention Within Services Limitations Related to Prevention Research

3.1. 'It's Different Things to Different People' - Understandings of Mental Health Prevention

This theme explored the different ways that participants understood the concept 'mental health prevention'. Participants did not appear to share a uniform or core definition of prevention and participants gave divergent views on the concept in a number of areas. For some, early detection and support appeared to be conceptualised along a continuum of prevention activities, whereas others argued that a clear distinction needed to be made between early intervention and prevention. Some participants suggested that the concepts and activities of mental health promotion and prevention naturally accompany each other whilst others warned of the potential misuse of terms associated with wellbeing promotion. There were also different perspectives on the merits of the conceptual framework of primary, secondary and tertiary prevention. Several participants described how, despite the theoretical distinctions between the classifications, they often moved between categories at different stages of prevention work. A major consideration was the question of what work was encompassed under the term 'primary prevention', as it relates to mental health. The majority of participants, however, made an explicit commitment to prevention work which was directed towards the social determinants of mental health and stressed the importance of the underlying causal model of mental health for determining the kinds of interventions that were developed.

3.1.1. Prevention Compared to Early Intervention

There were different views on whether or not prevention included early detection and support for individuals with initial signs of mental health difficulties. When early intervention was discussed, it was often in relation to individuals accessing mental health services earlier or preventing the need for services:

> *Interviewer: What do you understand by the term 'Mental Health Prevention'?*
>
> *Eve: To me, it [prevention] would be about thinking about limiting the exacerbation of distress so that it wouldn't meet criteria for engagement in*

services or would be limited compared to what it would be without intervention.

Caitlin: A lot of it [prevention] has been using the project's resource and partnership to be able to scaffold young people earlier on into services at a more appropriate point, so before things escalate into more acute.

These participants, and two others, described prevention as including earlier intervention in the trajectory of a person's difficulties, but emphasised that the greatest proportion of efforts should go towards preventing the causes of mental health problems. For example:

Sandra: You can take it [prevention] at an early intervention kind of level before people get more unwell or need services. You can take it a step further and really have a look at what we know are the big influences on people's mental health and wellbeing…That's the preventive end I'm particularly keen to think about.

These participants appeared to understand prevention along a continuum involving a progression of activities from early intervention, at an individual level, through to interventions focusing on the causes of mental health problems. In comparison, three participants argued that working with individuals sooner should more appropriately be labelled early intervention and that prevention should be accorded its own distinct status:

Alex: A lot of prevention that I've come across, a lot of when people talk about prevention, they're actually talking about, early intervention, you know, rather than prevention. The stuff that I try to engage in, it really is prevention. We're not talking about intervening with people who are struggling...but can we do things that might help to intervene, not in or with those people, but before that?

The view that, within the field of prevention, there should be less emphasis on working with individuals earlier in the trajectory of their problems was echoed by Julia:

For me, prevention isn't just about doing things earlier in a person's life. When people talk about prevention in the mental health world it often gets talked about in terms of just working with children or working with mothers.

> *I recognise that's important, but I don't think it changes the conditions in which people are experiencing distress. For me, it is the population-level work, looking at the social and economic determinants, some of the stronger predictors of distress - poverty and oppression or some form of trauma.*

Here, the timing and target of interventions is conceptualised differently to early intervention; prevention should not, primarily, involve working directly with individuals, but is understood to be work that seeks to change the origins and conditions that determine mental health. For Alex, this approach to prevention is closest to the true meaning of the concept - 'it *really* is prevention'. Implicit within both Julia and Alex's accounts is a perceived definitional slippage that occurs when early intervention gets spoken about as prevention, one which shifts focus away from addressing the determinants of mental health. Both Alex and Julia appeared to see themselves as taking a contrasting or alternative view to how prevention is typically understood and talked about by practitioners. This points to the wider discourse on prevention and the presence of different interpretations of the concept. A separate, but related, dilemma was the difficulty of establishing boundaries between prevention, early intervention, and treatment in practice. Amy highlighted the challenge of communicating prevention work to her colleagues in an NHS primary care service:

> *We've tried to use language that we feel people will understand, so information we've sent round to practice staff are that we think people who would most likely benefit are those presenting with some difficulties, but who are 'pre-caseness' or 'pre-diagnosis', so they're beginning to struggle but don't quite meet the IAPT referral criteria.*

Implicit within this is a blurred area between the absence and presence of difficulties and a perceived need to distinguish when treatment ends, and prevention begins. The consideration paid to this by Amy when advertising the work indicates that it may be harder to delineate between treatment, early intervention, and prevention in some contexts. Overall, there was variation in the extent that participants considered early intervention to be an aspect of prevention, or whether early intervention was thought to result in individual-level

interventions that would not change the conditions and contexts that determine poor mental health.

3.1.2 Prevention Compared to Promotion

Participants also held different views on the area of mental health promotion and its relationship to prevention. Two participants felt that there was considerable overlap between the activities and goals of mental health promotion and prevention.

> *Interviewer: Would you say that there's a difference between mental health promotion and prevention?*
>
> *Amy: The literature will tell you that they are something different, but then also recognises that they're commonly intertwined and that they're part and parcel of each other. I think I see them as talking to the same thing but said in different ways.*

Amy refers to the academic debates regarding the concepts and concludes that, in practice, they are so closely related that prevention cannot be considered separately from promotion. This view was echoed by Anna - '*you can't have one without the other*'. Three participants were more critical of terms popularly associated with mental health promotion and had concerns about the potential misuse of concepts such as 'resilience'. The potential for discussions on psychological resilience to place responsibility on individuals and communities to protect themselves from stressful and adverse conditions was highlighted by Paul, in relation to his involvement in a Community Action group:

> *It's really important that we don't just say that means communities can manage everything for themselves...making sure that the message we're giving out as psychologists around resilience, for instance, is not misinterpreted as 'just leave it up to people, they'll sort it out' because that's simply not the case, if you do that, you simply reinforce inequalities.*

The notion of where responsibility for change lies was also echoed by Julia, who highlighted the potential risks of conflating the concepts of prevention and promotion:

In the mental health promotion world…my impression is that people think that if you teach people skills for looking after their mental health, that is a way of preventing mental ill health. I'm not denying that those things are helpful, but they obviously don't get at the structural root causes of what distress is linked to.

The potential for mental health promotion to result in a focus on increasing psychological skills, in place of changing social and structural conditions, is emphasised. Interestingly, Anna did not view these two agendas as separate and felt that mental health promotion included efforts to change social conditions:

A wellbeing approach is about promoting people to stay well…and promoting environments that are conducive to maintaining a level of wellbeing.

This indicates that when terms such as mental health promotion were being used participants had different interpretations of the kind of work this involves. As illustrated, there were variations in participants' perspectives on what mental health promotion entails and the merits or risks associated with this approach, when compared to prevention.

3.1.3. Social, Rather Than Individual Level, Change

Nearly all participants emphasised the influence of social factors on mental health and the need for prevention efforts to change social conditions, rather than individuals. Three participants highlighted how differing causal models of mental health influence concepts of what prevention involves.

Interviewer: What do you understand by the term 'Mental Health Prevention'?

John: I think it [prevention] is different things to different people. For some it means fitting it into a relatively conventional medicalised model of there being disorders and one can prevent those disorders occurring. Persuading people to move towards a psychosocial model of mental health I think would be generally good…then you start into a different idea of what prevention means, because what you're doing is intervening in the social space.

John noted how interpretations of mental health prevention vary and connected this to the different professional disciplines and concomitant models of distress involved in prevention work. A consequence of this is that there are different beliefs about the nature of problems and, therefore, how to prevent them. Liz also highlighted how models of mental health determine acceptable modes of enquiry and action for prevention:

> *Mental health is about our circumstances, so in order to provide good prevention, we need to look at that. You could spend a lot of money on improving access to therapies and things like that, but it's only going to go so far, because if we take that medical or internal model view, then the solutions that we could have are cut off to us because of the way we think about that.*

As illustrated, the majority of participants emphasised the major influence of social determinants on mental health. A social ecological approach to prevention was presented as necessary for challenging an individualised and deficit model of mental health:

> *Caitlin: These problems that young people are facing are not problems with the young people themselves, but as a result of a range of health, race and social inequalities. And given that is our understanding of difficulties, it means that we intervene on multiple levels within the system. So not only is there direct work with young people and at a community level, we're also working at a wider system level, that's both at local level, as well as a national level.*

Understanding mental health this way meant working across individual, local, and national levels to enact change. Given the need for change at a community and national level, three participants emphasised the political implications of this understanding of prevention.

> *Alex: Some of it [prevention] is at the very political end of the spectrum really, it's about activism to try and address mental health problems.*

However, Adam noted the wider debates regarding whether psychologists should be overtly political in their capacity as professionals:

There's a separate discussion about which political party do you think will be most effective at reducing this [inequality] and I think that then lies outside the remit of a clinical psychologist, but in my remit as a private individual.

This indicates that psychologists may agree with the need for a social change agenda for prevention but connect this with personal beliefs and values, rather than a legitimate remit of psychologists. Overall, all participants spoke about the influence of social determinants on mental health and the need for prevention work to at least consider and, ideally, respond to this. However, participants varied in the extent they felt able to do this kind of prevention work. This aspect is discussed further in Section 3.5.1.

3.1.4 Debates about the Classifications of Primary, Secondary and Tertiary Prevention

All participants were aware of the classifications of primary, secondary and tertiary prevention, however there were different perspectives on the merits of the classifications and the kind of work the terms encompassed. Three participants described how the framework helped them to establish a direction or to reflect upon prevention work, but that day-to-day the distinctions between the categories were less clear.

Interviewer: In your work, do you use the framework of primary, secondary and tertiary prevention?

Alex: It tends to be something I find useful when I'm communicating to an academic or practitioner audience where I try to make sense of a project in relation to theory…When you do this kind of work it gets messy very quickly, the kind of neat primary, secondary, that just gets blown out the water because what you find is that the project is often in flux, it may look at some point like primary and then it changes because of the way in which the partnership works.

This indicates the indirect relationship between the application of prevention theory to practice. When prevention involves collaboration with other organisations and stakeholders, it is likely to be open to the influence of others and different ways of seeing problems and solutions. For Alex, this meant that prevention work requires responsiveness and adaptability. The potential to move

away from primary prevention was held to be more of a problem by participants located in NHS services, where there was considerable demand for individual treatment:

> *Amy: I already know we're going to get pulled into, you know, secondary and tertiary level. Some of the questions we've already had are "can you pick up people who are on the IAPT waiting list to give them something while they're waiting?" So, I guess I feel a bit apprehensive that we'll get pulled into tertiary level prevention.*

This indicates how practitioners may aspire to primary prevention work but that there may be other immediate needs and agendas. Interestingly, different examples of primary prevention work were given by participants. For instance, it included universal provision of mental health promotion - *'primary prevention can be universal, everybody has mental health that they need to look after*' (Amy) and work to prevent problems such as childhood trauma and poverty – *'what can be done to stop dreadful things happening to children?*' (Eve). This indicates that understandings of primary prevention may be influenced by particular values and beliefs about where efforts should be directed; ensuring everyone knows how to maintain their wellbeing or preventing childhood trauma. The potential for primary prevention to be conceptualised differently was noted by one participant:

> *John: One of the questions which bedevils me in this area is it depends if you're asking for primary and secondary prevention of what?...Many of my colleagues coming from a slightly more traditional background might see themselves as preventing people who are falling into debt becoming depressed. I would think that we might put a little bit more attention into preventing people falling into debt in the first place.*

This indicates an underlying causal hierarchy of problems and potential for there to be different understandings of how and where to intervene in this. John saw value in the classifications system, as long as the targets of interventions were clarified and ideally related to more distal causes of problems. In comparison, several participants spoke about the classifications as belonging to the disciplines of prevention or public health, rather than as a framework which shaped their thinking or practice as psychologists interested in preventative work:

> *Paul: I think they're all perfectly valid constructs and from a public health point of view they make a lot of sense. Any problems as far as I can tell, is that public health has diminished in its ambition to the point where it's almost pointless and it's things like stop smoking programs being delivered to people who are living in poverty.*

Delivering smoking programmes to individuals in poverty does not address the causal issue of poverty and was therefore held to be unlikely to lead to a meaningful change in people's lives. The view that primary prevention was not always associated with addressing the fundamental causes of mental health was echoed by Julia:

> *I don't think it's well enough understood within that language that it should include, you know, justice, equity, and more value-led ways of thinking about psychological distress. I draw mostly on community psychology theory and practice…I started talking about contextual prevention instead - how do we create a context that is preventative of distress?*

As illustrated here, several participants spoke about how their ideas about prevention were informed by other influences beyond the classification framework, such as liberation and community psychology (Alex and Julia) and economic theory (Paul and Julia). Overall, there was variation in participants' views on the meaning of primary prevention and the utility of the classifications in practice.

3.2. 'Looking Both Downstream and Upstream' - Understandings of the Influence of Social Determinants

This theme highlights how participants understood the relationship between social inequalities and the development of mental health problems. Participants viewed mental health as multiply determined, with adverse circumstances such as poverty, housing instability, trauma, racism and discrimination all identified as playing a role. Participants appeared to integrate understandings of epidemiological and population-level data with a range of theories and models from community and clinical psychology. A number of participants identified how it was necessary to draw on psychological theories in order to adequately conceptualise the ways that social determinants influence mental health at an

individual, community and population-level. As well as drawing on epidemiological research and psychological theories, participants described how their experience of working directly with communities and in clinical settings informed their understanding of the impact of inequality.

3.2.1. Informed by Epidemiological Models

Seven participants spoke about how the work of public health researchers and epidemiologists had informed their understanding of the links between different forms of inequality and mental health at a population-level.

> *Interviewer: Do you consider the research on social determinants in your work?*
>
> *John: I've been influenced a lot by Margaret Whitehead, her approach with Dahlgren is enormously influential. Looking at health outcomes and how health behaviour is influenced by, and shaped to an extent, by inequity, the links between social circumstances, politics, equity and health, that's shaped me a lot.*

Liz also highlighted the value of population data in demonstrating inequitable differences in mental health across groups:

> *It's not randomised at all, it's distributed, the more adversity you're exposed to, the higher your chances of experiencing poor mental health.*

Epidemiological research was described as something that participants '*hold in mind'* (Eve), use in teaching (Paul) and believe psychologists '*need to take more seriously'* (Alex). Two practitioners had worked alongside epidemiologists in academic settings (John) and during a placement in public health (Eve). Eve noted how it was unusual for epidemiologists and psychologists to work together – '*we don't have any intersection'*. A perceived consequence of this was a disjuncture between epidemiological research and psychological knowledge:

> *Eve: There's a huge gap between epidemiologists and mental health research and for psychologists to do some of that bringing together around measuring and researching mental health at a population-level. I cannot understand how they work with the big data that they do, but they don't have*

the same level of understanding of mental health, and the flaws in measuring emotional distress, and what outcomes might be relevant.

Similarly, Liz felt that the development of psychological distress was not fully theorised or understood within epidemiological models. She identified a need for further consideration of the psychological processes involved and the ways in which population differences influenced mental health at an individual level:

We talk about population-level, poor mental health, but we never really get down to the nitty gritty of what that it is that psychologically causes that… what are the psychological mechanisms and how do they play out? Why is this causing distress and why is it causing distress for this person?

As illustrated, participants spoke about how epidemiological research broadened their understanding of mental health at a population-level. Some participants felt that this understanding could be built upon further, through the integration of psychological knowledge.

3.2.2 Informed by Psychological Theory

Participants referred to a range of different psychological theories when articulating the relationship between social factors and mental health. Four participants referred to the theories of psychologist David Smail regarding the ways in which power differentials constrain individual's access to resources and shape mental health.

Eve: There is a very concrete manifestation of legal power when you're working with young people who have been removed from their families. When you're in court with barristers, it's very hard not to be acutely aware of the issues of class and the power that is associated within our culture with money and with class.

The influence of various forms of power and differentials in privilege were thought to produce disempowering conditions that reduce the sense of control individuals and families have over their lives. The need to consider the distal causes of distress and to locate individuals within the wider context of their lives was echoed by other participants:

Julia: Clinical psychology has got stuck on very intrapsychic processes and has really lost sight of the bigger picture in terms of power structures…He [David Smail] has this idea of things like 'outsight' rather than 'insight' and looking at what's going on in people's world.

Implicit within these participants' examination of mental health and social factors was an understanding of psychological distress as reasonable responses to inequitable distribution of power and opportunity. Four participants also described the role of narratives, assumptions and biases that exist towards less powerful groups who are often marginalised on the basis of class, ethnicity, religion or economic background. Groups that participants described included people who are homeless (Julia), Muslims, young black men (Adam), individuals with disabilities (Eve) and families experiencing material deprivation (Paul). Paul gave an example from his previous work in child and adolescent services delivering parenting programmes:

These interventions were targeting these particular families who were presented as being 'troubled', but also 'troubling', so the narrative around those people…they were seen as presenting a serious problem to their neighbours, to their communities and to wider society.

Processes of marginalisation and discrimination were seen as influencing the ways that these groups are perceived and treated. Identified consequences of these negative interactions were feelings of fear and mistrust towards statutory services:

Adam: Young black men, because there was a fear in the communities of their local mental health services or services altogether, and because young black men got banged up all the time by police or hospitals, they wouldn't go for help until there was a crisis and then they were banged up by the police and brought to hospital in handcuffs.

Therefore, processes of discrimination were seen as reducing access to services, resulting in a worsening of mental health, and reinforcing inequalities. Six participants spoke about increased exposure to trauma and adversity associated with a range of circumstances such as poverty and war (Paul), relationship breakdown (Amy), being taken into care and claiming asylum (Eve).

Eve: It's not okay that people could be sent home to places that are the cause of their trauma and will be retraumatising to them.

Across participants accounts was the view that numerous processes shape the relationship between mental health and social determinants and are often the result of the accumulation of different factors – '*this isn't as a result of one issue'* (Caitlin). When formulating the issue of youth violence Caitlin described the intersection of different areas such as unemployment, deprivation, reduced opportunities and exposure to trauma:

If you're living in an area that has high crime rates, unemployment, and deprivation, you are going to be faced with a number of challenges as a young person in terms of what your opportunities and options are. It's highly likely that you've been exposed to significant ongoing trauma as well as violence, that will inevitably have an impact on your mental health. Young people get pulled into not only cycles of offending, but then being more at risk from youth or gang violence, partly because feelings of safety are hard to come by in this area.

3.2.3. Informed by Practical Experience

All participants described how experiences of working in services and within different communities had informed their understanding of the relationship between inequality and mental health.

Eve: If carers don't have the financial means to care for children, those children are more likely to come into the mainstream care system, so there's a real recognition of poverty being a factor, this being absolute intuitive sense to me.

Participants described how the impact of social circumstances was evident in their work as psychologists. This was also reflected in participants' contextualised analysis of the social factors impacting the areas they were working in, for example, racism and youth violence in cities (Caitlin) and alcoholism and depression in poorer areas with a majority white population (Amy). Five participants described how clinical psychologists' experiences of directly working with communities and people accessing services was highly valuable and provided more insight than was typically held by researchers and policy makers.

Alex: Because of the nature of the work that they're doing, and the people they are supporting, their capacity to understand distress and the way in which it's socially and economically mediated…bringing together that rich clinical experience with that much broader way of understanding the relationships between social determinants of mental health.

Paul described how practical experience and understanding of the detrimental impact of certain social conditions was necessary for engaging in social change work and part of the reason he became a psychologist:

I didn't feel like I could just go off and try and do something political if I didn't really understand what was going on for people. It's kind of like 'upstream' - 'downstream'; I felt like I needed to go downstream, is the way I'm framing it now, in order to be able to look back upstream with any sense of what was actually going on for people at the sharp end of things.

As illustrated, participants described the importance of journeying both 'upstream' and 'downstream' in order to understand the lived experience of individuals and communities. This enabled participants to integrate multiple forms of understanding regarding the influence of social determinants.

3.3 'Formulating, But Not Just with One Person in the Room' – Psychological Skills for Prevention

This theme describes the skills and competencies, specific to clinical and community psychology, that participants saw as relevant to this area. Participants identified a repertoire of knowledges and skills, summarised here as the processes of assessing social context, formulating psychosocial problems, and translating prevention research and policy into practice. Participants spoke about analysing issues at a local and national level in order to facilitate understanding of the social context of problems and preventative actions. This included gathering different information and integrating population data with the perspectives of individuals and groups. Participants emphasised the application of formulation skills at a community, system-wide and population-level to make sense of complex psychosocial problems. Developing these formulations in different services and settings was thought to facilitate shared understanding and cross-sector consensus about where to direct prevention efforts. Participants

noted that the evidence-base and policy on prevention lacked specific recommendations that they could apply in their professional contexts. They drew on their knowledge of psychological theory and interventions when developing programmes in order to ensure interventions 'fit' and were successful.

3.3.1 Assessing Social Context

Participants drew on different methods as part of the process of assessment and problem definition. Three participants spoke about using public health resources and data as part of the first stage of deepening understanding of the local population. Participants referenced public health resources such as the Adverse Community Experiences and Resilience Framework (Liz) and planning resources from PHE's Prevention Concordat and database (Amy):

> *Amy: Looking at social determinants within the community helped us think about what the needs and assets were…it really helped me think about the different populations and you know children, young people, elderly population, ethnic minority groups. It helped me to think about what assets there are and what we have to build on in terms of building community resilience. I tried to think about how to tailor our interventions to that, as a result of that assessment.*

Here, public health practices provided a methodology for enhancing an understanding of the different demographics and issues within the local population and informed decision-making about intended goals and impact. Two participants felt that psychological skills in gathering and analysing data can be used to integrate both population data and the perspectives of community members:

> *Adam: I'm attracted to that scientist practitioner model and what's going on in the data alongside I guess 'What do you want? Who are you? Come and have a cup of coffee and talk to me about what worries you most and what you'd most like to see different'.*

Five participants described the need to engage members of the community in order to generate dialogue and an understanding of their perspective on the problems affecting their area. Julia described the process of speaking with young people connected to youth violence about the drivers of this issue:

We've taken a really youth-led and community psychology approach and asked 'What are the things that young people think are important to prevent their youngers getting involved? And what are some of the core issues that are affecting young people's lives?' And yeah, things like poverty comes up, school exclusion comes up, social media, consumerism, you know, and materialism in the sense of what young people get told is important by our wider society, housing, debt, domestic violence, exploitation by organised crime, you know all of these big issues.

Implicit within this is the view that psychologists may not have first-hand experience or understanding of the difficulties they are seeking to prevent. As illustrated, participants emphasised taking the time to understand the context they were working in, the individuals within it and the knowledge these people have of their own situations.

3.3.2 Formulating Psychosocial Problems

All participants described the use of psychological formulation as a key skill for public health and prevention work. Participants spoke about making sense of problems beyond an individual level and formulating whole systems.

Interviewer: What do you think psychologists can contribute towards prevention work?

Eve: We've got this wide range of skills and I don't just have to use them sitting in a room with someone, which is what, right up to my third year, I thought being a psychologist was. I can formulate but I don't need to do that with just one person in room, I can formulate a system or structure.

Participants also spoke about emphasising the local community context:

Liz: We can use our psychology skills, and our ways of understanding mental health and the importance of making sense of things, at a place-based level.

This was held to be a necessary part of understanding the drivers of distress in order to inform subsequent intervention and prevention work:

Alex:…to really make sense, not just of what therapeutic interventions people need, but actually to talk and relate the drivers of mental health and to formulate ways of acting that would intervene on those.

This process was echoed by John. He described attending a recent development meeting for NICE guidelines and using a formulation approach to shift discussion beyond a narrower focus on lifestyle factors towards consideration of how the drivers of distress prohibit behaviour change.

John: It's similar to the difficulties I had yesterday with NICE. You know, taking a formulation approach: why do people become depressed and what helps? And more to the point, why do things that one might presume should help when people are depressed actually don't work in practice? The fact that they aren't exercising is probably because there are various barriers.

This approach was also echoed in Anna's account of using formulation to shift focus in a public health department, where the weight management service was struggling to support people to lose weight:

Seeing weight as sometimes a symptom of a bigger problem, so I spoke around 'how can we formulate what's going on for this family or child'? And thinking about that in the context of children and family's lives… we thought about access to food in the community… poorer families struggle to access healthier foods, food available in the food banks, for example, is generally tinned or packets. What can we be doing about that?

Here, a formulation approach enabled new strategies to emerge which focused on contextual, rather than individual, factors. Four other participants also identified the ecological system model as particularly useful for a public health and prevention approach.

Caitlin: We normally present the ecological systems model and suggest to people that if young people are growing up within an area with huge health, race and social inequalities there is going to be some impact on the individual, particularly on their mental health and wellbeing…to be able to present this formulation that we are suggesting that a public health approach is needed to manage some of these issues, particularly around violence, but these issues around the social determinants of mental health.

The ecological systems model therefore provided a way of linking individual-level experiences with social determinants. Implicit within this is that psychological formulation enables complex ideas to be summarised and communicated to stakeholders, as part of getting preventative solutions on the agenda. Participants named a range of models and theories as part of their conceptualisation of problems, including The Power Threat Meaning Framework (Liz), trauma-informed care (Liz and Eve), behaviour change models (Anna and Sandra), systemic theory (Anna, Amy and Sandra) and attachment theory (Eve and Caitlin). As illustrated, participants felt that the use of formulation and developing shared understandings of complex psychosocial problems was an important skill for public health and prevention.

3.3.3 Translating Prevention Research and Policy to Practice

Four participants highlighted a disconnect between research and policies on prevention and practical application. A number of issues were identified, such as a lack of cogent detail on how to deliver interventions, existing evidence not always being relevant to particular contexts, and decision-making being determined by other factors, such as funding. Amy contrasted the extensive evidence-base for individual treatment with the lack of comparative resources and recommendations for prevention work: *'there's no NICE guidelines around what you should do in prevention'*. This meant that psychologists needed to draw on their existing skills and knowledge when designing interventions:

> *Amy: One thing I didn't find helpful in the policy documents is when they make vague recommendations…there's a lack of specifics around - ok, how do we actually do this? The interventions we've pulled together, are largely, I guess, just what I think would be helpful, being a psychologist and knowing different psychological theories.*

When discussing the gap between research and practice, Sandra noted how interventions need to be adapted for particular organisations and communities. Psychologists' skills in change processes and tailoring interventions were highlighted:

> *I'm really interested in the 'how' you do things, really using the clinical psychology skill set to think about how we actually make interventions fit, in terms of local communities, fit in terms of teams and organisations.*

This need to make intervention 'fit' was echoed by Anna, also working in a public health department.

> *I think sometimes there is a bit of a push to run with it because it's available, because there's money for it, rather than thinking about what are the issues of our population, doing a full scoping exercise and making sure it fits the needs of our population.*

This indicates that interventions are often guided by pragmatic factors, such as funding and commissioning trends. Implicit here is the role for psychologists in advocating for the needs of the population and making sure that interventions are relevant.

3.4 'Fitting in Where You Can Bring About Change' - Activities and Interventions

The quotes under this theme relate to the different kinds of prevention activities that practitioners were involved in. Compared with individual treatment, prevention work was more often done at a community or system level and involved a range of strategies with different groups and stakeholders. Activities included co-production, sharing psychological skills, working across sectors and influencing decision makers. The targets of interventions varied greatly, including parenting, education, economic strategy, housing, youth violence, unemployment and peer victimisation. This indicates that there are a range of settings and activities that psychologists engage in that might be called preventive. Across these different interventions, participants also emphasised the task of shifting narratives about mental health, away from individualising and medicalising perspectives towards an understanding of the role of social determinants.

3.4.1 Collaborating with Community Groups

Five participants spoke about the importance of collaborating with community groups and co-producing preventative solutions. Participants described how this was necessary in order to understand the contextual drivers of distress, as

experienced by local communities and groups. Alex described how, in his role as a town councillor, he was approached by a number of parents concerned that they were unable to get support from mainstream mental health services. Rather than seeking to find immediate solutions for those individuals, a town-wide and preventive response was developed:

> *Alex: We invited representatives of parent groups, the parent carers forum, headmasters, local councillors, people who worked in CAMHS, SENCOS, teachers, a whole raft of others and we said, look, what can we do preventatively? We did all sorts of exercises around like - 'What are the main drivers of distress? What are the main things that are supportive to families locally?' And we took these drivers and we asked people to vote at the end. And then one of the things that came up was bullying and peer victimisation.*

This approach views prevention work as a shared task that is community driven. Co-production efforts often took place outside the healthcare system and involved a coalition of cross-sector and community stakeholders. It involved engaging local groups from the very beginning and communities actively conceptualising prevention programs together.

> *Caitlin: The project has been co-produced with the young people that we work with and what that means is that the help that we deliver has also been shaped by the community that we serve.*

Implicit here is that interventions that are developed for community groups, not with them, may not provide the kinds of help and support needed. As part of this, four participants emphasised that practitioners must share their professional power and influence as part of prevention work, rather than assuming an expert position:

> *Alex: You fit in where you find that you are most use in terms of bringing about change, sometimes its advocating for people, sometimes it's getting involved in policy, other times it's using the academic capital you have to get resources or bring legitimacy to a partnership or a piece of work.*

3.4.2 Influencing Decision Makers

Participants also described prevention work that sought to influence a range of decision makers, such as local councillors, government select committees and ministers. This took place at both a national and local level and involved different approaches and actions.

> *Julia: I did a bit of consultancy to [name of area] council that tried to tie together some of their mental health strategies with their local inclusive economic strategies. Because they weren't making the links between how those things were connected. They were developing an adverse childhood experience strategy, but it was not linked with their local inclusive economic strategy. Supporting them to think about how they are going to make sure that really marginalised people in the borough are benefiting from some of this work.*

This indicates that prevention work at this level involves facilitating understanding of the interconnected nature of economic, social, and mental health problems, in order to produce local strategies that can adequately respond to this. The need to connect the consequences of economic policies with mental health was echoed in John's description of recommendations made during his work as an advisor within Public Health England:

> *There's not an awful lot that Public Health England can do itself to prevent the consequential damage of an economic recession. But it is relevant to mental health so our recommendations are, very clearly, that we need primary prevention in that anything that the Chancellor of the Exchequer can do to prevent businesses losing their jobs, he should do.*

Caitlin described how her organisation seeks to inform service development by involving the perspectives of young people on the solutions to problems being considered by select committees and commissioning groups.

> *Caitlin: Our involvement in that was the team and young people taking part in interviews and feeding into those committees with written or verbal submissions …young people sharing their experiences of the police and policing in the area and contributing to ideas about shifting things… as a project we've also worked quite closely with the mayor's group and the NHS*

who have their own violence action unit task force. So we've been able to feedback at a higher system level with commissioners who are shaping services and shaping these pathways at a very top-down level.

An activism approach to systems change was described by Alex:

Myself and a group of local residents together with a trade union organisation, we did a big survey in [region], we wanted to produce a mechanism to allow the public's voice is heard in the commissioning process and to be more involved in the decisions that were happening around cuts and privatisation… we went and presented it to the local council and the health and wellbeing board, saying, look, 'you've got a problem here'.

Here, prevention was framed as community organising and activism in order to prevent cuts and privatisation to health services. Alex emphasised the political nature of this work and suggested it required a disruptive approach – '*you should see some come back from the institutions you are looking to change'.* An alternative approach of finding opportunities to build relationships with decision makers was described by Liz:

Networking with politicians, ministers, key lobbying organisations and building relationships with policy offices. We've built a good relationship with the chair of the Children and Young People's Education Committee and the chair of the Anti-Poverty Cross Party working group. I've been trying to target and share knowledge and ideas in conversation.

This may indicate the respective merits of being 'inside' or 'outside' the systems practitioners are seeking to influence. As illustrated, participants described a range of approaches to influencing decisions makers, with the overall aim of influencing change from a 'top-down' level.

3.4.3 Working Across Sectors

Nearly all participants described how prevention work required practitioners to work jointly with different health, third sector and statutory services. Two participants emphasised in particular how the social causes of mental health exist outside of the remit of health services and that overall '*no one kind of service has the solution to an issue, which is a societal issue, a public health issue'* (Caitlin).

Sandra noted how working as a psychologist across a public health department meant she was able to have an *'overview of a system'* and co-ordinate efforts between different work taking place in the local authority:

> *What really hinders prevention is that we often work in silos, you know, if you're in this service you're providing this and if you're in this one, you're doing that. Having the scope not to sit in a service box, means you can be preventative when you can notice those gaps and opportunities to do it.*

Similarly, Anna described the value of having a more holistic and integrated approach. She described the development of a new service set up within her public health department:

> *It's a support mechanism that's sprung up from covid, and it's an opportunity for that holistic approach, so it's like a one stop, it can help with housing needs, food provision, medications, all the things that are essential to your mental wellbeing.*

Caitlin also described prevention work as finding opportunities for intersectoral engagement and action:

> *The local authority housing team were really aware that we were referring lots of young men from the service and that there was a real challenge in terms of meeting the needs of this particular cohort. As a result of that, some of the commissioners of the housing services were able to work with us to be able to co-produce and consult on informing a new aspect of their housing service.*

Increasing housing provision for this group required engaging different stakeholders and working at multiple levels in order to build sufficient consensus to make changes. Several participants emphasised how psychologists' knowledge and experience, of '*how statutory services work*' and '*the type of language that might be required*' (Caitlin), meant that they could use their position to facilitate change. Participants framed prevention and action on social determinants as a whole-systems approach requiring shared responsibility and cross-disciplinary action.

3.4.4 Sharing Psychological Skills

Participants discussed the need for disseminating psychological skills and understanding as part of an early intervention and prevention strategy. Five participants were involved in work equipping individuals outside of mainstream mental health services with relevant psychological skills. Anna described how training to community and voluntary services, on having conversations with people in acute distress, was one element of an overall suicide prevention strategy.

> *Anna: We do a lot of work on training and skilling people up to feel confident to have those conversations with people and know where to signpost to people if they do express any ideas of suicide.*

Amy was involved in developing a primary care system with more emphasis on prevention, for example, ensuring that GPs had relevant mental health knowledge and skills:

> *Training practice staff around mental health prevention and promotion, specific focused prevention advice so for example, around sleep, understanding anxiety, stress, relaxation, healthy lifestyle advice.*

Eve emphasised the need to introduce psychological skills and understanding on areas such as attachment and emotions to both staff and carers supporting Looked after Children:

> *A lot of my work is around training people who come into the lives of young people who are looked after, thinking about a broader skillset within professionals and carers which has a preventative effect in the long run. I work very closely with social care service managers, thinking around how trauma-informed their services are…and talking to carers about things you hope will make individual interactions more sensitive and more attuned.*

Sharing psychological skills was viewed as particularly important in the context of the coronavirus pandemic and three participants had been tasked with developing resources, guidance, and strategy to support population mental health during the crisis.

> *Sandra: I've worked to help get some preventative messages out across the local system to help members of the public and staff to really have an early*

understanding of, you know, what people can do to help themselves through this period to reduce the chance of mental health problems.

Of note here is that that, whilst a system wide approach to prevention is initially described, the overall aim of individuals 'helping themselves' indicates the potential for prevention to become focused on individual level change, elsewhere described as 'lifestyle drift' (Williams & Fullagar, 2019).

Overall, participants described how equipping cross-sector professionals with knowledge of psychological issues and actions for responding to this helps create preventive systems. Mental health prevention was therefore presented as a multi-professional endeavour, rather than something that is the remit of specialist psychology services.

3.4.5 Changing Narratives about Mental Health

Eight participants described shifting narratives and understanding about mental health as a central part of prevention work.

Interviewer: What can psychologists contribute to this area?

Sandra: Something I feel is really important is sharing that narrative a bit differently around wellbeing and mental health in the different streams I'm working in, helping people to recognise that when we're talking about mental wellbeing, taking it away from that very medicalised model and helping them [public health departments] think about it differently.

This often involved challenging dominant narratives on the role of biological or intrapsychic processes, which were thought to prohibit focus on addressing social factors.

Paul: We had a meeting with stakeholders, which was heavily at the senior management end of public services, and spoke about the impact of austerity on mental health...we wanted to present a different perspective on psychology and mental health than the one that they may be used to hearing. You know about diagnosis, for instance, and thoughts and feelings.

Paul described his role on a health and wellbeing board as using professional capital to '*get in the room'* and be '*part of the conversation'* in order to influence narratives about mental in settings which could enact change. Caitlin also

described the value of having a '*seat at the table'* in order to shape conversations about social inequalities and mental health at a higher level:

> *Communicating with the broadest wider system, so that's local government commissioners, funders and politicians, heads of services to be able to feed into an understanding and narrative around these issues… getting those professionals that are going to be informing these services to be able to think about mental health slightly differently, rather than if somebody has got a diagnosis of 'X' or falls neatly into a box, they should go to a specific service.*

As illustrated, most participants appeared to feel that prevention work required shifting narratives on mental health away from medicalised and diagnostic language.

3.5 ''It's Difficult, from a Service Perspective, to Justify' - Barriers and Constraints

This theme relates to participants' discussion of the barriers and challenges for the application of prevention theory into practice. The lack of difference within the profession of clinical psychology in terms of class and ethnicity was highlighted. Participants felt that the way courses selected individuals for training precluded different perspectives, experiences and skills that would be suited to prevention work. Participants also noted that more teaching and training on public health and prevention methods was needed. Service-level challenges such as a lack of posts related to prevention work and the demand for psychologists to respond to individuals currently experiencing acute distress was highlighted. Finally, participants spoke about issues regarding measurement, timescales and outcomes for prevention work and emphasised the need to find innovative methods for research and evaluation, which could lend itself to the complexity involved in systems-change work.

3.5.1 Barriers within Psychology

Participants identified challenges for prevention work within the profession of clinical psychology. This was related to the lack of difference and representation within the profession, as well as the emphasis on individual models and

ameliorative therapeutic interventions within training. Three participants highlighted the problems related to a profession '*predominantly made up of white middle class women*' (Eve).

> *Interviewer: Is there anything that you think gets in the way of psychologists working in this area?*
>
> *Eve: The issue of class within clinical psychology is really relevant. I think it's a big barrier for our understanding of people and their lives. It's really hard to have a visceral understanding of what poverty might feel like.*
>
> *Adam: The fact that, you know, clinical psychologists don't necessarily match or understand the cultures [they're working with].*

These participants felt that the fact psychologists, as a profession, are rarely exposed to high levels of deprivation is a barrier to being able to understand and find preventative solutions to the problems that marginalised groups encounter. Two participants highlighted how the ways that training courses '*select and value certain bits of experience*' meant that the profession was '*not really attracting the diversity that it should'* (Sandra). This problem was extended to the types of pre-training experience that individuals had. Adam noted how a prerequisite for acceptance to training courses was experience in individual therapeutic interventions, to the detriment of applicants with experience that may be more suited to prevention work.

> *Adam: If you said, 'well, I've never done adult mental health work, but actually I know a lot about organisational change', I don't think it's going to get you in. We are self - selecting people who are interested in the individual thing.*

These participants also highlighted the lack of teaching on public health and prevention received by trainees during their professional training.

> *Sandra: There isn't very much training on preventative mental health… placements weren't until more recently likely to be in public health or in community organisations...So again it starts with who gets onto the courses and then how we train people on the courses.*

A related consequence of this highlighted by Eve was that some psychologists might not be aware of this kind of working or think that it is within the remit of clinical psychologists.

> *Eve: I think there's wider issues about, you know, what is a clinical psychologist? When I look across my cohort, we had really divergent views around what it was. For me, it would be helpful to have some other more diverse, different models about what it could be earlier on. I think that would have been really helpful for my journey. And maybe more reflection within training on - how much do you want to get political?*

The implications of this are also that, despite the efforts of some psychologists to move towards transformative system-change work, the emphasis within the profession remains largely focused on individual treatment and remediation:

> *Paul: A lot of stuff that psychologists, you know, primarily do is ameliorative intervention work.*

3.5.2 Barriers Within Services

Participants described how the existing model of mental health provision made it more difficult to do prevention work. Five participants highlighted how mainstream services were not orientated towards a preventative model – '*there's no set posts, it's not a known career pathway' (Sandra).* Two of these participants noted that a consequence of this was a lack of funding for posts in this area:

> *Adam: …it's a dilemma because there's a question of who would pay us to do it.*

Anna highlighted how the lack of set posts or job descriptions for psychologists in this area meant fitting in with existing posts that don't sufficiently align with their skills and intended aims. She identified a need to develop this further:

> *What doesn't fit well for me is my job title 'public health program manager'. I feel the job description doesn't necessarily describe the skill sets that clinical psychologists have. If clinical psychology is going to stay in the public health teams and be prioritised, there needs to be a focus on prioritising what that job description looks like and what specific skills clinical psychologists offer.*

Participants' accounts indicated that, due to the lack of a national service model and funding, public health and prevention is currently delivered by psychologists on an ad-hoc basis and in idiosyncratic ways. Four participants spoke about the challenges of trying to do preventive work within existing clinical roles, in NHS services primarily orientated towards crisis support. Eve described the personal and professional dilemma of trying to shift towards prevention in services when there is substantial demand for therapeutic treatment.

> *Eve: Children are experiencing acute distress, as a professional and someone who's trained to support, there is a real personal pull, as well as a professional pull, to do what you can, when that need is so great. To pull back and say 'I'm not going to see that young person for direct work'…it's a hard moral question.*

As illustrated, despite believing that public health and prevention work could have more impact, participants identified a series of challenges to working preventatively within the existing model of mental health provision.

3.5.3. Limitations Related to Research

Five participants highlighted the particular difficulties for public health and prevention for researching and evidencing change.

> *Caitlin: Systems change work is slow and the relationships are slow to build. I think the timelines with funding make it difficult to ensure the consistency of the work that's needed to really create longer term change.*

Prevention work was associated with creating longer term and transformative change in communities and systems. Participants noted how conventional evaluation methods and funding timelines presented challenges for this kind of work. Methodology grounded in models of cause and effect was not seen as amenable to evaluating prevention work:

> *Liz: We need to stop taking a reductionist approach and trying to break things down to the smallest part so that we can get numbers and outputs. We need to respect complexity…and find ways to move against just using numbers and getting that fuller, richer, picture.*

This indicates that alternative and innovative ways of evaluating prevention work are needed. Eve noted that the lack of research into prevention and public health

methods makes it harder to advocate and argue for this kind of work over individual treatment.

> *Eve: The research literature isn't necessarily there to be able to clearly advocate and articulate for why doing some of this broader stuff is going to be more helpful. The outcomes being less immediately felt, being less discernible, being less easily quantifiable…it's difficult from a service design and delivery perspective to justify.*

As illustrated, participants felt that the nature of prevention work presented challenges for conventional research methods, and therefore evidencing change in ways there were necessary for buy-in from commissioners and services. This indicates that there is a need for alternative and innovative research methods for demonstrating the kind of transformative change required for preventing mental health problems.

4. DISCUSSION

The five main themes developed from the data will now be discussed, considering each research question in detail and in relation to the research literature.

4.1.1. How do Clinical and Community Psychologists Understand the Concept of 'Mental health Prevention'?

A singular understanding or definition of prevention did not emerge from participants' accounts, and a range of views on mental health prevention were described. The variation in perspectives on prevention, and its relationship to promotion and early intervention, is indicative of the contentions identified within the literature regarding the term's core definition when applied to mental health (Cowen, 1998; Radden, 2018). The findings support the suggestion by Davies (2014) that there is a lack of consensus regarding definitions and boundaries between key components within public mental health. For some participants, prevention was understood to mean a variety of activities, along a continuum, that included interventions directed towards individuals with early signs of distress. This is in line with some models of prevention which describe prevention

along a spectrum of interventions (e.g., O'Connell's, 2009). However, in contrast to this, other participants were concerned that a definition that included early intervention would be overly inclusive and would divert focus from the 'true' meaning of prevention, which in their mind meant addressing the social determinants of mental health. The notion of 'true' prevention is prevalent within the literature, reflecting the numerous efforts to redefine the concept during the field's development and the debates regarding its targets and methods (Cowen, 1997; Coie et al., 2000).

Contrasting accounts were also provided regarding mental health promotion strategies. Some participants suggested that promotion activities are so closely related to prevention that they should be considered a core aspect of it, echoing Durlak and Wells (1997). Others were concerned that a focus on enhancing the psychological skills and resiliency of individuals constituted attempts to mitigate the effects of inequitable social conditions, a concern shared by some authors (Friedli, 2020). Participants' accounts regarding the classifications of prevention indicated that, in practice, distinctions between primary, secondary and tertiary prevention may not be clear cut, similarly suggested by Radden (2018). Use of different approaches are likely to be influenced by shifting needs and requirements and participants suggested that a pragmatic approach to their application was needed. The findings suggest that, rather than determined by the application of prevention theory, a problem-driven approach involving the assessment and formulation of psychosocial issues, as well as collaboration with relevant stakeholders to reach preventative solutions, is recommended. Primary prevention was still considered as something to aspire to, however participants had different interpretations of its meaning, something that is highlighted in the literature (Cowen, 1998). Most participants felt that the definition of primary prevention was most useful when it evoked intentions to address the social causes of mental health. However, these participants did not think this was a consensus necessarily shared by most psychologists or prevention practitioners. The findings indicate that definitions of primary prevention are likely to be indistinct and numerous within the psychology professions.

On the one hand, a system for classifying interventions may be necessary for ensuring that researchers, practitioners, commissioners and policymakers 'speak the same language' (Davies, 2014). However, these findings suggest that there are variations in how the classifications are understood by practitioners, even when the same terms are being used. Participants' understanding of prevention, and where efforts should be directed, appeared to be connected to their values, explanatory models of mental health, and beliefs about where important change should occur. For example, prevention was associated with a need for social change, political action, resiliency building, taking a non-deficit approach, universal wellbeing and ending childhood trauma. Psychologists and prevention practitioners' conceptualisations of primary prevention have not previously been studied; therefore, this finding is of significance. Rather than attempting to further define and regiment the terminology around prevention within the field of public mental health, which Radden (2018) has argued has so far been unsuccessful, it may be more important to consider reflexivity and examination of beliefs and judgements about mental health. This is especially pertinent given the need for an interdisciplinary approach to public mental health, advocated for by Walker et al., (2019). There is likely to be a diverse range of theories and assumptions regarding mental health and it's causes, which may explain some of the definitional issues regarding prevention within the existing literature (Papworth & Milne, 2001; Cowen, 2000). The findings of this study suggest that the act of practitioners positioning themselves within the debates on prevention, acknowledging a standpoint and associated values, may help to reach a consensus regarding a range of goals and priorities within public mental health.

4.1.2 How do Clinical and Community Psychologists involved in Prevention Understand and Address the Influence of Social Determinants on Mental Health?

The findings indicate that the evidence-base for social determinants provides an important framework for conceptualising public mental health and prevention interventions, which has been advocated for in several places (Public Health England, 2017; Compton & Shim, 2020). The term was used by participants to highlight the limitations of approaches targeting individuals, without consideration of the contextual influences on mental health. As in previous literature, mental

health was understood to be determined by a number of factors; participants described a range of interacting social factors and processes, including inadequate housing, financial problems, racism, discrimination, exclusion from education and experiences of violence and trauma (Pickett & Wilkinson, 2010; World Health Organisation, 2010). Some participants suggested that more could be done to build on existing epidemiological models by using psychological theory to develop understanding of the complex ways macro- and meso-level factors impact mental health at the level of the individual. The need to clarify the processes that shape the unequal distribution of social determinants and mental health problems among less advantaged groups has also been emphasised within the literature (Graham, 2004). Drawing on psychological theory, participants described how the distribution of power and resources, processes of marginalisation and discrimination, feelings of insecurity and unsafety and experiences of threat and trauma shape poor mental health and reinforce inequalities. Elsewhere, psychosocial explanations have been criticised for placing too much emphasis on personal characteristics, perceptions or dispositions, and therefore potentially individualising the impact of social inequalities and discounting material and political factors (Friedli, 2016). However, participants' accounts of the psychological and relational processes involved appeared to be understood as embedded in, rather than separate from, material influences. This points to a 'false antithesis' between material and psychosocial explanations regarding social inequalities and health outcomes, which has been suggested elsewhere (Orford, 2008). Previous research into psychosocial factors has been dominated by population-level epidemiological studies, located within a positivist scientific paradigm, which risks a reductionist approach to isolating specific individual factors or pathways (e.g., Pickett & Wilkinson, 2015). Participants accounts suggest that, in practice, the use of psychological formulation and theory, as well as working directly with community stakeholders, may allow for greater contextualisation and analysis of the complex interaction between structural and material conditions, inequity, individual experiences and mental health.

Within their accounts, participants often made implicit distinctions between different levels of causation, differentiating between proximal influences (e.g.,

victimisation, levels of debt) and more distal influences (e.g., economic recession, class structures), with factors at the distal level identified as having the most influence. Models on social determinants make comparative distinctions between different levels of influences such 'meso' and 'macro' (Bronfenbrenner, 1979) and 'intermediary' and 'structural' (World Health Organisation, 2010). With some exceptions, most individuals were working at the local, rather than national, level. Structural determinants, such as class structures and macroeconomic policies, have the most influence on mental health (World Health Organisation, 2010). However, the debates regarding 'upstream' versus 'downstream' approaches have been described as oversimplified (Sniehotta et al., 2017). The findings of this study indicate that working at a local level presents several opportunities and advantages. Participants described the importance of understanding the local context and issues facing people, the value of building relationships with cross-sector stakeholders and collaborating directly with community groups. This supports the literature on 'placed-based' interventions, which argues for having an in-depth understanding of specific contexts, where particular psychosocial problems are concentrated (Rayment-McHugh et al., 2015; Public Health England, 2019b).

Some participants had found ways of influencing decision makers through cross-sector action and consultation with select committees, health and wellbeing boards, local authorities and within organisations, such as Public Health England. This often involved shifting the mindset of policy makers by emphasising the links between poor mental health and wider economic strategy. This supports existing evidence that mental health often isn't an explicit driver within policy and strategic planning on social determinants and provides further argument for a 'mental health in all policies' approach (Public Health England, 2017). Participants emphasised how the current configuration of statutory services prohibit action on social determinants and that multi-sectoral initiatives, involving organisations such housing, employment, schools, the police, and health services, are needed. This indicates that that addressing complex psychosocial problems, such as deprivation and mental health, should be considered a 'wicked issue' - a problem that is difficult to solve due to complex interdependencies with other social issues, therefore requiring co-ordination between multiple agencies (Jacquet et

al., 2020). Interestingly, the role of health and social care services is rarely accorded a place within models on social determinants (Graham, 2004). The work described by these psychologists however, such as developing a housing pathway for young men affected by youth violence and action to prevent cuts to services, suggests that this is an important area to consider. While all participants emphasised the fundamental role of social determinants in shaping mental health and the need for action in this area, not all participants were as involved in this work. Participants described a number of factors that made involvement in direct work on social determinants difficult, such the way programmes were commissioned within public health departments and the fact that NHS services are not orientated towards prevention, which means that there is a pull towards individual treatment. This indicates that, whilst psychologists may want to be involved in preventive action on social determinants, there are a number of barriers and constraints to overcome.

4.1.3 What Models and Theories Inform the Work of Clinical and Community Psychologists Involved in this Area?

Participants spoke about drawing on a range of psychological theories and models, including systems theory, trauma-informed care, attachment theory, behaviour change models, the ecological systems model and the Power Threat Meaning framework. The breadth of theories and frameworks used by participants support the suggestion that understanding complex psychosocial problems in context requires the integration of different theoretical perspectives, and that psychologists can contribute theories and perspectives applicable at an individual, population or policy level (Browne et al., 2020; Jenkins & Ronald, 2015). Central to participants' discussion of theory and models was their use of psychological formulation. Participants highlighted the ecological systems (Bronfenbrenner, 1979) model as particularly useful for public health and prevention. The findings highlight the value of formulation in translating complex information about the social determinants on mental health, and for providing an alternative understanding of mental health within public health and policy settings.

Several participants gave the opinion that change is best achieved by engaging people in the community, indicating the value of community psychology principles within prevention, as argued by a number of authors (e.g., Orford, 2008). Most participants described using mainly clinical or community psychology models in their work. Fewer participants said that they made use of epidemiology or public health models (e.g., Whitehead & Dahlgren, 2006). This finding indicates that epidemiological research and public health models did little to add to the knowledge of social inequalities these psychologists had already gathered from working within services. This could be due to a number of factors, including the complexity of some social determinant models or the fact that such models rarely explicitly identify actions for intervention, as highlighted by Graham (2004). Some participants had made use of public health resources, such as the Adverse Community Experiences and Resilience Framework and planning resources from Public Health England's Prevention Concordat (Public Health England, 2017). This finding might indicate that practical public health resources are considered to be more useful for psychologists in this area, compared to conceptual models.

Two main paradigms within public mental health and prevention are frequently highlighted within the literature (Blair, 1992; Phillips & Green, 2015). The dominant approach is located within a largely biomedical model of mental health, based on specific causal factors for psychiatric disorders, and an ideological emphasis on individual responsibility for health and wellbeing (e.g. Mrazek & Haggerty, 1994; Murray et al., 2020). This is contrasted with approaches based on an understanding of mental health as a social phenomenon, with certain contexts increasing the likelihood of problems, therefore requiring a broader agenda of social change (Hage & Kenny, 2009; Hepworth, 2004). The psychologists in this research most often promoted a social ecological approach to prevention which recognises the range of intersecting social influences on mental health (Hage & Kenny, 2009; Bronfenbrenner, 1979). Participants' descriptions of their work indicate how it is possible to develop prevention interventions outside the language and frameworks of diagnostic risk factors and individual vulnerability. This can be considered in line with the recommendations of a number of authors and policy makers, who argue for the need to shift focus from a biomedical paradigm of health, which seeks to cure individuals by

targeting disorders, towards efforts to change the social structure in which people are embedded (United Nations, 2017; World Health Organisation, 2014).

4.1.4. What Kinds of Public Mental Health and Prevention Work are Clinical and Community Psychologists Involved In?

The term mental health prevention was used by participants to refer to different types of interventions and actions, indicating that there are a diverse range of starting points and views associated with how best to prevent mental health problems. Participants highlighted the limited availability of research and policy guidance on delivering interventions in contexts and settings relevant to them, contributing to what has elsewhere been described as the 'public mental health implementation gap' (Campion, 2019). The findings indicate that a consequence of this is that psychologists must draw on, and adapt, existing skills and knowledge in order to develop prevention interventions. As part of this, participants described the use of assessment methods, such as population data analysis, consultation with community groups and problem-formulation. This finding indicates that the early stages of preventative work are important for establishing a consensus on the drivers of problems and orientating services towards preventative solutions.

Given the different interpretations of primary prevention, an initial role for some participants was facilitating shared understanding of complex psychosocial problems and decision making regarding the target of interventions. Many participants described a process of disseminating psychological skills to other sectors and professional groups as part of prevention work. For example, crisis management and suicide prevention training to third sector organisations, mental health promotion skills for GP practice staff, and supporting trauma-informed care for professionals working with looked after children. This indicates the value of a whole-systems response to mental health prevention, rather than this being the work of just public health or mental health services, similarly suggested by Sims and Aboelata (2019).

Participants were primarily working at a community level, with some seeking to influence decision making at a national level through consultation with select committees, Public Health England and government departments. Participants described finding opportunities for prevention work and 'fitting in where you can bring about change' (Alex). For example, by building relationships with local councillors and MPs or partnering with community groups. Whilst this allows for a responsive and problem-driven approach, it also points to the inconsistent development and delivery of public mental health and prevention nationally, as highlighted by Walker (2019). Participants described how interventions need to be relevant to their specific context, respond to the priorities of the groups they are intended to benefit, and account for changes processes and organisational readiness. These are important principles to consider as part of improving the coverage of public mental health nationally (Campion, 2019).

4.2. Critical Evaluation

Criteria for formally assessing quality within qualitative research has been the subject of much debate over the last two decades (Willig, 2013). It is not possible to simply apply criteria used within quantitative research, given the differing methods and epistemological positions employed within qualitative research (Willig, 2013). A number of frameworks have been developed (e.g., Elliot, Fischer, & Rennie, 1999; Yardley, 2008), however, in their review, Northcote (2012) concluded that there is no consensus on a set of criteria by which qualitative research should be evaluated. However, Spencer and Ritchie (2012) argue that it is possible to identify recurring, and widely held, principles that underpin assessments of quality. The authors provide a useful set of principles for the evaluation of qualitative research, as well as questions to guide assessment (Spencer & Ritchie, 2012). In addition, Braun & Clarke's (2020) guidelines for quality when using thematic analysis were held in mind throughout the research. This is reflected upon in Section 4.2.4. Finally, potential limitations of the study and reflexive review are provided.

4.2.1. Contribution

This refers to the value and relevance of the research and whether existing knowledge and understanding has been advanced. This study is timely given the growing emphasis on preventative approaches to mental health in the UK, as indicated by the recent establishment of the BPS Public Health and Prevention sub-committee and the NHS Long Term Plan (2019). Furthermore, the coronavirus pandemic has alerted the wider public to the vital role of public health programmes in protecting and enhancing population health and wellbeing. This study sought to extend knowledge regarding how clinical psychologists understand the concept of mental health prevention and how they apply this understanding to practice. The findings indicate how psychologists can utilise their skills at a public health and population-level, by assessing local context, formulating psychosocial issues, and translating prevention research and policy to practice. It also highlights the new areas that psychologists are pursing, such as influencing decision makers, cross-sector initiatives, and work to address the social determinants of mental health. Psychologists appear to attach different meanings to the concept of prevention and where change should occur, which should be an important consideration for the development of future prevention programmes. It is hoped that these findings encourage other psychologists and practitioners to embark on the area of public mental health. The potential impact of this research further is discussed in section 4.3.

4.2.2. Credibility

This relates to whether the study's findings can be considered defensible and that plausible conclusions have been drawn, that are supported by evidence. A detailed outline of the research process and the methods involved in collecting and analysing the data is provided in sections 2.5. and 2.6. In an attempt to avoid seeing only themes based on the researcher's personal relationship to the topic, data analysis and examples of extracts were discussed with the research supervisor. Instances that did not appear to fit with developing themes were actively searched for in order to ensure a range of perspectives were captured. The interpretation of data was closely linked to the data and an excerpt of the

way the data was coded, and how these codes were then developed into themes, is provided in Appendix J and K. The results of the study are presented in section 3, where the claims are supported with data extracts, enabling the reader to reach conclusions on the claims made. In line with a critical realist epistemological position, the researcher's interpretation of the data is considered to be one perspective. This is discussed further in section 4.2.7.

4.2.3. Rigour

This refers to the transparency of the research processes, and the extent to which a clear account of how and why decisions about the research strategy have been provided. The rationale for the choice of method, and decisions regarding recruitment and participant sample, is described in sections 2.2 and 2.5.2. The processes of data collection, analysis and theme development is depicted in section 2.6., in order to demonstrate how this has been conducted. Consistent with steps in thematic analysis (Braun & Clarke, 2006), the data was read multiple times while attending to variations or contradictions within, and between, participants' accounts. A coded excerpt is included in Appendix J to provide an example of the analytic process. Interpretation of the data is grounded in excerpts from across the data sets, through which the reader can make their own judgement on how the data has been analysed and interpreted, and the resulting presentation of themes. An extract from the reflexive journal kept throughout the research process can be found in Appendix M.

4.2.4. Use of Thematic Analysis

Quality in thematic analysis should also be considered (Braun & Clarke, 2020). Different types of thematic analysis are informed by differing epistemological assumptions and approaches to qualitative research. Therefore, rather than describing universal quality criteria, Braun and Clarke (2020) provide guidelines and 'critical questions' for ensuring quality. These were held in mind throughout the analytic process and a summary of how this was demonstrated will now be discussed.

In line with Braun and Clarke's (2020) guidelines, the selection of thematic analysis, over other forms of analysis, and how this is consistent with the stated research aims, has been described in section 2.2.1. The decision to use thematic analysis that is theoretically informed by a critical realist position, and why this is a 'good fit' for the current study, is detailed in section 2.2.1. Guidelines and literature on thematic analysis were reviewed to avoid what Braun and Clarke (2020, p. 345) describe as "conceptual and procedural confusion" (i.e., adopting a constructionist approach whilst using positivist concepts such as coding reliability). To demonstrate this, the analytic procedures that were undertaken are clearly outlined in section 2.6.2. Theme development was discussed with the research supervisor, following which themes were revised and renamed in order to reduce the number of themes, and to ensure that theme titles were specific enough to provide an overall narrative. A table has been provided in section 3, in order to clearly present the identified themes and sub-themes. A detailed description and introduction to each theme is provided, along with exemplar quotes from the dataset. In line with a critical realist approach to thematic analysis, participants' accounts of prevention were treated as more or less straightforward reflections of their understanding and experiences of prevention work, whilst not implying that this constitutes a direct or 'true' representation of an underlining concept. The various meanings attached to the notion of 'true' prevention by participants are discussed and reflected upon in section 4.1.1. The researcher's personal and social positioning, motivations for the research and how this may have influenced the analytic process, are described in section 4.2.6. and 4.2.7.

4.2.5. Limitations

As with all research, there are some potential limitations to consider. Whilst the sample size used in this study is typical for thematic analysis, the sample was still relatively small, which may limit generalisability of the findings. As this is a new area for psychologists to be working in, there was no criteria for selecting participants based on the setting or the focus of their mental health prevention work. As a result, the sample is heterogeneous in this aspect, with participants working in a range of mental health, public health and community settings, and

focusing on differing issues. As the interviews progressed themes began to emerge but, due to the varied work that participants were engaged in, further interviews continued to present new and interesting data. The researcher discussed the issue of data saturation with the research supervisor, and it was determined that the data that had been collected was sufficient for theme development and for the purposes of the study, meaning that no further participants needed to be sought. However, as this is the first study to research the way in which psychologists engage with public mental health and prevention, further research into this area would be valuable. Should this field continue to develop, future studies may want to consider setting a narrower focus, such as interviewing only psychologists working with a particular group or issue, such as older adults, housing, or discrimination.

Most of the participants were recruited using a BPS online survey advertised on social media and the BPS website. The survey was advertised for a relatively short period and, given that not all psychologists will regularly access these sites, this may have affected recruitment. Participants were also recruited by way of contacts of the researcher's supervisor and snowballing methods from the participants already recruited. However, it is possible that individuals working in this area, potentially in different ways, will not have been recruited as part of the present study. Information sent out about the study during the recruitment process sought to recruit individuals involved in mental health prevention and social determinants work. 'Prevention' and 'social determinants' are concepts usually associated with the field of public health and are just one way to conceptualise work in this area. For example, anti-racism campaigns may be considered to have preventative aims, and address social determinants, but are not typically part of public health discourse. Therefore, there are potential implications for the kind of work captured in this research and what has yet to be explored.

All participants were white professionals, which may reflect the lack of difference and diversity within the profession, a problem that was highlighted by some participants. Whilst discussions of racism, culture and ethnicity were not absent from the interviews, discussion would likely have been richer had the participants

been more representative of different identities. Participants were working in the North and South of England and Wales, therefore the findings are likely to be relevant to different areas, not just reflecting the experiences of professionals working in one region or city. However, as public health, health and social care is devolved in Scotland and Ireland, further research may illuminate particular contextual issues within those nations.

As described in section 2.5.2., the first stage of the recruitment strategy sought to recruit only clinical psychologists. As a result, only one participant who was not a clinical psychologist was recruited. Four clinical psychologists in the sample described engagement with the models, theories, and practice of community psychology, meaning that community psychologists were represented within the sample. However, had additional participants been working solely as community psychologists, there may have been more discussion regarding potential disadvantages of clinical psychologists' involvement in this area or further description of community psychology concepts (e.g., conscientisation, praxis or empowerment) relevant to prevention. In order to explore this, future research could consider recruiting only community psychologists.

4.2.6. Personal Reflexivity

As previously discussed, within qualitative research there is a need for researchers to address what assumptions and values they bring to the research. This is because it is not possible for the researcher to absent themselves from societal context and comment on social processes in an objective or neutral fashion (Pilgrim, 2014). As such, my perspective and motivations for the research will have influenced the research aims, analysis and conclusions formed from the data, and the subsequent narrative presented. Therefore, my personal and professional context, reflections on the research and how the data has influenced me are described here.

My interest in the research resulted from my awareness of the harmful effects of social inequalities on mental health. Similar to the participants within this study, this understanding was shaped by my observations as an assistant and trainee

clinical psychologist in NHS services, and further informed by well-established evidence on the unfair distribution of social determinants and psychological distress. Within the profession of clinical psychology, there is a growing emphasis on the need for psychologists to respond to these factors, and I believe that professionals have an ethical responsibility to do so. Despite this, I felt there was much more to be learnt about the potential ways for psychologists to engage in prevention work. I was interested in what a psychologically informed, preventative, and population-level, approach to mental health might look like.

I have noticed how my understanding of the concept of primary prevention has changed over the course of the research. At the beginning, I understood primary prevention as work that seeks to addresses the upstream social causes of distress. However, it became apparent during the process of the literature review that the concept of primary prevention, and mental health prevention in general, is more complicated and contested. Kessler & Albee (1975) compared the sometimes vague and contradictory nature of prevention research to the Okefonokee Swamp, luring practitioners and researchers into quagmires. This description stood out to me and I noticed that, as I became more emersed in the literature, I became less clear about the meaning of primary prevention. Ultimately, I find myself taking a similar view to some participants, that primary prevention and Caplan (1964)'s classification system is one framework through which to consider social change efforts. It may have limitations in certain contexts and, as with any theoretical framework, requires pragmatic application. The emerging term 'contextual prevention' highlighted by one participant, which has been used to describe a neighbourhood and organisational approach to prevent sexual assault and HIV (Morales, 2009), may convey the need to change contexts, rather than individuals, more explicitly. This is just one ways of working shared by participants which I hope to take forward.

Given the integral role of the researcher in qualitative research, it is important to reflect on the social context and identities of the researcher, which may have influenced the interview process and data collection (Willig, 2013). I am a white able-bodied woman in her late twenties and all of the participants were also able-bodied and white. This is likely to have impacted the research interviews and the

areas discussed. Whilst participants described a range of social injustices and inequalities, had our identities been different, we may have explored certain areas in more detail. I noticed myself and participants sometimes using the term 'social determinants' as a heuristic to quickly convey the impact of a range of inequalities. Whilst I sought to unpack what this meant, I wondered whether our position as relatively powerful professionals constrained our ability to fully discuss the ways these issues affect people. The academic and research context felt very removed from the lived experience of people experiencing the issues we were discussing. This is something that some participants also alluded in their discussion of the lack of difference in the profession.

4.2.7. Epistemological and Methodological Reflexivity

During the process of data analysis, I was conscious of how my beliefs about the value of psychosocial models of mental health, and the need for prevention work to consider social determinants, may interact with the process of developing themes (Willig, 2008). I read the data multiple times actively looking for variations in participants' understanding of mental health prevention (Braun & Clarke, 2006). An 'empathic' rather than 'suspicious' approach to data analysis was taken, which treated participants' accounts as a more or less straightforward descriptions of their perspective on this area. However, within a critical realist approach, attempts to 'make sense' of ideas and experiences are not thought to constitute a direct reflection of those things (Pilgrim, 2019). As previously described, understandings of prevention have changed over time, often reflecting particular social contexts. It is likely that the concept of prevention will continue to be 'remade' within the fields of psychology and public mental health.

4.3 Research Implications

4.3.1. Implications for the Profession of Clinical Psychology

Prevention is not a new concept in mental health, however it has received little attention in the training and activities of clinical psychologists. The findings of this study indicate that psychologists are becoming increasingly involved in this area.

In order to respond to the increasing demand on services, and to meet the complex challenges of health inequalities, there is a need for prevention to be a core feature in the theory, training and practice of clinical psychologists. By 2024, NHS health systems will be expected to have operational plans for reducing health inequalities within the local population (NHS Long Term Plan, 2019). The majority of clinical psychologists in the UK work in the NHS and could therefore play an important role in influencing these plans. The BPS Public Health and Prevention sub-committee should therefore consider developing best practice guidelines for prevention, such as those developed by the American Psychological Association (2014). Based on the findings of this study, key areas to consider would be assessment of social context, formulation of psychosocial problems, cross-sector working, methods to influence decisions makers and developing preventative solutions with community groups. Psychologists should also advocate for the delivery of prevention and public mental health to be incorporated into NHS transformation plans, governance, and board structures, therefore establishing accountability, as has happened in places such as Wigan (Public Health England, 2017).

As highlighted by a number of participants, there remains an emphasis on individual therapeutic skills within most clinical psychology training programmes. There is a need for more emphasis on the application of psychological theory and problem formulation at a population-level. The structural competency framework which has emerged within the field of medical training within the United States could also facilitate analysis of how mental health is influenced by public policies and economic conditions (Ali & Sichel, 2014). The framework involves recognising how upstream social determinants shape clinical presentations and interactions, as well as competencies related to advocacy and engagement with community health activism. More courses should offer placements within public health departments, local authority and policy areas, as done by the Lancaster and Canterbury training programmes.

Participating in an interdisciplinary public mental health approach will require psychologists to learn from other professionals. Further teaching on epidemiology and public mental health models would facilitate this. The Public Mental Health

Special Interest Group, within The Faculty of Public Health, recently delivered a joint conference with the Royal College of Psychiatrists. It would be interesting to consider what an equivalent conference with applied psychologists could look like in the future. Prevention and public health are already embedded in the practices of some psychologists, particularly those in community and health psychology, therefore building alliances within applied psychology would facilitate the development of a comprehensive psychological approach to public mental health. The East London clinical psychology training course has delivered joint teaching with the education psychology programme on the role of psychologists in schools. A similar approach, focusing on public health and prevention, could be employed with a range of applied psychology trainees.

There has been considerable discussion regarding the involvement of clinical psychologists within political debates (British Psychological Society, 2020). Preventative action on social determinants requires analysis of the ways in which public policy and political decisions influence mental health. As noted by one participant, this has become a divisive issue, relating to personal and professional identities, and requires ongoing reflection regarding the psychology professions' core values and aims.

4.3.2. Implications for Public Mental Health and Prevention Practice

A number of professional groups, including psychiatry, nursing, economists and educators have committed to delivering public mental health and there is consensus that a range of expertise and interventions are required (Mental Health Foundation, 2016; Walker et al., 2019). Understandings of prevention appear to be influenced by different explanatory models of mental health, and there are implications for accommodating different beliefs about mental health and where change should occur. Given the substantial evidence on the influence of social circumstance on mental health, the field of public mental health should consider the underlying principles of a traditional biomedical approach and the extent to which this advances action on social determinants. The findings of this study indicate that it is possible for prevention and public mental health approaches to be conceptualised without the language of diagnostic risk factors.

Intersectoral workforce training with public health practitioners, third sector organisations, health and social care may facilitate consensus building about where to direct efforts. Given the emphasis on reducing health inequalities within the NHS Long Term Plan (2019), the priorities and aims of public mental health should be in line with this, and the links between social determinants, inequality and mental health should be made explicit across reports and policy.

Participants in public health settings identified a growing recognition of the need for population-level mental health initiatives since the start of the coronavirus pandemic. Whilst governmental measures, such as lockdowns and self-isolation, have been important in preventing coronavirus transmission, there are concerns regarding the mental health and psychosocial consequences of these interventions (Pierce et al., 2020; Stansfield & Shah, 2021). Public mental health interventions are more important than ever to prevent psychological suffering at a population-level. Poverty, race, debt and unemployment, have been linked to greater severity of coronavirus symptoms, further exposing pre-existing health inequalities (Bambra & Lynch, 2021). Due to this, the coronavirus pandemic has been described as a potential 'watershed' moment for action on health inequalities and public mental health (The Health Foundation, 2020). Therefore, further clarity on the functions and priorities of the new Office for Health Promotion, which is set to replace Public Health England, is needed. As highlighted by participants, detailed recommendations and guidelines for public mental health and prevention do not yet exist. Whilst prevention planning should be responsive to local needs, and ideally developed in collaboration with community groups and stakeholders, overarching strategy and national priorities would support buy-in from commissioners and decision makers.

4.3.3. Implications for Further Research

There are several avenues of research, drawing upon the findings of this study, which could contribute to the further development of public mental health and prevention. The findings indicate that psychologists can attribute different meanings to public mental health concepts, such as early intervention, prevention, and promotion, and that they can hold different views on the merits of

these approaches as part of a prevention agenda. Given the emphasis on interdisciplinary action within public mental health (Walker et al., 2019), equivalent research with other professional groups, such as behavioural scientists, psychiatrists, and public health practitioners, would be beneficial to explore how they conceptualise prevention and their views on the classification system in practice.

Several participants described prevention work as requiring a shift from psychological 'expert' to collaborating with community groups. The perspectives of different community groups on the main drivers of distress, and what they want from prevention programmes, is under-researched within public health (Green & Mercer, 2001; Campion, 2019). There is a need for participatory action research, with different stakeholders and groups, on psychosocial issues of concern to people (e.g., sexual assault, unemployment, discrimination) in order to reach public health solutions. Some participants felt that the relationship between social conditions and mental health needs to be further theorised. Research into psychosocial factors has been dominated by large scale epidemiological research, located within a positivist scientific paradigm, primarily focused on social comparison and shame (Pickett & Wilkinson, 2015). Further research is needed that focuses on personal narratives and the meanings people give to experiences of social inequality, in order to enhance understanding of the impact on mental distress.

There were different perspectives on the potentially political nature of prevention work that aims to change social conditions, and the involvement of clinical psychologists in this. Further qualitative research that aims to elucidate clinical psychologists' relationship with politics, and the advantages and dilemmas associated with this, would be useful to ascertain whether concerns related to this are a barrier for preventative action on social determinants. Finally, the findings of this study indicate that these psychologists have adopted an approach of 'fitting in' where they can bring about change, primarily drawing on existing psychological skills and knowledge to develop interventions. Less is known about the effectiveness of interventions which are most likely to improve the wider determinants of health, a problem which has been described as 'inverse evidence

law' (Ogilvie et al., 2005). The findings support the assertion that a shift in research priorities from aetiology and treatment to prevention programmes is required to meet the challenge of widespread health inequalities (Harper, 2017). This would the facilitate the development of a more systematic approach to the delivery of public mental health and intervening in the social determinants of distress.

5. Conclusion

This research aimed to explore how psychologists understand the concept of prevention when applied to mental health, what models and theories inform work in this area and what role there is for action on the social determinants of mental health. The main findings indicate that there are a range of understandings of prevention and its relationship to other concepts within public mental health. Participants' explanatory models of mental health and associated values about where change should occur appeared to inform understandings of prevention. These psychologists appeared to have taken an approach of fitting in where they could bring about change and had employed a range of psychological skills, models, and theories in their prevention activities. A problem-driven approach, involving assessment, formulation and application of psychological theory appeared to be useful for developing preventative solutions to complex psychosocial issues. Most felt that there was a need for prevention efforts to address the wider determinants of mental health and some had found ways to do this through cross-sector working, increasing access to vital services, and influencing decision makers. The findings indicate the value of the psychology skillset in contributing to the development of a public mental health approach. Implications and recommendations for future research, clinical psychology training and practice, further integration of applied psychology, and the field of public mental health were made.

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APPENDIX A: UEL ETHICAL APPROVAL APPLICATION

UNIVERSITY OF EAST LONDON
School of Psychology

APPLICATION FOR RESEARCH ETHICS APPROVAL
FOR RESEARCH INVOLVING HUMAN PARTICIPANTS
(Updated October 2019)

FOR BSc RESEARCH
FOR MSc/MA RESEARCH
FOR PROFESSIONAL DOCTORATE RESEARCH IN CLINICAL, COUNSELLING & EDUCATIONAL PSYCHOLOGY

1. Completing the application

1.1 Before completing this application please familiarise yourself with the British Psychological Society's Code of Ethics and Conduct (2018)and the UEL Code of Practice for Research Ethics (2015-16). Please tick to confirm that you have read and understood t✓e codes:

1.2 Email your supervisor the completed application and all attachments as ONE WORD DOCUMENT. Your supervisor will then look over your application.

1.3 When your application demonstrates sound ethical protocol, your supervisor will submit it for review. It is the responsibility of students to check this has been done.

1.4 Your supervisor will let you know the outcome of your application. Recruitment and data collection must NOT commence until your ethics application has been approved, along with other research ethics approvals that may be necessary (see section 8).

1.5 Please tick to confirm that the following appendices have been completed. Note: templates for these are included at the end of the form.

- The participant invitation letter ✓
- The participant consent form ✓
- The participant debrief letter ✓

1.6 The following attachments should be included if appropriate:

- Risk assessment forms (see section 6)
- A Disclosure and Barring Service (DBS) certificate (see section 7)
- Ethical clearance or permission from an external organisation (see section 8)
- Original and/or pre-existing questionnaire(s) and test(s) you intend to use
- Interview protocol for qualitative studies
- Visual material(s) you intend showing participants.

2. Your details

2.1 Your name: Orla Gibbons

2.2 Your supervisor's name: Professor David Harper

2.3 Title of your programme: Professional Doctorate in Clinical Psychology

2.4 UEL assignment submission date (stating both the initial date and the resit date):

May 2021 (no resit date)

3. Your research

Please give as much detail as necessary for a reviewer to be able to fully understand the nature and details of your proposed research.

3.1 The title of your study:

Conceptualisations of public mental health: The role of primary prevention and the social determinants of mental health

Your research questions:

How do psychologists/public health practitioners involved in prevention work understand the concept of 'mental health prevention'?

What kinds of mental health prevention work are they involved in?

What models and theories inform the work of psychologists/public health practitioners involved in this area?

How do psychologists/public health practitioners involved in prevention work understand and respond to the social determinants of mental health?

3.2

3.3 Design of the research:

The study will involve qualitative methodology using one-to-one semi-structured interviews. Eight to twelve interviews will take place.

3.4 Participants:

Participants will be psychologists working in the area of Mental Health Prevention. This will include both clinical and community psychologists and/or Public Health Practitioners.

3.5 Recruitment:

Participants will be recruited through contacts known to the researcher and via online social media groups related to the area of mental health prevention. Whilst some participants may work in the NHS participants will not be recruited via their workplace or in relation to their role within an NHS service.

3.6 Measures, materials or equipment:

An interview schedule will be used for the interviews. An audio-recorder will be used to record the interviews, transcripts will be typed and stored on a password protected computer.

3.7 Data collection:

Data will be gathered via a semi-structured interview. An interview schedule using questions related to the research questions with additional prompts will be used to facilitate discussion. Interviews will last up to 60 minutes. They will be conducted via the telephone or using Microsoft Teams software. Should the current situation with Covid-19 improve and restrictions regarding social distancing are lifted then interviews in person, at the workplace of the interviewee, will be offered as an option, as well as telephone/Microsoft Teams.

3.8 Data analysis:

The interviews will be transcribed and analysed using Thematic Analysis.

4. Confidentiality and security

It is vital that data are handled carefully, particularly the details about participants. For information in this area, please see the UEL guidance on data protection, and also the UK government guide to data protection regulations.

4.1 Will participants data be gathered anonymously?

Data will be collected via interviews and therefore will not be anonymised at the point of data collection.

4.2. If not (e.g., in qualitative interviews), what steps will you take to ensure their anonymity in the subsequent steps (e.g., data analysis and dissemination)?

Steps to be taken to ensure the participant's anonymity are described below.

4.2 How will you ensure participants details will be kept confidential?

Transcripts will be anonymised and all identifying information will be changed, with pseudonyms used instead of names. Participants will be informed that quotes from their interview may be used during dissemination of the findings but that they will only be referred to by a pseudonym and no information that might identify them will be included.

4.3 How will the data be securely stored?

The recording of the interview and the transcripts will be stored in password-protected files on a password-protected computer. A list of names and contact details will be stored separately from the sound files and transcripts.

4.4 Who will have access to the data?

Only researcher, research supervisor and thesis examiners will have access to the recorded interviews and transcripts.

4.5 How long will data be retained for?

The audio file and transcript will be saved onto a computer that is password protected and secure. After thesis examination, the audio recordings will be deleted. The transcripts will be kept for three years and may be used for subsequent publications.

5. Informing participants

Please confirm that your information letter includes the following details:

5.1 Your research title: ✓

5.2 Your research question: ✓

5.3 The purpose of the research: ✓

5.4 The exact nature of their participation. This includes location, duration, and the tasks etc. involve ✓

5.5 That participation is strictly voluntary: ✓

5.6 What are the potential risks to taking part: ✓

5.7 What are the potential advantages to taking part: ✓

5.8 Their right to withdraw participation (i.e., to withdraw involvement at any point, no questions as ✓:

5.9 Their right to withdraw data (usually within a three-week window from the time of their participati ✓

5.10 How long their data will be retained for: ✓

5.11 How their information will be kept confidential: ✓

5.12 How their data will be securely stored: ✓

5.13 What will happen to the results/analysis: ✓

5.14 Your UEL contact details: ✓

5.15 The UEL contact details of your supervisor: ✓

Please also confirm whether:

5.16 Are you engaging in deception? If so, what will participants be told about the nature of the research, and how will you inform them about its real nature.

The proposed research involves no deception.

5.17 Will the data be gathered anonymously? If NO what steps will be taken to ensure confidentiality and protect the identity of participants?

Following the interviews the transcripts of the recordings will be anonymised and pseudonyms used. All subsequent reporting of all participants' data will be anonymised. This will be made clear in both the information sheet and consent form. The recording of the interview and the transcripts will be stored in password-protected files on a password-protected computer. A list of names and contact details will be stored separately from the sound files and transcripts on a password protected computer. Original recordings will be deleted following examination.

5.18 Will participants be paid or reimbursed? If so, this must be in the form of redeemable vouchers, not cash. If yes, why is it necessary and how much will it be worth?

Participants will not be paid or reimbursed.

6. Risk Assessment

Please note: If you have serious concerns about the safety of a participant, or others, during the course of your research please see your supervisor as soon as possible. If there is any unexpected occurrence while you are collecting your data (e.g. a participant or the researcher injures themselves), please report this to your supervisor as soon as possible.

6.1 Are there any potential physical or psychological risks to participants related to taking part? If so, what are these, and how can they be minimised?

There are no known risks of physical injury to participants. Participants may become upset if they talk about topics that are distressing. The researcher will look out for any signs that someone is becoming upset and will ask the participant if they would like the interview to be paused for the participant to have a break. They will be given the option to continue or to end the interview. Participants will be advised that they can speak to their

supervisor or line manager if they have any concerns following the interview. Support services will also be recommended in the debrief letter.

6.2 Are there any potential physical or psychological risks to you as a researcher? If so, what are these, and how can they be minimised?

There are no specific risks to the researcher. Interviews will be conducted via telephone/Microsoft Teams or at a location agreed by the researcher and the interviewee. The researcher's director of studies will be aware of the location and times of any interviews taking place in person. Steps agreed with the research supervisor include letting a responsible person know who the researcher is meeting and where, what time the interview will finish, telling them the researcher will call them after the interview to let them know the interview has concluded and what they should do if the researcher does not contact (e.g. they should call the researcher or the interview location).

6.3 Have appropriate support services been identified in the debrief letter? If so, what are these, and why are they relevant?

At the end of the interview, participants will be given a list of support organisations, such as the Samaritans, they could contact if they require further information or support.

6.1 Does the research take place outside the UEL campus? If so, where?

If so, a 'general risk assessment form' must be completed. This is included below as appendix 4. Note: if the research is on campus, or is online only, this appendix can be deleted. If a general risk assessment form is required for this research, please tick to confirm that this has been comp ✓ d:

6.2 Does the research take place outside the UK? If so, where?

If so, in addition to the 'general risk assessment form', a 'country-specific risk assessment form' must be also completed (available in the Ethics folder in the Psychology Noticeboard), and included as an appendix. If that applies here, please tick to confirm that this has be ☐ ncluded:

However, please also note:

- For assistance in completing the risk assessment, please use the AIG Travel Guard website to ascertain risk levels. Click on 'sign in' and then 'register here' using policy # 0015865161. Please also consult the Foreign Office travel advice website for further guidance.
- For *on campus* students, once the ethics application has been approved by a reviewer, all risk assessments for research abroad must then be

signed by the Head of School (who may escalate it up to the Vice Chancellor).

- For *distance learning* students conducting research abroad in the country where they currently reside, a risk assessment must be also carried out. To minimise risk, it is recommended that such students only conduct data collection on-line. If the project is deemed low risk, then it is not necessary for the risk assessments to be signed by the Head of School. However, if not deemed low risk, it must be signed by the Head of School (or potentially the Vice Chancellor).
- Undergraduate and M-level students are not explicitly prohibited from conducting research abroad. However, it is discouraged because of the inexperience of the students and the time constraints they have to complete their degree.

7. Disclosure and Barring Service (DBS) certificates

7.1 Does your research involve working with children (aged 16 or under) or vulnerable adults (*see below for definition)?

YES / NO

7.2 If so, you will need a current DBS certificate (i.e., not older than six months), and to include this as an appendix. Please tick to confirm that you have included this: ☐

Alternatively, if necessary for reasons of confidentiality, you may email a copy directly to the Chair of the School Research Ethics Committee. Please tick if you have done this instead: ☐

Also alternatively, if you have an Enhanced DBS clearance (one you pay a monthly fee to maintain) then the number of your Enhanced DBS clearance will suffice. Please tick if you have included this instead: ☐

7.3 If participants are under 16, you need 2 separate information letters, consent form, and debrief form (one for the participant, and one for their parent/guardian). Please tick to confirm that you have included these: ☐

7.4 If participants are under 16, their information letters consent form, ☐

and debrief form need to be written in age-appropriate language. Please tick to confirm that you have done this

* You are required to have DBS clearance if your participant group involves (1) children and young people who are 16 years of age or under, and (2) 'vulnerable' people aged 16 and over with psychiatric illnesses, people who receive domestic care, elderly people (particularly those in nursing homes), people in palliative care, and people living in institutions and sheltered accommodation, and people who have been involved in the criminal justice system, for example. Vulnerable people are understood to be persons who are not necessarily able to freely consent to participating in your research, or who may find it difficult to withhold consent. If in doubt about the extent of the vulnerability of your intended participant group, speak to your supervisor. Methods that maximise the understanding and ability of vulnerable people to give consent should be used whenever possible. For more information about ethical research involving children click here.

8. Other permissions

9. Is HRA approval (through IRAS) for research involving the NHS required? Note: HRA/IRAS approval is required for research that involves patients or Service Users of the NHS, their relatives or carers as well as those in receipt of services provided under contract to the NHS.

NO If yes, please note:

- You DO NOT need to apply to the School of Psychology for ethical clearance if ethical approval is sought via HRA/IRAS (please see further details here).
- However, the school *strongly discourages* BSc and MSc/MA students from designing research that requires HRA approval for research involving the NHS, as this can be a very demanding and lengthy process.
- If you work for an NHS Trust and plan to recruit colleagues from the Trust, permission from an appropriate manager at the Trust must be sought, and HRA approval will probably be needed (and hence is likewise strongly discouraged). If the manager happens to not require HRA approval, their written letter of approval must be included as an appendix.
- IRAS approval is not required for NHS staff even if they are recruited via the NHS (UEL ethical approval is acceptable). However, an application will still need to be submitted to the HRA in order to obtain R&D approval. This is in addition to a separate approval via the R&D department of the NHS Trust involved in the research.

- IRAS approval is not required for research involving NHS employees when data collection will take place off NHS premises, and when NHS employees are not recruited directly through NHS lines of communication. This means that NHS staff can participate in research without HRA approval when a student recruits via their own social or professional networks or through a professional body like the BPS, for example.

9.1 Will the research involve NHS employees who will not be directly recruited through the NHS, and where data from NHS employees will not be collected on NHS premises?

NO

9.2 If you work for an NHS Trust and plan to recruit colleagues from the Trust, will permission from an appropriate member of staff at the Trust be sought, and will HRA be sought, and a copy of this permission (e.g., an email from the Trust) attached to this application?

NO

9.3 Does the research involve other organisations (e.g. a school, charity, workplace, local authority, care home etc.)? If so, please give their details here.

NO

Furthermore, written permission is needed from such organisations if they are helping you with recruitment and/or data collection, if you are collecting data on their premises, or if you are using any material owned by the institution/organisation. If that is the case, please tick here to confirm that you have included this written permission as an appendix:

Please note that even if the organisation has their own ethics committee and review process, a School of Psychology SREC application and approval is still required. Ethics approval from SREC can be gained before approval from another research ethics committee is obtained. However, recruitment and data collection are NOT to commence until your research has been approved by the School and other ethics committee/s as may be necessary.

9. Declarations

Declaration by student: I confirm that I have discussed the ethics and feasibility of this research proposal with my supervisor.

Student's name (typed name acts as a signature): Orla Gibbons

Student's number: U1826614 Date: 20/4/20

Supervisor's declaration of support is given upon their electronic submission of the application.

APPENDIX B – UEL ETHICAL APPROVAL LETTER

School of Psychology Research Ethics Committee

NOTICE OF ETHICS REVIEW DECISION

For research involving human participants

BSc/MSc/MA/Professional Doctorates in Clinical, Counselling and Educational Psychology

REVIEWER: Fiorentina Sterkaj

SUPERVISOR: **David Harper**

STUDENT: Orla Gibbons

Course: Professional Doctorate in Clinical Psychology

Title of proposed study: Conceptualisations of public mental health: The role of primary prevention and the social determinants of mental health

DECISION OPTIONS:

1. **APPROVED:** Ethics approval for the above named research study has been granted from the date of approval (see end of this notice) to the date it is submitted for assessment/examination.

2. **APPROVED, BUT MINOR AMENDMENTS ARE REQUIRED BEFORE THE RESEARCH COMMENCES** (see Minor Amendments box below)**:** In this circumstance, re-submission of an ethics application is not required but the student must confirm with their supervisor that all minor amendments have been made before the research commences. Students are to do this by filling in the confirmation box below when all amendments have been attended to and emailing a copy of this decision notice to her/his supervisor for their records. The supervisor will then forward the student's confirmation to the School for its records.

3. **NOT APPROVED, MAJOR AMENDMENTS AND RE-SUBMISSION REQUIRED** (see Major Amendments box below)**:** In this circumstance, a revised ethics application must be submitted and approved before any research takes place. The revised application will be reviewed by the same

reviewer. If in doubt, students should ask their supervisor for support in revising their ethics application.

DECISION ON THE ABOVE-NAMED PROPOSED RESEARCH STUDY
(Please indicate the decision according to one of the 3 options above)

Approved

Minor amendments required *(for reviewer)*:

Discuss the recruitment process with supervisor to ensure appropriate contact strategy for known participants. Typo on second research question, do not to.

Major amendments required *(for reviewer):*

Confirmation of making the above minor amendments *(for students)*:

I have noted and made all the required minor amendments, as stated above, before starting my research and collecting data. Student's name: Orla Gibbons Student number: u1826614 Date: 01/06/20 *(Please submit a copy of this decision letter to your supervisor with this box completed, if minor amendments to your ethics application are required)*

ASSESSMENT OF RISK TO RESEACHER *(for reviewer)*

Has an adequate risk assessment been offered in the application form?

YES

Please request resubmission with an adequate risk assessment

If the proposed research could expose the researcher to any of kind of emotional, physical or health and safety hazard? Please rate the degree of risk:

☐ HIGH

Please do not approve a high risk application and refer to the Chair of Ethics. Travel to countries/provinces/areas deemed to be high risk should not be permitted and an application not approved on this basis. If unsure please refer to the Chair of Ethics.

	MEDIUM (Please approve but with appropriate recommendations)
X	LOW

Reviewer comments in relation to researcher risk (if any).

Reviewer *(Typed name to act as signature)*: Dr F Sterkaj

Date: 19/05/20

This reviewer has assessed the ethics application for the named research study on behalf of the School of Psychology Research Ethics Committee

RESEARCHER PLEASE NOTE:

For the researcher and participants involved in the above named study to be covered by UEL's Insurance, prior ethics approval from the School of Psychology (acting on behalf of the UEL Research Ethics Committee), and confirmation from students where minor amendments were required, must be obtained before any research takes place.

For a copy of UELs Personal Accident & Travel Insurance Policy, please see the Ethics Folder in the Psychology Noticeboard

APPENDIX C: PARTICIPANT INFORMATION

PARTICIPANT INFORMATION

Invitation to participate in a research study

The purpose of this letter is to invite you to participate in a research study being conducted as part of a Doctorate in Clinical Psychology at the University of East London. Before you agree it is important that you understand what your participation would involve, please take time to read the following information carefully.

What is the research about? The aim of the research is to explore how practitioners involved in prevention work understand the concept of prevention, what psychological models and theories they draw on in this work and their use of government policy on public mental health. My research has been approved by the School of Psychology Research Ethics Committee. This means that my research follows the standard of research ethics set by the British Psychological Society.

What will your participation involve? If you chose to take part in the research, you will be invited to an interview to discuss your understanding of the concept of prevention. Individual semi-structured interviews will be facilitated by the researcher, Orla Gibbons. The approximate time available to conduct the interview will be agreed at the start. I will not be able to pay you for participating in my research, but your participation would be very valuable in helping to develop knowledge and understanding of my research topic

Your taking part will be safe and confidential You are free to decide whether or not to participate and should not feel coerced. Your privacy and safety will be respected at all times. There are no known risks or dangers involved in taking part. Participants do not have to answer all questions asked of them and can stop their participation at any time. Participants will not be identified by the data collected, on any written material resulting from the data collected, or in any write-up of the research.

What will happen to the information that you provide?

- Interviews will be recorded on a digital recorder and transcribed by the researcher, Orla Gibbons.
- All names and identifiable information will be anonymised in the transcripts. Anonymized quotations from the interviews will be used in the write up of the research.
- The anonymized transcripts may be read by the researcher's supervisor at the University of East London and examiners assessing the thesis.

- A list of names and contact details will be stored, on a password protected computer, separately from the sound files and transcripts.
- The audio file and transcript will be saved on a computer that is password protected. After examination, audio recordings will be deleted. The anonymised transcripts will be kept for three years and may be used for additional articles or publications based on the research.
- The finished research will be in the form of an academic thesis but additional articles may be submitted for publication in academic journals.

What if you want to withdraw? You are not obliged to take part in this study and should not feel coerced. Should you choose to participate, you are free to withdraw at any time without any obligation to give a reason. After the interview has taken place, you may also request to withdraw all or part of your data from the study, provided that this request is made within 3 weeks of the data being collected (after which point the data analysis will begin, and withdrawal will not be possible).

Contact Details

Please contact me by email if you have any questions or would like to discuss this study further [MY UEL EMAIL].

If you have any questions or concerns about how the research has been conducted please contact the research supervisor [SUPERVISOR'S NAME]. School of Psychology, University of East London, Water Lane, London E15 4LZ, Email: [SUPERVISOR'S EMAIL]

or

Chair of the School of Psychology Research Ethics Sub-committee: Dr Tim Lomas, School of Psychology, University of East London, Water Lane, London E15 4LZ. (Email: t.lomas@uel.ac.uk)

Thank you in anticipation.

Yours sincerely,

[Name and date]

APPENDIX D: CONSENT FORM

UNIVERSITY OF EAST LONDON

Consent to participate in a research study

Conceptualisations of public mental health: The role of primary prevention and the social determinants of mental health

I have read the information sheet relating to the above research study and have been given a copy to keep. The nature and purposes of the research have been explained to me, and I have had the opportunity to discuss the details and ask questions. I understand what is being proposed and the procedures in which I will be involved have been explained to me.

I understand that my involvement in this study, and particular data from this research, will remain strictly confidential. Only the researcher involved in the study will have access to identifying data. It has been explained to me what will happen once the research study has been completed.

I hereby freely and fully consent to participate in the study that has been fully explained to me. Having given this consent I understand that I have the right to withdraw from the study at any time without disadvantage to myself and without being obliged to give any reason. I also understand that should I withdraw, the researcher reserves the right to use my anonymous data after analysis of the data has begun.

Participant's Name (BLOCK CAPITALS)
.....

Participant's Signature
.....

Researcher's Name (BLOCK CAPITALS)

.....

Researcher's Signature
.....

Date: .....

APPENDIX E: DEBRIEF LETTER

PARTICIPANT DEBRIEF LETTER

Thank you for participating in my research study on mental health prevention. This letter offers information that may be relevant in light of you having now taken part.

What will happen to the information that you have provided?

The following steps will be taken to ensure the confidentiality and integrity of the data you have provided.

- Interviews have been recorded on a digital recorder and will transcribed by the researcher, Orla Gibbons.
- All names and identifiable information will be anonymized in the transcripts. Anonymized quotations from the interviews will be used in the write up of the research.
- A list of names and contact details will be stored separately on a password protected computer separate from the sound files and transcripts.
- After the interview has taken place, you may also request to withdraw all or part of your data from the study, provided that this request is made within 3 weeks of the data being collected (after which point the data analysis will begin, and withdrawal will not be possible).
- The transcripts may be read by the researcher's supervisor at the University of East London and examiners assessing the thesis.
- The audio file and transcript will be saved on a computer that is password protected. After examination, audio recordings will be deleted. The transcripts will be kept for three years and may be used for additional articles or publications based on the research.
- The finished research will be in the form of an academic thesis but additional articles may be submitted for publication in academic journals.

What if you have been adversely affected by taking part?

It is not anticipated that you will have been adversely affected by taking part in the research and all reasonable steps have been taken to minimise potential harm. Nevertheless, it is still possible that your participation – or its after-effects – may have been challenging, distressing or uncomfortable in some way. If you have been affected in any of those ways you may wish to speak to your line manager, supervisor or Occupational Health Department. You may also find the

following resources/services helpful in relation to obtaining information and support:

The Samaritans
Telephone number: 116 123
Website: https://www.samaritans.org/how-we-can-help/contact-samaritan/
Email Address: jo@samaritans.org

You are also very welcome to contact me or my supervisor if you have specific questions or concerns.

Contact Details

If you would like further information about my research or have any questions or concerns, please do not hesitate to contact me.
Email: [MY UEL EMAIL].

If you have any questions or concerns about how the research has been conducted please contact the research supervisor [SUPERVISOR'S NAME].
School of Psychology, University of East London, Water Lane, London E15 4LZ,
Email: [SUPERVISOR'S EMAIL]

or

Chair of the School of Psychology Research Ethics Sub-committee: Dr Tim Lomas.
School of Psychology, University of East London, Water Lane, London E15 4LZ.
Email: t.lomas@uel.ac.uk

APPENDIX F: INTERVIEW SCHEDULE

Interview Schedule

Introduction

Thank you for agreeing to take part in this study. The study aims to understand Clinical Psychologists' involvement in public health and prevention approaches to mental health. This is a broad area which can encompass a range of different kinds of work, but which usually refers to efforts to prevent the development of mental health difficulties, rather than the dominant approach of providing psychological treatment after problems have arisen. It can include work termed 'upstream' interventions, population level approaches and policy work. I am interested in hearing your thoughts on this wide area and how you understand and think about the areas of prevention and public mental health.

Conceptualisation of Mental Health Prevention

What do you understand by the term 'Mental Health Prevention'?

Prompts: *What models or psychological theories do you draw on? Are you aware of the classifications of primary, secondary and tertiary prevention? How does this relate to the evidence base on the social determinants of mental health?*

Examples of Prevention Work

Could you briefly outline your role? Could you describe an example of mental health prevention work that you have been involved in?

Prompts: *Proportion of time? What needed to change? What were the steps involved? Any work that would be termed primary prevention? Any work addressing social determinants? What were the outcomes?*

Use of Policy

Do you draw on any policy related to prevention or the social determinants of mental health?

Prompts: e.g. *The Marmot review, The Prevention Concordant, NHS Long Term Plan. Does this inform your work? In what way? If not why do you think this is?*

Facilitators and Barriers

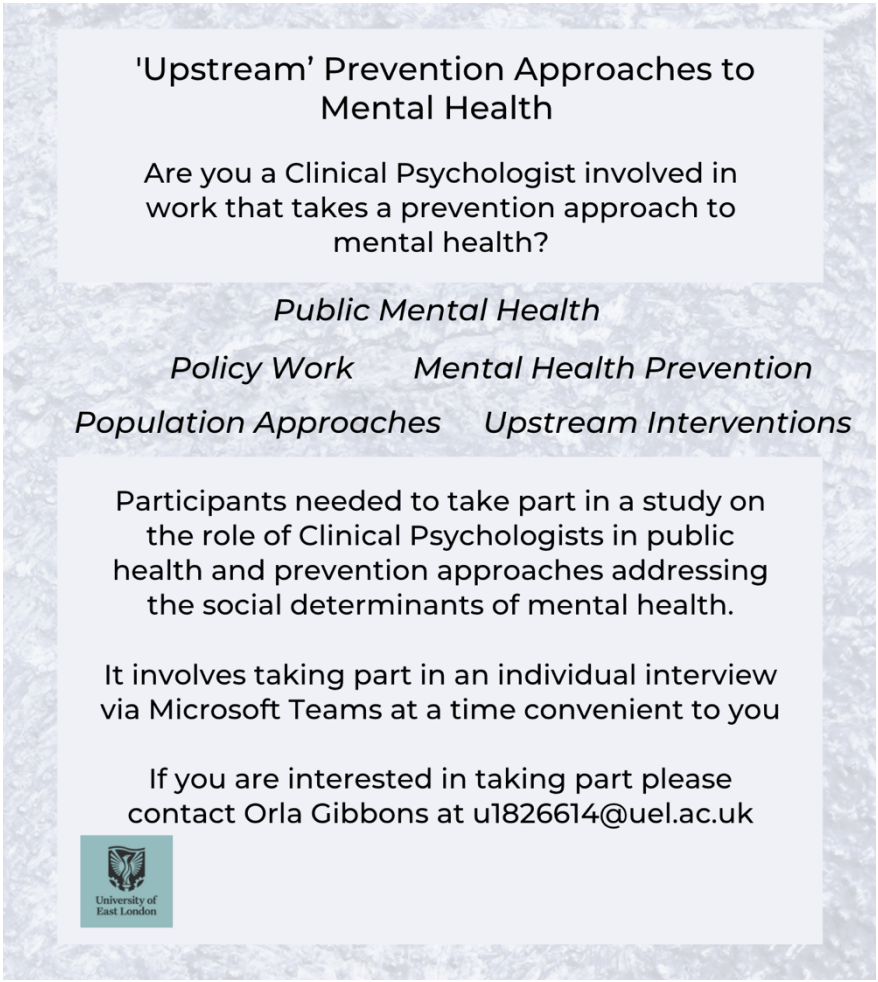
What aspects have gone well? Has there been anything that got in the way of your work?

Prompts: *How did you deal with this? What personal or professional skills were involved? What can psychology contribute to this area?*

Closing Section

That's all of my questions. Do you have any other thoughts about this topic?

APPENDIX G: RECRUITMENT INFORMATION



APPENDIX H – DEMOGRAPHICS FORM

Participants Information

Please could you provide the following brief information about yourself and your work.

Job title:

Gender:

Ethnicity:

Please indicate the area(s) of public health or prevention work you are involved in:

Early Years	
Parenting Programmes	
School Based	
Workplace and Employment	
Housing	
Debt	
Violence and Abuse	
Social Isolation	
Wellbeing Promotion	
Mental Health Stigma	
Mental Health First Aid	
Policy Level	
Other (Please specify)	

APPENDIX H: CODED EXCERPT

Sandra: The way I see it is that we've all got mental health. We all need to look after it…working preventatively, we can't prevent mental health….we've all got it, but we can work to really think about the kind of the social determinants of mental health and really work at kind of a population level…thinking about the things that impact on people's wellbeing that then leads to much more pronounced mental health problems. And rather than focusing our attention on kind of individual therapy and other things for people that have, you know, maybe experienced multiple traumas and the like…and having a very understandable reaction to very difficult circumstances. It's about kind of almost going up the stream and having a look 'Ok what is happening here and how can we prevent or decrease the likelihood of that occurring'. You can take it at a kind of early intervention, self help, kind of level before people get more unwell or need services. You can take it a step further and really kind of have a look at what we know are the really big influences on people's mental health and wellbeing. And you know, for me, that's the kind of preventive end that I'm particularly keen to think about. Again, things like employment, I think there's a real role for supporting around employment programs. That can have a massive impact on people's wellbeing. Then kind of helping services or helping you know, say employers, if they're making people redundant to really think about you know linking with them so they get the right helpful messages out to people nice and early. So again, all those kind of things that are kind of a step before. **Interviewer:** So for you it's about looking at the influences of mental health and doing work there. Does that relate to the kind of work you do in your role? **Sandra:** Yeah, So I work for [names of services]. In that role I use my clinical psychology skills to work on a variety of public health programs which I guess by its very nature is all about population health and wellbeing. It's obviously very heavily slanted towards kind of prevention and those kind of more upstream ways of working with people rather than at the kind of service end of things. Within the NHS my remit is the same, to really use my psychology skill set to support a range of different services to think about, that preventative angle, but using kind of a psychology behaviour change skill set to kind of undertake those programs in collaboration with teams, services, that kind of thing. It's completely indirect work, and so it's not about providing any therapy. It's about kind of using our clinical psychology skill set, to kind of work indirectly and….develop assessments and bespoke interventions with organisations rather than kind of with the individual, which is perhaps the more traditional sort of service model. Something I feel is really important is	Problems with the definition of prevention Focus should be on social determinants Population level Rationale for prevention work Mental health response to social circumstances Role of trauma Going 'upstream' Early intervention Preventing need for services Prevention should be directed towards causes of mental health problems Prevention target Employment Organisation Employment practices Working across programmes Emphasis on prevention Upstream Both public health and NHS Use of psychology skills Behaviour change Indirect work

kind of sharing that narrative a bit differently around mental wellbeing and mental health and in all the different streams I'm working at helping people to recognise, you know, that when we're talking about mental wellbeing taking it away from that very medicalised model and help them think about it differently. So, I support, there's a drug and alcohol employment project and I was working with their staff team to increase engagement and helping to kind of think about some of the kind of mental health difficulties, maybe anxiety presentations you might see in a different way rather than you know - they've got 'anxiety', they've got a medical condition. That's it. We can't work with them. Kind of really thinking a bit more about well, what is it about the way we operate, or the scenario i.e. maybe anxiety around benefits in terms of entering an employment program. How can start to understand that differently? And actually let's you know, let's think about how we might address anxiety that someone might be experiencing so that actually the employment program becomes more accessible to someone rather than seeing it as a fixed diagnostic category which means someone you know is going to have a certain scenario happened to them. **Interviewer:** Are there particular ways of thinking or skills you feel you bring to that as a psychologist? Sandra: Yeah, I suppose the key thing, maybe to emphasise is that the role is very much about collaboration, both roles for me are very much about collaboration and working with teams and working…..kind of acknowledging the different specialisms you've got within services, in teams and organisations. So it's very much not a model of an expert being parachuted in at all. It's very much working alongside people….kind of co-creation of solutions, helping teams to really implement them and really using the clinical psychology skill set to think about how we kind of actually really make interventions fit, kind of in terms of local communities, fit in terms of teams and organisations rather than what you sometimes see, which feels a bit kind of 'off the shelf' - you know "this model works" and its almost just landed, but it doesn't fit. It's not embedded. There's not that real understanding of kind of where the organisation is or where that team is or where that community is…which would help you really tailor how you introduce the intervention, how you maybe try and get it off the ground, how you make it more effective. So for me I'm really interested in the 'how' you do things and in terms of kind of working with teams, really interested in working with people rather than people fear that it's being done to them which you know again in psychology, that's how we make therapy effective. We don't tell someone how to change.	Use of assessment Designing interventions Different narrative on mental health Involvement in different streams/areas Alternative to medical model Shifting understanding Working with staff Non-diagnostic Use of formulation? Employment programme Increasing access to services Collaboration Not expert Mult-disciplinary Psychological skills Importance of context Application of models/interventions Making intervention fit Importance of community context How to make interventions effective Working with organisations Change processes

APPENDIX I: EXAMPLE OF CODES WITH ASSOCIATED EXCERPT

Challenges - Lack of difference within profession	P10: The fact that you know Clinical psychologists don't match or understand the cultures I'm talking here from the middle of [region]. P10: You know.... a lot of Clinical Psychologist don't look and understand what it's like to visit your mosque. P3: I think poverty is hard for us to label and are to talk about as psychologists. I don't think we're often given the language to think about how poverty and how class impacts on the power structures of our work and the ways in which services are set up, but for me there's a really clear link between, yeah, children who have come from backgrounds of disadvantage where parents perhaps don't have the support structures that they need, and the stresses that have been placed on their lives have meant that they are unable to care for children in the way that we would hope that they would. P3: I think...we as a profession are predominantly made up of white middle class women. So I think....I can see the great work that's that's going on to think and try desperately.... far too late and often in indelicate ways, but to think a little bit more about diversifying our profession in terms of the the racial, cultural aspects of it. P3: I think for me personally.....the issue of class within Clinical Psychology is really relevant and I think it's a really big barrier for understanding of people and their lives and the way that the world works an. I think, yeah, I think that gets in the way a lot of us, recognising....yeah, the challenges that often face people work. P3: Yeah, so I think it's therefore really, really hard to recognize the barriers that people you are not in that position, might have faced. It's really hard to have a visceral understanding of what poverty might feel like. What it feels like to live in a position of disadvantage, and I think...yeah, we still haven't found ways to articulate that as a professional or reflect upon that as a profession P3: In the same way, as our profession has shown to be, hopefully I think less so now, but until very recently around race. That's a really big barrier for us being able to recognize the structural inequality's we don't....we don't recognize the ways in which we are advantaged because we don't notice those advantages, so we can't recognize and deal with them as disadvantages for other people which is a huge barrier P1: And I think that is something about the way we select and value certain bits of experience, and you know, I think that probably also feeds into some wider narratives about our profession, not really attracting the diversity that it really should do in it. And it not being representative. P9 - I guess with we come from quite a middle class population.
Challenges – no defined career	P1: Preventative mental health, it's not sort of a known…there's no set posts, so posts are often, if they are even available their short term. And obviously then there's kind of implications for services trying to

pathway, not prioritised	you know second someone out and then try and staff itself. I took on a temporary post because I really believed in this role. But obviously, yeah, yeah, not everybody would choose to do that, so I think that kind of makes it harder for people to work in a preventative area. P1: I've always had an interest, in my more traditional clinical roles I've just kind of squeezed in where I can because I knew it mattered and I cared about it. But I knew my managers and commissioners weren't possibly interested so much in that aspect of it. P1: I think some of those roles have traditionally maybe not been as well supported as they could be. You are much more likely put a consultant in a specialist service than think you should put a consultant in a kind of early intervention community based organization. So it's the way it's seen and bagged up and badged up. P1: I think under resource in mental health services generally is a massive barrier to people being about to even have the headspace to think a bit more preventatively, to think differently. To think if we didn't do it like this, how could we do it? Because to ask the team that's overstretched....it's impossible to do that. So I think, you know it's very hard as a professional to do anything differently because, you need space to do that. You need support to do that. P2: What kind of doesn't fit so well for me is my job title, so 'public health program manager', I don't identify my skill sets as necessarily being one of kind of project management, which I think all the program managers in the public health team definitely do have and that is their remit. But I think what they had to do was find the job description that kind of fit with the council priorities and the way that they usually recruit and there wasn't really the time to think about developing a specific job description for my role, which I think hopefully in the future maybe there could be scope for that. P2 : I feel the job description doesn't necessarily describe the skill sets that clinical psychologists have. I think there is some work to do on developing that, if clinical psychology is going to stay in the public health teams and be prioritized with public health teams, there needs to be a focus on prioritizing what that job description looks like and what specific skills clinical psychologists offer that are different to existing members of public health teams. P7: Psychologists should be trying to bring about social change to address the psychological suffering that they see. But they are not orientated towards it as a discipline and certainly the NHS are not oriented towards it, they're orientated towards crisis support. P7: But unfortunately, the BPS and DCP are still pretty institutionally conservative organisations, I'd love to see those organisations much more involved in supporting psychologists, clinical psychologist to do more preventative work. P8: If we're going to be in services then there should be some expectation that some of clinical psychologists' time is taken up looking at policy locally or nationally, and given time to do that within the jobs

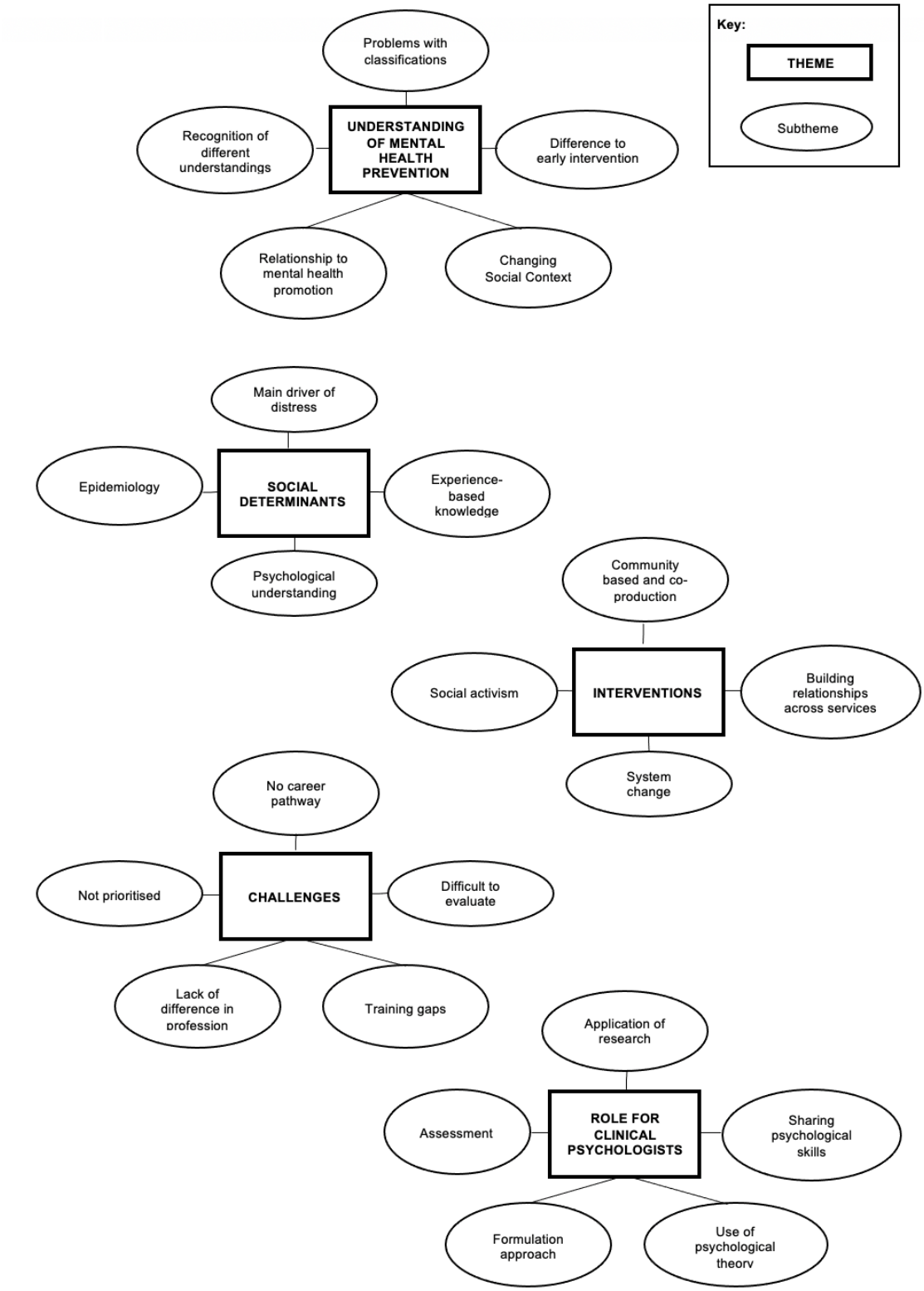
	P10: And it's a dilemma because there's a question of who would pay us to do it. Who would employ? P10: There's a 'who would appoint you to do this kind of work?' issue, if you move outside the NHS again. So a lot of issues around how you recruit and yeah, keep people decently paid, if you're going to ask them to do this.
Co-production	P4: The project has been co-produced with the young people that we work with and what that means is that…the help that we deliver has also been shaped by the community that we serve P4: We've been able to do as a project is, alongside the young people that we work with, and with the kind of the team's knowledge now after five or six years of working in this way, together with the community, we've been able to feedback at a higher system level with commissioners who are shaping services really and shaping these pathways kind of very top down level. P6: And I think what I would say is, you know we start with coproduction, we start with community groups, we start with facilitating what's on the ground. We give individuals who are distanced from power access to power. We don't expect them to exercise power, we give them access to power P7: You can be involved in facilitating and bringing together partnership work and just kind of stewarding that process to try to bring about change, sometimes it's about bringing and getting hold of resources for a group of people in order to make some of this change. P7: Bring the clinical experience together with the rich expert experience that people have by living these lives come together and work with groups of people. P7: Working directly with people who are affected by the issue you're interested in, but also with other stakeholders P9: So, there are going to be two placed based projects.... they're going to be looking at co-produced interventions into the area where we're going to be looking at reducing inequalities. So we're going to have, what we want is, you know collaboration with local communities, we also want to be able to look at 'so what are the things that are happening locally?', that might make a difference here to the inequalities. P11: We've got some different projects where we're working in a geographical locality to do essentially the clinical cycle and clinical formulation, but with co-productive principles and at a place-based level. We're bringing together key stakeholders, important members of the community…organizations that work there, voluntary sector as well as statutory sector providers, as well as education. How do we make sense of the challenges that are in the area using, you know our psychological knowledge and population skills and then how do we co-construct solutions to that?

APPENDIX J: FINAL LIST OF CODES

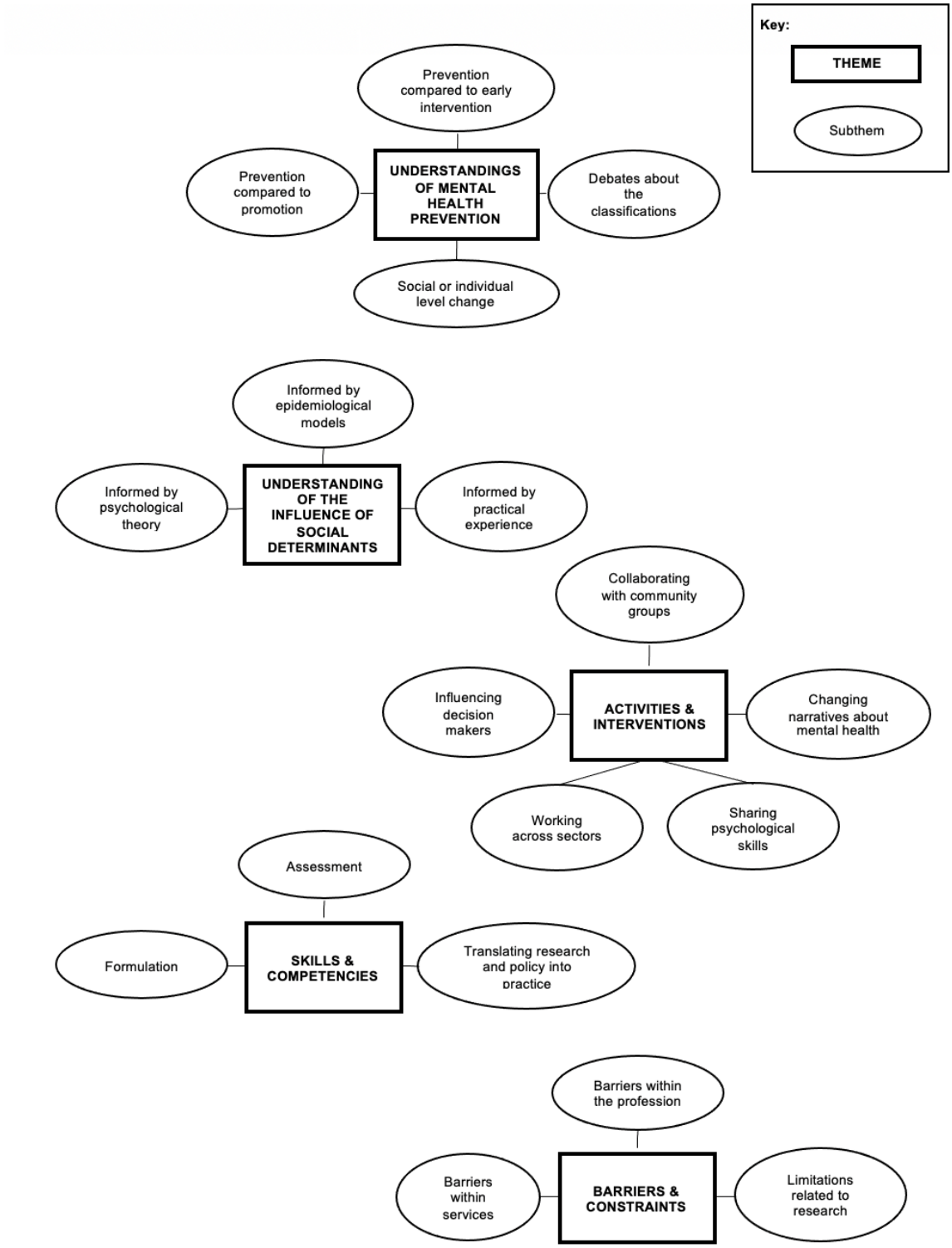
Codes	
Adverse childhood experiences	Experiential, experience
Advocacy role	Facilitating alternative understanding of mental health
Amount of time for prevention work	
Behaviour change interventions	Facilitators and support
Being a critical friend	Formulation
Biopsychosocial	Future work
Challenge of understanding prevention	Generating buy in for social determinants work
Challenges related to doing SD work	Giving a voice to other groups
Change processes	Group – adults
Changing policing	Groups - looked after children
Changing social context	Groups - young people
Clinical psychology training placement	‘Hard to reach’ groups
Collaboration	Housing
Commissioning issues	Impact of social determinants
Community organising	Improving access to services
Community psychology approach	Indicators of social determinants
Community-based	Indirect work
Complex systems work	Individual responsibility
Concept of a Clinical Psychologist	Influencing government
Consultation	Integrative, multiple theories
Co-production	Lack of difference in profession and services
Coronavirus impacted work	
Coronavirus increased awareness of inequality	Lack of funding
	Lacking skills
Coronavirus increased awareness of mental health	Language important
	Lending influence and power
Currently a fragment approach	Liberation psychology
Definition of mental health prevention	Lifestyle factors
Depression	Linking epidemiological understanding to practice
Diagnosis	
Different understanding leads to different intervention	Local authority work
	Making intervention effective
Difficult to do in current system	Mapping community resources
Early intervention	Medical
Early years work and parenting	Mental health promotion
Ecological Model	Methods for addressing social determinants
Economic factors	
Epidemiology	Moving between contexts or settings
Evaluating change difficult	Multi-level work
Evidence base – practice	Need to be 'disruptive'

Codes	
Need to be political	Recognition of different understandings of prevention
Needs to be community based	Relational
NHS and Local Authority relationship	Relationship between social determinants and behaviour
No clear career pathway	Requires cross-sector work
Non-traditional	Resilience
Other professional groups	Role for psychologists
Other ways of working	Role of power
Part of the conversation	Role of trauma
Partnership	Schools
Personal enjoyment	Science practitioner model
Personal influences	Selection bias in training
Personal interest	Service development
Personal journey	Sharing psychological information
Personal understanding of prevention	Social activism approach
Physical health	Social determinants - multiple and complex
Police	Social determinants evidence base
Policy to practice	Social Model
Political Context	Suicide prevention
Poverty	Systems work
Prevention as ‘needs met’	Target of prevention work
Prevention should address social determinants	Theory - practice
Prevention work not ‘neat’	Threshold for intervention
Primary care	‘Traditional’ prevention
Primary Prevention	Training gaps
Primary, secondary, tertiary categories	Trauma informed care
Problems with classification system	Type of prevention work
Problems with current mental health provision	Understanding community assets
Problems with dominant prevention model	Understanding the problem
Problems with the definition of prevention	Unemployment
Psychological theory	Universal
Psychologists for Social Change	Upstream
Psychologists should be involved in social determinants work	Upstream
Psychology skills	Use of assessment methods
Public Health	Useful skills
Public Mental Health	Value led
Pull to mainstream ways of working	Very broad
raining	Wellbeing
Rationale for prevention	Workforce development
	Working with different stakeholders
	Working with families
	Youth violence

APPENDIX K: INTIAL THEMATIC MAP



APPENDIX L: FINAL THEMATIC MAP



APPENDIX M: REFLEXIVE DIARY

Reflections after the Fourth Interview

I've noticed that during interviews with the individuals in public health departments its difficult to decide which examples to explore further, due to the range of work they're involved in. In the interview today they very quickly described a number of different pieces of work that were interesting. I'm reminded of the different areas this research covers and the need to keep different areas in mind at once, which at times feels a bit overwhelming when I need to make decisions about where to explore next. Someone was describing a piece of work they were doing that was related to physical health, so not directly mental health, but it was relevant to thinking about social determinants, so seemed worth exploring. I've also noticed that sometimes people want to know my thoughts on an areas, it's difficult to balance making sure the interview feels comfortable whilst making sure we stay on track and I hear just their thoughts for the research. I think this must be because not many psychologists are working in this and they're interested that someone is researching it.

Reflections During Analysis

I'm finding that as I'm reading extracts its more clear what kinds of activities might relate to working at a higher level. During the interviews sometimes I wasn't sure how I would pin down or convey some the things people are describing but now I can compare transcripts it is more apparent as there are commonalities (like trying to change understandings about the nature of mental health in different setting). This relates I think to the more 'diffuse' nature of working at different levels, compared to individual interventions which can quickly be labelled as 'therapy' or 'assessment'. I'm feeling a bit apprehensive about translating all the examples people have given about their work as I want to do it justice. Especially given this is a relatively new area for psychologists and people seems to be finding ways in this area without much guidance or service oversight. Another thought was that the policy and information coming out on this public health is developing quite quickly due to covid-19. I'm finding it quite hard to stay on top of the different developments with the changes to public health england and what the potential issues are.