A critical analysis of prevention and population health discourses in mental health policy

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ABSTRACT

Discourses around prevention and population health have been gathering momentum in UK mental health policy for over a decade. This trend has been influenced by an economic rationale, prominent reports into the social determinants of health and mental health, and pressure from national and international organisations to take a population based approach to address them. And yet despite this, there are indications that the political focus on mental health prevention has not resulted in clear preventative action.

The current study aimed to address the social problem of prevention through a critical appraisal of the discursive features of recent mental health policy. The intention was to facilitate clinical psychologists' engagement with the political context of their work. A 5 stage framework for Critical Discourse Analysis (Fairclough, 2001) was utilised to explore the underlying conceptual frameworks of relevant policies, and the impact these had on the way preventative action was operationalised. This was undertaken from a critical realist epistemological position.

On the basis of a historical analysis into prevention and population health discourses, two representative policies were selected for more detailed discursive analysis. These were Advancing our Health: Prevention in the 2020s (Department of Health and Social Care, 2019) and the NHS Mental Health Implementation Plan 2019/20 – 2023/24 (NHS England, 2019a). The analysis indicated that potential discursive obstacles to preventative action could be found in; how the target of prevention was conceptualised, conflicting notions of responsibility for prevention, and the malleability of the concept of prevention itself. This was discussed in reference to the network of policy structures and practices that also present a barrier to prevention. Implications for clinical psychologists in terms of individual, community and policy level actions were considered.

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1. INTRODUCTION

1.1. THE ROLE OF POLICY IN CLINICAL PSYCHOLOGY PRACTICE

Social policy is integral to the structure of mental health service provision and the work of clinical psychologists in the UK. The majority of clinical psychology training may focus on specific therapeutic competencies, the individual attributes, and the values of therapists (British Psychological Society, 2019c), emphasising the individual as both the locus of control and the focus of intervention in clinical psychology practice. However, this often belies the experience of clinical psychologists entering the workforce, who find their practice heavily shaped by the service models, culture and policies within which they work (Browne et al., 2020).

The need for clinical psychologists to broaden the lens of their practice can be considered from the perspective of ecological systems theory, which has been utilised in a range of settings to highlight the spheres of influences on people beyond their individual human connections (Bronfenbrenner, 1992; Eriksson et al., 2018). Richard et al. (2011) summarised the progressively more distal levels within ecological systems theory as intrapersonal, interpersonal, organisational, community and political. If applied to clinical psychology practice, one might conceptualise individual psychologist's knowledge, values and attributes as the intrapersonal level. The interpersonal level may be considered the interaction between these and the attributes of colleagues and service users within the workplace. Taking a wider view, organisational influences may include the policies and procedures within a particular mental health service, which constrain practitioners' immediate working environment.

More distal still are the social policies laid down by government, which can be viewed as the political level identified by Richard et al. (2011), and exert substantial influence over the

systems within which clinical psychologists work. It is clear that clinical psychology practice is not conducted in a vacuum, and government policy relating to mental health is a vehicle by which political power is exerted upon the profession (Patel, 2020; Rose & Miller, 1992; Wodak, 2001). Mechanisms for this include policy's potential to; define the problem being addressed by mental health services (McWade, 2016), outline how services are organised, set the priorities for funding and resourcing (Callaghan et al., 2017), dictate the makeup of the workforce (NHS England, 2019a), and decide the targets by which services are judged (Dalal, 2018).

Yet despite this, the competencies for clinical psychology training do not necessarily reflect the integral role that policy has on shaping clinical psychology practice and the mental distress or wellness of the population, nor do they emphasise clinical psychology's role in addressing this at a policy level (British Psychological Society, 2019c; Rahim & Cooke, 2020). Clinical psychologists could therefore benefit from engaging in the critical appraisal of key mental health policies and their rhetoric, development and directions. This could facilitate a greater understanding of their professional context, the influences upon this, and the potential conflicts they may encounter as a result. The following section begins by introducing some recent trends within policy that currently shape clinical psychology practice.

1.2. BROAD TRENDS WITHIN MENTAL HEALTH POLICY

Mental health policy has been shown to circumscribe the work of clinical psychologists. Therefore, awareness of the context and direction of policy can help clinical psychologists understand and navigate the systems they are part of. This section will give an introduction to recent mental health policies and their broad themes, including the inter-related policy narratives that exist alongside prevention and population health discourses.

When considering mental health policy development in recent years, Moth (2020) outlines three phases. The first is represented by the period 1990-1997, which was dominated by

the NHS and Community Care Act (National Health Service and Community Care Act, 1990), brought in by a Conservative administration and focusing on increased choice, consumer rights, and the marketisation of services. The second is the following period of 1997-2008, during which these notions continued to be built upon, with additional focus on modernisation and centralisation as key aspects of policy. Thirdly, following the financial crisis of 2008, policy from this time to the beginning of the 2020s has been coloured by austerity and reduced spending on welfare. This period was characterised by "policy discourses promoting personalization, individualized conceptions of well-being, recovery as 'self care and resilience' and social inclusion through labour market engagement" (Moth, 2020, p. 135).

Moth (2020) characterises the aforementioned policy directions from the 1990s onwards as an outcome of a neoliberal policy context. Neoliberalism represents the overarching social order of current politics within the UK, both on the right and left of the political spectrum (Fairclough, 2001). As opposed to the Keynesian welfare capitalism that preceded it, which advocated for comprehensive state provision of public services, neoliberal capitalism places value on free market competition and views this as the most efficient means by which to allocate resources. It is therefore characterised by a decreasing role of state intervention in both economic and social arenas. Cosgrove & Karter (2018) note that the reach of neoliberalism doesn't end with economic policy, and can be thought of as the dominant attitude to science, knowledge, and subjectivity in the UK. Its assumptions therefore extend into the values held within society, our understandings of mental health, and the make-up of services to address it.

As a policy from the most recent phase identified by Moth (2020) The Coalition Government's No Health without Mental Health (NHWMH; Department of Health, 2011) established their intentions in relation to mental health, widening the net of mental health services to include the experience of wellbeing, parity of esteem between mental and physical health, and improved physical health for those with mental health problems. The term 'recovery' was liberally stated as the desired outcome of mental health support, and for the purposes of the policy was defined as, "A deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills and/or roles. It is a way of living a

satisfying, hopeful and contributing life, even with limitations caused by the illness." (Department of Health, 2011, p. 16). A neoliberal lens within this conceptualisation of recovery has been highlighted, which responsiblises individuals in the management of their distress. Being empowered to make changes in one's life could be very meaningful and positive for someone's quality of life, if they are in a position to be able to make these changes. However, this conceptualisation of recovery does obscure the role of the state in either creating the conditions for wellbeing, or supporting the amelioration of mental distress (Harper & Speed, 2012; Thomas et al., 2018; Tilley & Cowan, 2011).

The theme of responsibilisation is present in other areas of NHWMH. In line with its Big Society ideals, the policy's aims were to be achieved through service user involvement in the development of services, volunteerism, and by local decision making to personalise the mental health offer. The vision was of socially cohesive, strengthened community getting together to resolve issues for themselves, as opposed to intensive state involvement. However, Scott (2015) points out that without corresponding investment in state provision, this form of localism can fall short of the empowering message that it suggests, and instead become burdensome for local communities that are already struggling to thrive under neoliberal policies.

Scott (2015) also suggests that policies from this period have drawn on a particular view of wellbeing, through which individual choice and control are conceptualised as the route to quality of life. Personalisation and choice of treatment is therefore presented as a self-evidently positive thing, with service users judged to be able to make the use of such choices in the management of their own wellbeing through individual treatment. In many instances this will be possible for people, particularly those experiencing more mild forms of distress and who have access to the information and economic means to make use of increased choice. For example, this might allow someone experiencing mild depressed mood, who has a good understanding of the therapeutic options available to them, to select an appropriate model and a delivery method that can fit around their lifestyle, for example remote cognitive behavioural therapy (CBT) accessed via a laptop. However, Fotaki (2014) suggests that access to the information and resources to make the most beneficial healthcare choice can be influenced by education and income, inequalities in which can

then deepen inequalities in health. In addition, what is not being prioritised by this conceptualisation of wellbeing is also problematic, for example the responsibility of government social policy to create the conditions for individuals to thrive.

This is reflected in the type of treatments on offer, with evidence based, National Institute for Health and Care Excellence (NICE) recommended, and therefore individualised interventions such as CBT featuring heavily. While these forms of support certainly have positive attributes and a place in the provision of mental healthcare, they also have limitations if taken as the main approach to managing mental distress in the population, which will be discussed more fully in later sections of the study. One area of critique levelled at the evidence base for CBT relates to the diagnostic, biomedical assumptions that it rests upon (Thomas et al., 2018). This pertains to another feature of mental health policy that continues to be dominant in this period, namely the biomedical approach to distress which positions mental health as analogous to physical health. Parallels between the two are regularly drawn in concepts and language utilised in mental health policy, such as diagnoses, individualised treatment, symptom management, preponderance of medical professionals, and medical settings such as hospitals. It is argued that this conceptualisation of mental health presents a reductive, individualised view of mental health, which again conceals the social and environmental context from which mental distress originates (Johnstone & Boyle, 2018; Mollon, 2009; Read et al., 2009; Thomas et al., 2018).

Later in the Coalition administration, the themes of service marketisation, self-care, individual choice and control, responsiblisation, volunteerism, evidence based practice and biomedical discourses remain prominent aspects of the Five Year Forward View (FYFV; NHS England, 2014). In addition, this document framed the NHS as outdated, and cited its inability to meet present day demands as a justification for redesign and modernisation. Priorities for mental health focus on better integration of services, both between mental health and social care, and mental and physical health. This was combined with an emphasis on investment in primary care as a means to reduce reliance on more intensive, and more expensive, services later down the line. Hughes (2017) has explored the drive towards service integration despite the lack of evidence to suggest that it does decrease the

reliance on higher intensity services. They explain the popularity of this trend as a means of managing tensions that exist in relation to the crisis of funding an increasingly costly NHS.

This is a key context to any mental health policy in this period, and in line with this, documents such as the FYFV speak increasingly of mental health in terms of its negative economic impact. Also present is an emphasis on productivity and the role of treatment as a means to enable people to return to work. This can again be linked to a neoliberal agenda, whereby the individual's functioning within a market-based economy is paramount, and recovery from mental distress is seen through the filter of reducing symptoms that present a barrier to work and productivity (Fisher & Lees, 2016).

Each of these messages coalesce in the succeeding Conservative Government's guiding policy for health, The NHS Long Term Plan (LTP; NHS England, 2019). This document also focuses on the utilisation of digital and technological innovations as the means to bring about greater efficiency and allow the NHS to meet the growing demands on its resources. The LTP commits £2.3billion to mental health, and describes the target of this investment as service expansion and faster access to community, crisis, perinatal and child and adolescent provisions. This is set to a backdrop of proposed legal changes to the financial architecture of the NHS.

The LTP generated a cluster of policies aimed at clarifying the Government and NHS's intentions in relation to mental health. The NHS Mental Health Implementation Plan 2019/20 – 2023/24 (MHIP; NHS England, 2019) operationalises the pledge of the LTP through outlining funding streams, service transformation proposals and workforce planning. This is followed by the Community Mental Health Framework for Adults and Older Adults (CMHF; NHS England & National Collaborating Centre for Mental Health, 2019). The message delivered in this document reinforced the notion that current ways of working within the NHS were not functioning, focusing on Community Mental Health Teams (CMHT) as the subject of redesign. Siloed working, hard to reach services, inefficient use of current funding, disconnect with other community and third sector services and lack of centralised policies for guidance were framed as the problem to be overcome. In line with this, integration of services was again seen as a suitable means to address the issue.

This section highlights the progression of dominant themes within recent mental health policy. However, throughout each of the policies discussed, an additional narrative in relation to prevention and population health also gathered momentum. This could arguably be seen as a fourth trend within recent mental health policy, progressing from those stated by Moth (2020) at the outset of this section.

The LTP discusses prevention in the sense of intervening upstream to avoid problems with physical and mental health arising in the first place, and providing optimal care in the correct setting to stop an existing difficulty worsening. This relates to the work of Caplan and Grunebaum (1967) who outline three levels of prevention; primary prevention, where the cause of mental health difficulties are tackled before they develop; secondary prevention, where those at greater risk of developing mental health difficulties are targeted with preventative action; and tertiary prevention, where relapse or worsening of existing mental health difficulties are the focus of intervention. Cowen (1977) went on to specify that primary prevention should be designed to promote health before difficulties arise, and be focused on measures that impact upon the whole population. Gordon (1983) classed these as universal prevention strategies.

The term population health is a current label for such approaches. The King's Fund define population health as, "An approach aimed at improving the health of an entire population. It is about improving the physical and mental health outcomes and wellbeing of people within and across a defined local, regional or national population, while reducing health inequalities. It includes action to reduce the occurrence of ill health, action to deliver appropriate health and care services and action on the wider determinants of health. It requires working with communities and partner agencies." (Buck et al., 2018, P. 10). In this sense, the term extends concepts such as health improvement, health protection and health promotion, acknowledging the need to reach beyond the scope of traditional health services and target broader determinants of mental health such as living conditions, childhood adversity, education, discrimination, and employment (The King's Fund, 2019).

Taking the example of one such broader determinant that has a pervasive and damaging effect on the population's mental health, racism intersects with many of these aspects noted by The King's Fund (2019). Racism acts both as a cause of distress, but also a cause of

structural discrimination in mental health services. Both were highlighted in a model conceptualising the link between racism and health outcomes by Paradies et al. (2013). Racism was thought to underpin mental distress through its contribution to elevated psychological stress, including through the reduced access to resources, exposure to interpersonal racism, and racial assault. Mental health was also considered to be influenced by reduced access to resources, including living conditions and the provision of suitable, quality health services. Racism as a cause of distress will be discussed here, with its impact on structural discrimination in services being returned to in The Reality in Services section below.

Some research into the mechanisms by which racism leads to mental health difficulties has focused on its impact on psychological stress, and the effect of this both on children's brain development and parenting relationships (Center on the Developing Child, 2022). However, Afuape and Hughes (2015) point out that many of the bio-psycho-social frameworks that psychologists use to explain concepts such as child neurological development, attachment and trauma are often located within a Eurocentric, White, Western, middle class perspective. This may hinder our conceptualisation of racism and its impact, or limit it to a reduced range of positions. For example, parenting behaviours may not differ among racialised groups solely due to the psychological stress inflicted by racism. Rather, those who have grown up in the context of racism, and in a community shaped by its presence, may parent their children in a way they have learnt that they must in order to prepare their children to have the best chance of surviving in this context. This links to the idea of 'cultural paranoia' developed by Grier and Cobbs (1968) who used this term to describe the adaptive and healthy response of Black people to survive experiences of racism.

What is clear is that racism exerts its influence on mental health in various and complex ways. Considering this example highlights the necessity of taking an upstream approach to population health, in the way that was outlined by The King's Fund above (Buck et al., 2018), considering the deeply impactful and pervasive social determinants of distress such as racism. And yet, mental health policy does not frame prevention and population health reliably in these terms, and multiple definitions can be at play within a single document. Prevention has also been conceptualised as the prevention of a disorder from developing by

reducing precipitating factors, for example, as opposed to intervening to address systemic injustice and inequality. Therefore, these constructs and the influence that the trend has on mental health services require further exploration.

1.3. PREVENTION AND POPULATION HEALTH

This section goes on to outline the building focus on prevention and population health within recent mental health policy.

1.3.1. Recent developments

Newton (2013) points to the Labour Government's New horizons: Towards a shared vision for mental health (Department of Health, 2009) as an early example of the most recent shift towards prevention and the role of social inequality within mental health policy. Similar themes gathered steam throughout the Coalition administration, including the white paper Healthy Lives, Healthy People (HLHP; Department of Health, 2010), NHWMH and into the FYFV.

In a review of health policy under the Coalition Government, The King's Fund (Gregory et al., 2012) condoned the steer towards prevention, alleviation of the social determinants of ill health, and the development of environments and public services that promote mental wellbeing. However, their paper levelled criticism at the government for at the same time limiting the growth of the NHS budget to zero in real terms and cutting local government spending on social care. The King's Fund also pointed out that in accepting that wider social determinants impact the nation's health, the government and the public require new procedures to hold departments beyond the Department of Health and Social Care accountable for the effect of their policies upon health.

In an inquiry into the progress of the FYFV, the All Party Parliamentary Group on Mental Health (2018) leant support to these concerns. Contributing authors and organisations suggested that not enough action had been taken to improve the experience of children in order to prevent the development of later mental health problems. Community approaches to adverse childhood experiences (ACEs) such as domestic violence, abuse and victimisation had not materialised, and the provision of early years and parental support from mental health services had not been given sufficient weight by the policy. In addition, the arrangement of services was found to be contrary to the tertiary prevention of severe mental health difficulties, with strict, diagnostic based inclusion criteria preventing people accessing support at the early sign of distress.

Arising from the FYFV, the subsequent Conservative Government announced the Prevention Concordat for Better Mental Health (Public Health England, 2017). The intent of this programme was to take a public health approach to the prevention of mental health difficulties and reduce mental health inequalities through commissioning and service planning. Organisations signing up to the Concordat made a public pledge of their contribution towards prevention, with the aim to enact cumulative systemic change for the benefit of the population's mental health. This agenda was reinforced in a speech to the International Association of National Public Health Institutes by the then health secretary, Matt Hancock (The Rt Hon Matt Hancock MP, 2018), during the launch of the policy document Prevention is Better than Cure (PBC; Department of Health and Social Care, 2018).

However, the Prevention Concordat was criticised for its waning progress over time, curbed by budget cuts to local government which made optional investment in prevention by organisations an increasingly remote prospect (All Party Parliamentary Group on Mental Health, 2018). Similar arguments have been brought against PBC. While welcoming the vision of the policy, Oliver (2018) suggests that its ambitious language is hollow without proper investment, tangible implementation and workforce planning. Moreover, Oliver highlights that the strategies suggested by the policy focused on nudging towards behaviour change and individual responsibility for health, and prioritises funding for service provision rather than prevention. This neglects the wider environmental and social determinants of

health, both mental and physical, that need to be addressed for primary preventative work. Instead, Oliver points out the funding for public health, community and local authority agencies that are best placed to deliver change in these areas are being progressively cut.

Despite these criticisms, policy momentum towards the prevention agenda continues to build, and in 2019 resulted in the green paper Advancing our Health: Prevention in the 2020's (AoH; Department of Health and Social Care, 2019). The language in this document has altered to acknowledge the detrimental impact of health inequalities and their cumulative effect on some individuals and communities, and the issue of primary prevention is explicitly discussed. However, The British Psychological Society (2019a) and the Centre for Mental Health (2019) again highlight the lack of proposed action towards tackling social determinants of mental and physical health or workforce planning to address the prevention agenda.

The question as to why this escalation of policy announcements relating to mental health prevention and population health continues in the face of repeated criticism from multiple commentators is of interest to the present study. This warrants further consideration, given the national impact should these policies fall short of their ambitions to prevent mental health difficulties. This section has outlined some apparent contradictions within this policy move. For example, population level preventative action requires a serious investment of funds, and yet much of the focus towards prevention has occurred during times of austerity, and without a ringfenced budged over and above that of traditional mental health service delivery. Also, these policies are either produced by or for those working within the NHS or the Department of Health and Social Care, and yet it has been acknowledged that prevention and population health require changes to occur that are outside of this remit, for example in relation to income inequality, housing and employment.

As aforementioned, these policies impact the nature of clinical psychologists' work and the structure of the services in which they are based. Therefore, further analysis of these policy's theoretical underpinnings and inherent contradictions are necessary for clinical psychologists to take a critical stance on their practice. The following section takes this forward by exploring the social and political context of this shift towards prevention and

population health, to consider why political attention to the prevention agenda is occurring now.

1.3.2. The context of the trend

Although the flurry of policy documents in the last decade may give the impression that prevention and population health are a recent preoccupation, in reality these narratives have become prominent within mental health literature in various historical and geographical contexts. Turner et al. (2015) notes that in the UK in the 19th and early 20th centuries it was commonly acknowledged that those who utilised mental health institutions often shared more characteristics with other marginalised and disadvantaged groups, for example immigrants and those living in poverty, than they did with each other. Later in America in the 1960s, psychologists such as George Albee were influential in raising the profile of community psychology and the role of social determinants in mental health, highlighting that "[i]ndividual psychotherapy is available to a small number only. No mass disorder has ever been eliminated by treating one person at a time" (Albee, 1999, p. 133).

This begs the question as to what is driving the focus on prevention and population heath in the UK at this moment in time? In the policy documents highlighted previously, a key motive is clearly economic. AoH points to the cost of mental health difficulties, which are estimated between £74 billion and £99 billion per year (Department of Health and Social Care, 2019), as a rationale for preventative approaches to reduce the burden on the NHS. Taking a reactive approach to this by continuing to only provide individual therapies would, as Albee stated, be a questionable method for policy makers to condone, and would come at a prohibitively expensive cost. This approach is rendered even less effective by the UK's aging population reducing the proportion of taxable income to fund an NHS that is under increasing demand (Newton, 2013). There are also indications that, paradoxically, mental distress across developed nations is on the rise despite their increasing wealth (Easterlin et

al., 2010). This increased demand poses a problem for governments in the management of resources allocated to mental health, making preventative measures an appealing prospect.

The connection between rising mental distress and income inequalities gathered momentum through publications such as The Spirit Level (Wilkinson & Pickett, 2010), which indicated that in societies such as the UK where the gap between the rich and the poor is great, mental health outcomes were considerably worse. The Marmot Review (Marmot, 2010) published a year later, brought the social gradient of mental health inequalities in the UK into sharp focus by using population level data to demonstrate a correlation between people's health and wellbeing and their social characteristics, such as educational attainment and the qualities of their neighbourhood.

The resulting advice to policy makers was to prioritise prevention for the sake of people's wellbeing and the economic burden on the NHS, prompting political action in the form of the white paper HLHP. This has been kept on the agenda by reports that continue to highlight a shortfall in progress in addressing social determinants of mental distress, for example the report from the independent Mental Health Taskforce (2016), which reviewed the progress of the FYFV. This recommended greater cross departmental working to tackle housing, unemployment, poverty and discrimination.

Pressure has also arisen from the international community, with similar recommendations on tackling social determinants levied at the Government in a report by the United Nations Special Rapporteur (Alston, 2019) which delivered a heavy critique of the UK policies of austerity since 2010. Internationally, the World Health Organisation (2008) has also advised nations to adopt 'whole-of-government' approaches in order to achieve these aims.

The question as to why these widely endorsed, cross departmental changes have not come to fruition despite the policy narratives around prevention is another inconsistency worthy of exploration. It raises questions as to the political will behind these policies beyond the NHS and ministers for health, and the backing that would actually be required to make these changes a reality. Firstly, the context of the Covid-19 pandemic on the prevention and population health agenda must be acknowledged.

1.3.3. The impact of Covid-19

It is clear that the Covid-19 pandemic has made it hard to ignore the issue of social inequality and its impact upon health and mental health (Allwood & Bell, 2020; Keys et al., 2021) These have been laid bare in Governmental reports (Public Health England, 2020) and have been the subject of extensive media coverage, making this a salient issue in the public consciousness. Many people's personal experiences during the pandemic may also have made it apparent that mental health is contingent upon people's environment. In addition, it has been widely acknowledged that the pandemic has left in its wake a huge demand for mental health support (Department of Health and Social Care, 2021). In line with these factors, public health and preventative approaches to mental distress are more pertinent than ever.

However, a concurrent effect of the Covid-19 pandemic is that shifting priorities towards keeping the virus in check and the massive disruption to service delivery meant that resources where diverted away from these aims in the short term (Parkin, 2021) and mental health services have been left reeling. If the All Party Parliamentary Group on Mental Health (2018) questioned the probability that organisations would allocate decreasing funds into optional preventative measures prior to the pandemic, the chances of this occurring now are remote. Initial responses from the Government to the mental health crisis also did not indicate a move towards the preventative approaches required to meet this new demand, but rather focused on maintaining the same individualised approach to mental health, while demanding increased activity from stretched services (Parkin, 2021).

As the pandemic has progressed, the prevention agenda has now taken on a specific meaning within Government, becoming focused on health protection and the prevention of infectious disease. Just as attention to prevention and population health was gaining traction prior to the pandemic, in the aftermath of Covid-19, Public Health England has been dissolved. Its replacement, the UK Health Security Agency, has a narrower focus on external

threats to health, with responsibility for preventative approaches to be overseen by the new Office for Health Improvement and Disparities (Brodie, 2021). Although framed as a natural response to the new challenges of Covid-19, Oliver (2021) suggests that dissolving Public Health England has the secondary advantage of allowing a shift of blame for the Covid-19 response to this organisation, giving the impression that tangible action has been taken, and creating a department with greater ministerial control. Although these departmental changes are beyond the scope of this study, given its timing and the rapidly changing landscape of policies being produced, the impact on the mental health prevention and population health agenda requires further study in the future.

However, this recent shift in the concept and language of prevention in order to adjust to the needs of policy makers is still of interest to the current study. It poses questions as to whether this process has occurred in other contexts, and whether this impacts upon government action towards the mental health prevention agenda, which the current study will explore in later chapters. In the following section, consideration will be given to the preventative action that is currently on the ground, under the present iteration of the term prevention.

1.3.4. The reality in services

The Centre for Mental Health (2019) suggest that in practice, work on prevention and population health are not prioritised or well resourced within services, a finding that the authors attribute to the extended timeframe for the outcome of these efforts to be detected. Townley et al. (2018) argues that community mental health services have disengaged from efforts to alleviate the social determinants of distress or promote social inclusion and empowerment in the face of the scale of the demand and the extent of poverty and marginalisation experienced by their service users.

The lack of focus on prevention and population health may also reflect a shift in the allocation of mental health budgets towards the Improving Access to Psychological

Therapies (IAPT) initiative over inpatient services and CMHTs, despite of evidence to contradict the idea that the need for IAPT is greater (British Medical Association, 2018; Centre for Mental Health, 2017). The nature of IAPT is such that its nationally set targets are largely centred around the provision of individualistic therapies such as CBT to manage existing symptoms (Layard et al., 2007), and are therefore not easily aligned with the prevention or population health agenda.

This direction of paring back genuinely preventative action can be seen to disadvantage some social groups over others. In a previous section of the Introduction, the example of racism was outlined as a contributor towards mental distress, and used to highlight the need for a broad, upstream approach to its prevention. This need is left unaddressed by a mental health system that prioritises individual therapies for common mental health problems but does not address the structural causes of distress. A failure of preventative measures was highlighted by the Independent Review of the Mental Health Act 1983 (Department of Health and Social Care, 2018a), which showed that young Black men were over represented in services that provide support for distress at the severe end of the spectrum, such as crisis and inpatient services, and were more likely to be subjected to compulsory powers within these services than their White counterparts. As an illustration of this, Black men were four times as likely to be subject to seclusion or restraint. In addition, a national survey found that Black men in England were diagnosed with psychotic disorder, considered a relatively severe form of distress, approximately 10 times more frequently than White men (McManus et al., 2016).

The Independent Review of the Mental Health Act (Department of Health and Social Care, 2018a) outlined a multitude of interlinking determining factors for this pattern. Some of these underscore the need for primary prevention to eliminate racism's role in causing distress, as discussed earlier in the Introduction section. This would involve targeting other structural causes of mental distress that intersect with racism, such as poverty. But in addition to this is the report's suggestion that structural racism within mental health services also has a bearing on the findings above. It is suggested that young Black men do not have sufficient access to, or reason to trust in, services that provide care earlier in their

experience of distress. This is an example of discrimination in services leading to a gap in secondary and tertiary prevention, and contributing to racialised mental health inequalities.

Returning to the need for primary preventative strategies that are implicated through the example of racism, Bambra et al. (2010) suggests that a barrier to their development is agreement on the conceptualisation of preventative measures. In a systematic review of the literature into effective population health, the management of social determinants of health and health inequalities, they state that a high proportion of studies actually focus at the more proximal level of influencing lifestyle change to prevent illness. This is opposed to addressing the broader determinants that would constitute primary, population level preventative measures. Meaningful work on prevention and population mental health is likely to be further hampered by the level of investment into research in this area. Studies have indicated that of the total spend on mental health research, under 5% was directed towards prevention, whereas 80% was allocated to biomedical research (British Psychological Society, 2019a), and 49% focused on the underpinnings and aetiology of mental health difficulties (MQ: Transforming Mental Health Through Research, 2018). This leaves services without a steer as to effective courses of action, and proponents of the prevention agenda armed with less information to persuasively lobby policy makers into investing into mental health prevention and population health.

However, limited action towards mental health prevention is not universal. One area of mental healthcare that has received a firm backing in policy resulting in tangible impact on service delivery is that of early intervention for psychosis. This services aims to provide multidisciplinary support to 56% of individuals experiencing a first episode of psychosis in the UK, delivering pharmacological and cognitive behavioural interventions as primary provisions (NHS England, 2021). Nevertheless, it is clear that this also represents a fairly narrow conceptualisation of prevention, mapping onto Caplan and Grunebaum's (1967) secondary and tertiary preventative approaches. The question of why this type of preventative measure is taken forward by policy makers and others are not of interest to the current study. The following section will outline why questions such as these are of relevance to the field of psychology.

1.3.5. The implications for clinical psychology

As a profession, clinical psychology does not currently centre itself around the primary prevention of mental distress. Training focuses heavily on therapeutic competencies for individual therapies (British Psychological Society, 2019c), and it is suggested that the profession has benefitted from, and colluded with, the current agenda towards the management of symptoms thorough NICE recommended psychotherapy (Mollon, 2009). And yet, this has not always been the case. Historically, the remit of clinical psychology was characterised by the delivery of psychometric and neuropsychological tests. The profession is therefore not static, and needs to flex in line with both the government agenda towards prevention, and increasing calls to contribute to the political and social landscape that influences mental health (Rahim & Cooke, 2020). Currently, the provision of therapy has been funded by successive governments, but this may not always be the case.

There are indications that the role of clinical psychology in relation to mental health prevention and population health is being reconceptualised. Richard et al. (2011) suggests that there has been a shift away from the individual and towards ecological models when considering health promotion as, "disappointment over results from experiments and trials in behavior change has led to calls for interventions and programs addressing not only individual behaviors and their cognitive determinants but also the multiple settings and social contexts that shape behaviors, including large social and cultural dimensions" (Richard et al., 2011, p. 308). This dissatisfaction with the status quo is mirrored by the development of activist-practitioner organisations such as Psychologists for Social Change (*Psychologists for Social Change*, 2021). It is also partially reflected in the actions of professional bodies such as the British Psychological Society, for example in the creation of the community psychology subdivision in 2010, which outlined psychologists' role in population health and wellbeing (*Community Psychology Section*, 2021).

As is always the case with new professional directions, there will be a lag time between these changes occurring and the training to follow suit. Clinical psychologists need to contribute to a vision for the future of our profession, and conceptual thinking with regards

to how mental distress is understood, and how prevention can be addressed. There is an ethical argument for doing so, particularly if clinical psychologists see their purpose as reducing mental distress on as broad a scale as possible (McGrath et al., 2016). This is in line with professional ethical codes that advocate for sensitivity to issues of power and the acknowledgment of broader societal and environmental influences on mental health (British Psychological Society, 2021).

The critical appraisal of policy and its development are a necessary aspect of this work. With regards to prevention, important questions for psychologists to be aware of might include: how is a policy constructed, who is the target audience, are they in a position to implement the necessary change, what are the conceptual underpinnings in relation to mental health and prevention, are there any contradictions present within the policy, what are the actions endorsed, is this receiving the appropriate investment, and so on.

It is argued that the production of new knowledge and understanding of policy in this way has the potential to lead to emancipatory change (Fairclough, 2001). In line with this, the outcomes of this investigation may provide a rationale for clinical psychologists to use their relative power to contribute to the reconceptualisation of future policy questions and influence the development of future policy towards primary preventative measures. It might also provide clinical psychologists working in managerial or clinical roles to advocate for organisational changes that could better serve their communities. In an ethnographic study within a community mental health team, Moth, (2020) found evidence that this can be achieved, and that professional groups are able to work in line with their ethical obligations, despite the weight of policy agendas that contradict these.

1.3.6. Aims of the study

It has been noted that there is a discrepancy between the recent focus on prevention and population health in policy, and the level change to funding for preventative approaches, preventative activity at a service level, or wider social inequalities that impact on the mental

health of the population. With this in mind, the present study aims to attend to the social problem of the prevention of mental distress, and the role of policy in progress or inertia in relation to this aim, with a view to producing new knowledge that can contribute to clinical psychologists' engagement in preventative action.

A historical consideration of the recent trend towards prevention will seek to establish the context of this policy drive. This will highlight the most relevant and impactful policies to consider in more in depth through a discursive analysis. The aim of this will be to highlight the key assumptions and contradictions inherent to current, influential policies that pertain to mental health prevention and population health. It has been highlighted that certain concepts are politically useful given their malleability and potential to be adjusted to fit different discursive ends (Scott, 2015). If this is true of concepts such as prevention and population health, it would important to shed light on how and why this is being done, what effect this has, and who benefits from the process, to further the agenda for genuine preventative action on mental distress.

1.3.6.1. Research questions

To attend to the overarching social problem of preventing mental distress, the proposed research will explore the following research questions:

- What are the underlying conceptual frameworks present in the selected policies and how do they interrelate.
- How are these operationalised within the policy documents in relation to action towards prevention and population health?

2. EPISTEMOLOGY AND METHODOLOGY

In order to engage with the problem of mental health prevention and address the research questions, Critical Discourse Analysis (CDA) was selected as the most appropriate methodology (Fairclough, 1995). There were a number of available avenues to explore the influences on preventative action, for example through the analysis of interviews with policy makers or clinical psychologists, or consideration of public or media engagement with the topic. However, the critical analysis of policy allowed for the direct investigation of the synthesis of the Government and NHS positions on prevention, without the potential for the discussion to be shaped by the context of an interview, or the interviewee's particular agenda. Policy is also a powerful form of discursive activity that holds significant potential to instigate social change (Fairclough, 2013), as well as fundamentally shaping the context within which clinical psychologists work, and is therefore integral to social actions towards prevention.

CDA has similarities with other forms of discursive analysis that could have been utilized, for example, Willig (2001) outlines both Discursive Psychology (DP) and Foucauldian Discourse Analysis (FDA). Although DP has similarities to CDA in that it considers the deployment of discursive strategies for a particular function, this is generally in relation to social interactions such as conversations.

FDA and CDA on the other hand are both applicable to the consideration of policy texts, and both critique the taken for granted notions and contradictions that these might contain. Both are also interested in the workings of power and the role of discourse within its broader context. However, FDA draws specifically on Foucauldian theories, for example the construction of objects and subjectivities within the text. CDA, in contrast, seeks to link language to the social processes and structures that produce it, and its outcomes in the real world (Fairclough, 2001). It considers the function that a social problem serves for certain groups, and hence why certain discourses are sustained. As opposed to FDA, CDA takes a

more explicit position on social change, highlighting the mechanisms of power within discourse for the purpose of emancipation (Fairclough, 2009). These features were applicable to the current study, which aims to consider the impact of policy narratives around prevention on the tangible actions of mental health services, and the reasons that these may have been perpetuated. This is for the purpose of advocating for social change, should these narratives be likely to negatively impact certain groups.

Having settled upon a phenomena to investigate, Meyer (2001) suggests that the theoretical assumptions of the study must be made explicit, so that alignment between these, the research questions and the methodology can be demonstrated. The study takes a Critical Realist perspective, for reasons described below.

2.1. EPISTEMOLOGY

2.1.1. Critical Realism

Critical Realism underpins the current research for similar reasons that CDA was deemed the most suitable methodology, in that it is interested in the influence of language and power, and the effects of these on the real world (Pilgrim, 2020). Alternative positions could have been taken, for example, Social Constructionist perspectives are also interested in the power that language has to shape reality. However, this position is generally focused upon the various constructions of reality among different accounts, and the multiple narratives that exist in relation to a topic, rather than the tangible impact that they have on a material reality (Willig, 2001). This reflects a key difference between the two perspectives in terms of ontology, or assumptions held about the nature of reality and what is assumed to exist (Willig, 2019). Pilgrim outlines three core assumptions of Critical Realism, which align with the research questions and methodology of the current study. These include

ontological realism, epistemological relativism, and the notion of judgemental rationalism. Each will be elaborated in the following sections.

2.1.2. Ontological realism

Pilgrim (2020) describes the realist ontological position of Critical Realism, in that a material world is assumed to exist beyond our understanding of it, despite our methods for knowing this reality being imperfect. Although individual people's conceptualisations of the nature of reality might be varied and go on to have an impact upon reality, they are seen to be separate from the tangible aspects of the world, for example structures, objects and events that we experience. This is in contrast to the ontological relativism which suggests that literally multiple realities exist, and that, "what is experienced as 'real' depends upon the mindset of the person who is experiencing it and that there is no 'reality' beyond such subjective realities" (Willig, 2016, p. 2).

This is felt to be the most appropriate grounding for the current study, given the researcher's assumption that policy has tangible impact on mental health services and the material lives of the people who experience them, and that the social structures and mechanisms governing this relationship are also tangible. Policy, alongside the media, religion, and other distal layers of the ecological system (Bronfenbrenner, 1992), also contribute significantly to the framing of the construct of mental health, which will impact on the actual lived experience of peoples' distress.

2.1.3. Epistemological relativism

Epistemology on the other hand concerns the nature of knowledge, how we come to understand the world around us, the extent of what can be known, and questions pertaining

to the validity and 'truth' of knowledge (Willig, 2019). Critical Realism takes a relativist epistemological stance. Rather than implying a one-to-one correspondence between reality and our understanding of it, a relativist position suggests that the world can be thought of, construed and discussed from a multitude of perspectives (Pilgrim, 2020). Willig (2016) highlights a common misunderstanding within qualitative research that a relativist epistemology necessarily goes hand in hand with a relativist ontology, i.e. that there are literally multiple realities in existence. However, Willig argues that often realist ontological assumptions, those that reflect the realist premise that a material world exists beyond our understanding of it, are implicit within the aims of much research with a relativist epistemology.

This aligns with the current study, given its aim to explore policy discourses for their underpinning theoretical assumptions and the contradictions between them. Inherent to this endeavour are the following assumptions; concepts such as preventing mental distress can be thought of from a range of theoretical standpoints, they are expressed within the language of policy, multiple theoretical assumptions can exist within one text, they can be in conflict with each other, and they develop across time and contexts. From a relativist epistemological stance, knowledge of what exists and how society operates is seen to be socially constructed, and research can be used to develop an understanding as to how and why different perspectives arise and gain influence within society.

Through Critical Realism, epistemological relativism and ontological realism are held alongside each other (Pilgrim, 2020). Our understanding of reality may inevitably be a socially constructed, incomplete and subjective representation of that reality, without this implying that social or material realities do not exist beyond our conceptualisations of them (Willig, 2016). The distinction between the material world and our constructions of it maps roughly into the concept of transitive and intransitive aspects of the social world, outlined by (Bhaskar, 1997).

Transitive knowledge is that which is socially constructed and embedded within discourse (for example conversations, thoughts and texts). Intransitive objects on the other hand are, "invariant to our knowledge of them; they are the real things and structures, mechanisms and processes, events and possibilities of the world" (Bhaskar, 1997, p. 22, as cited by

Joseph & Roberts, 2004). Knowledge in the form of discourse can be seen to rely upon these intransitive aspects to exist, and yet also be responsible for shaping them, in a dialectic process (Joseph & Roberts, 2004). From Willig's (2016) perspective, constructions of the world are realised in the sense that they have tangible consequences for people, by shaping the practices, institutions and wider social structures that influence their lives.

In the example of the current research, the transitive elements are the knowledge, language and theories embedded within policy. These influence how mental health and prevention are constructed, how the role of clinical psychology is conceptualised, the focus of our work, and the degree to which this will be orientated towards prevention and population health. This impacts the intransitive aspects of social reality, for example the work of clinical psychologists within mental health services, the interventions they deliver, how they interact with services users, which services are commissioned, how they are structured, their operating procedures, where they are located, the amount of funding that they receive, and so on. There are therefore real world implications for the lived experience of individuals, and the population's mental wellbeing.

2.1.4. Judgemental rationalism

This makes it fundamentally important to clinical psychologists which transitive elements of policy are taken forward. As Pilgrim states, "Some construals might be honest and persuasive (e.g. persistent inequalities in health mean the poor will be sicker and die younger than the rich on average) or dishonest and unfounded (e.g. there are no health inequalities only 'health variations' and being healthy is merely and matter of personal choice" (2020, p. 4). Pilgrim highlights an advantage of Critical Realism, which is that it allows researchers to go beyond acknowledging the existence of multiple conceptualisations, towards taking a stance as to which of these they believe will be more or less likely to have a deleterious impact on people's experience. Fairclough et al.(2004) go as far as to say that critical realists are interested in making judgements as to the

truthfulness and appropriateness of transitive understandings. This positioning is termed judgemental rationalism, and is named alongside relative epistemology and realist ontology as one of the three tenets of Critical Realism (Pilgrim, 2020).

2.1.5. The researcher's position

The judgemental rationalist aspect of Critical Realism allows a stance to be taken on the relative strengths, limitations and implications of policy, while also allowing the researcher to maintain epistemic humility (Pilgrim, 2020). That is to say that the researcher need not assume that the understanding of reality presented in their research necessarily represents a singular, objective or definitive reality. It is understood that neutrality on the subject is not achievable given that my position is shaped by the discursive processes that shape all of human understanding (Jager, 2001). Willig (2001) instead advocates for reflexivity during the process of research, acknowledging that the researcher's individual perspective will shape its direction and outcomes. Rather than diminishing the findings of the study as one individual's perspective, this reflects the epistemological assumption that all research is a fallible and partial reflection of reality.

With regards to personal reflexivity, this process recognises the values, beliefs and identities from which the author approaches the research. Harper (2003) suggests that this shouldn't end with a list of social locations held by the author, but should consider their possible impact upon the analysis, and how this will be addressed.

It is relevant to acknowledge here that my views align with the left of the political spectrum. I am generally in support of policies that prioritise social equality and function to reduce discrepancies in status, power, health and wealth across the population. I hold the position that mental distress is significantly contributed to by inequalities in power and privilege, and that these are detrimental to society at large, not only those most directly impacted upon by them. These assumptions combine with my professional position as a clinical psychologist, where I hold a compassion focused stance and resist narratives that place

blame on individuals. This informs where I locate the 'problem' in terms of what sustains mental distress, and whose responsibility it is to address this, emphasising the need for interventions based on social justice rather than individual treatment.

I am more critical of neoliberal attitudes that individualise distress, prioritise economic arguments above all others, encourage competition, and locate responsibility for ones' position in society on personal qualities, or lack thereof. I also question the simplistic biological explanation for difficulties in mental health and its treatment, and hold beliefs about the influence of powerful groups such as the medical and psychiatric professions and pharmaceutical industry in maintaining this stance.

This has the potential to influence my attunement to examples of these discourses within the text, which could result in the over emphasis of these themes in the analysis. I will therefore be mindful not to arrive at the text with a predetermined notion of what it might include, and to be receptive to examples that go against my expectations or the dominant discourse of the text. This will result in a more nuanced account of the text and avoid the circularity, by which the analysis becomes a reflection of the author's pre-existing views (O'Reilly et al., 2021). The steps that were taken to limit the impact of my values on the analysis will be expanded upon in the Critical Reflections section of the study. Here I will refer to examples from the research, where personal reflexivity was necessary in order to reduce bias in the analysis of the policies.

2.2. METHOD

The next stage of the research process is to select a methodology that is in line with these values, the research questions and a critical realist position. In this section, I outline CDA as the most appropriate methodology to meet these requirements.

2.2.1. Critical Discourse Analysis

CDA is an approach to the analysis of discourse that is interested in the relationship between language and power (Wodak, 2001). Fairclough et al. (2004) defines 'discourse' as a positioned way of representing both social practices and the material world through language. The term 'text' refers to all forms of linguistic activity, including written texts as well as conversations, for example. In the current study, text refers to the written policy document under analysis.

Willig attests that, "The words we use to describe our experiences play a part in the construction of the meanings we attribute to such experiences" (2001, p. 56). In this sense, the discourses available to us deeply influence our experience of reality, enabling and constraining the possible ways of seeing the world. This process is vulnerable to the exercise of power, and discourse can be used to construct reality in the interests of certain groups. During CDA, texts are studied for the manifestations of power, dominance and control operating within them, and the linguistic strategies by which these are maintained.

In this way, CDA goes beyond what can be gleaned from a straightforward critical reading of policy, which would involve bringing a socially and politically informed lens to the text, considering its terminology, assumptions, conceptualisations, and the impact of these on, for example, the activity of mental health services. Rather, CDA aims to avoid representing a simplistic cause and effect relationship between texts, such as policy documents, and their impact on social life (Wodak, 2001).

Its focus is on mapping the web of influences that shape the particular discursive direction of a text, and the dominance of some themes and ideas over others. CDA posits that this is influenced by the agenda of groups that hold the most power and sway within society. However, this process often remains hidden, and the dominance of certain discourses can become taken for granted as the natural order of things. In this way, ideas can be sustained despite their deleterious or discriminatory impact on certain groups within society. In the example of the current research, this could mean that particular ways of understanding

mental health prevention are perpetuated, despite not being fit for purpose or likely to achieve their stated aim. CDA hopes to resist this process by contributing new knowledge that can shed light onto the wider influences on policy.

CDA therefore does not restrict itself to an isolated analysis of a text, but also considers the context that has shaped its discursive features. These preconditions include not only the influence of powerful groups, but also the specific historical and geographical setting that the text has emerged from. These constrain both the discourses available for inclusion within policy, and how the policy will be interpreted by its readers. CDA's reference to extralinguistic factors was felt to be suitable for the current research given its interest in the political structures that result in policy, and how policy is operationalised, for example through funding and service planning.

CDA was also considered particularly fitting given that it was developed for use in the analysis of political or media discourses, where the workings of power are most overt. In line with its critical aspect, it aims to make this process more transparent, highlighting the ideologies and theoretical constructs that are either overtly stated, or are inherent to the discourse without being spoken or acknowledged (Blommaert, 2005). It is the stated aim of those involved in the development of CDA that this understanding is used to highlight the role of discourse in maintaining social inequalities, and to advocate for those oppressed by these processes (Wodak, 2001). Although this may seem a partisan position, all research can be considered to be biased by its particular lens and the researchers' interests in the outcome (Harper, 2004), and a multitude perspectives are considered to be necessary for a broader understanding of any topic (Horkheimer, 1992, as cited in Wodak, 2001).

This aligns with both the judgemental rationalist aspect of Critical Realism, as well as my own values and aims for the research. As clinical psychologists' role is to support the disempowered groups who would benefit the most from preventative, population level action towards alleviating mental distress, understanding the meanings constructed within policy documents on this topic, and how they could reinforce power imbalances, is essential. This allows for the critical consideration of clinical psychologists' work settings, and opens up space to consider alternatives that might better serve those who hold the least power in society.

As Willig (2001) explains, discursive approaches to research are more than a methodology. Rather, they represent a fundamentally different way of relating to language and texts than traditional psychological approaches. They are viewed more as theoretical frameworks than a set of methodological procedures, given the distinctive ways in which they understand the nature of discourse, its role in shaping social life, and the questions for research. The methodologies available for use in CDA are not prescribed, and can be selected to best fit with the research question (Wodak, 2001). In the interests of providing rigour in the current study, a framework developed by Fairclough (2001) was drawn upon (see Table 1). However, the order and form that these stages took in the research were applied in a flexible way to meet the needs of the study.

Table 1

5 Stage Framework for CDA

Stage	Description
Stage 1	Focus upon a social problem that has a semiotic aspect
Stage 2	Identify obstacles to the social problem being tackled. You can do this through analysis of: a) The network of practices it is located within b) The relationship of semiosis to other elements within the particular practice(s) concerned c) The discourse (the semiosis itself) by means of: o Structural analysis: the order of discourse o Interactional analysis o Interdiscursive analysis o Linguistic and semiotic analysis
Stage 3	Consider whether the social order (network of practices) 'needs' the problem
Stage 4	Identify possible ways past the obstacles
Stage 5	Reflect critically on the analysis

Note. From "The discourse of New Labour: Critical Discourse Analysis" by Fairclough, N., 2001, in M. Wetherell, S. Taylor, S. J. Yates, & N. Fairclough (Eds.), *Discourse as Data: A guide for analysis*. Sage.

As such, the influence of this framework is evident throughout the current study. Stage 1 is to focus upon a social problem that has a semiotic aspect. This goes beyond taking a research question as a starting point, but in line with CDA's critical nature, selects an issue that has potential consequences for more disempowered social groups. This is represented in the Introduction, Methods and Historical Analysis sections, whereby the rationale for focusing on the social problem of preventing mental health difficulties through consideration of specific policy documents is explored.

For example, the Introduction section outlines why the prevention of mental distress is a current social problem worthy of analysis, given that it disproportionally impacts those who are socially disadvantaged, there is an increasing amount of unmet need for support, the theorised causes of distress are considered to be preventable, and yet despite political focus on this, change to facilitate prevention has not been forthcoming. In terms of the semiotic element of this social problem, how mental health prevention is spoken about is seen to enable or constrain the preventative actions that can be considered. This makes government and NHS policy regarding prevention a fundamental aspect of the social problem, given its powerful position to inform this conversation.

Having selected this social problem, Stage 2 is to identify obstacles to it being tackled. This is achieved in part through the Discursive Analysis section, which represents Stage 2, Part c of Fairclough's model. Rather than representing a straightforward reading of policy with a critical lens, this analysis specifically considers which out of the possible pool of discursive themes relating to mental health and prevention are included in the text, and importantly which are left out by this particular way of framing the issue. An additional focus is the way that different, sometimes conflicting, discourses are treated in order to combine them together in a way that allows some to achieve dominance over others. This includes analysis of the specific linguistic strategies that make this possible, for example the use of vocabulary or metaphors which guide the reader to a particular conclusion or representation.

Through this means, the analysis extends to consider the power the policy has to make certain options appear to be natural, taken for granted ways forward in tackling the problem of mental health prevention. Bringing this process to the foreground is considered

to be the way in which CDA can add new knowledge to inform social change towards the prevention of mental distress.

Following this, the Discussion section will consider the network of practices and structures that contribute to the social problem of preventing mental health difficulties, and the way in which these ‘need’ the problem to remain. This represents a combination of Stage 2, Part a and b, and Stage 3 of Fairclough’s model. These aspects of CDA go beyond the textual analysis of Stage 2, Part c, in a way that sets it apart from other forms of discourse analysis, including FDA. Rather than considering the text in isolation, this section sets the problem within its social context. This might include the nature of influential groups or institutions relevant to the problem of preventing mental distress, such as government, or the clinical psychology profession, for example. Consideration of practices and structures within such institutions, for example the workings of the policy making process itself, would be relevant to this analysis. As would exploration of the ideological assumptions that prevail within such organisations, and in the wider society that they are a part of. This is also picked up in the Historical Analysis section, another aspect of the current research that extends the analysis beyond the texts selected, by considering how they fit within their temporal context, and how they relate to other policies.

In addition, the Discussion section includes Stage 3 of Fairclough’s model by assessing the function that the status quo holds for powerful groups, who may stand to gain from the problem in question being maintained. For example, primary preventative strategies around income equality might impact the privileges and freedoms of certain groups, and therefore face opposition. Due to the parameters set for the current research as a doctoral thesis, it was hard to do justice to all five stages of Fairclough’s model equally. I therefore decided to focus more on the Discursive Analysis of Stage 2, Part c. Nevertheless, the additional analysis of the network of social structures and processes that surround preventative action towards mental distress, and the vested interests involved, contributed additional knowledge as to why inertia around mental health prevention might continue to exist.

This knowledge was taken forward in the next section of the Discussion, which addressed the implications of the findings. This relates to Stage 4 of Fairclough’s model, the

identification of possible ways past the obstacles to mental health prevention. Again, this is an important element of CDA that differs from other discursive analyses, for example FDA. In the interests of emancipation and social change, CDA researchers are thoughtful about how the new knowledge generated by the analysis, for example its perspective on the workings of power and dominance within policy, can be used to advocate for groups who may be disadvantaged by its particular way of representing the issue. For example, this might include ways that clinical psychologists can choose to resist the effects of policy by contributing alternative discourses around mental health prevention.

Finally, the critical reflections section of the Discussion represents Stage 5 of the model. In this current example, this space was used to explore reflections on the process, critiques of CDA, and efforts taken to improve the credibility and rigor of the research.

In the next section, the procedure for the Historical Analysis and the Discursive Analysis will be elaborated upon.

2.2.2. Procedure

2.2.2.1. Historical analysis

The analysis began with an exploration of the historical context of prevention and population health narratives within UK policy. Fairclough (2013) and Fairclough et al. (2004) identify this as a necessary aspect of CDA, given that researching discourse outside of its context risks an incomplete and reductive view of the text and how discourse functions within it. In the example of mental health policy, attending to the constellation of other discourses, events and social phenomena at that timepoint will help elucidate the preconditions for why these policies were developed when they were. Although historical

analysis is an aspect of all CDA research, no defined process for conducting a historical review is outlined (Meyer, 2001), so this was developed to fit the needs of the research.

In the current study, the literature review in the Introduction represented an initial aspect of historical and contextual exploration. This was expanded upon in the Historical Analysis, where discursive themes relating to prevention were tracked in more detail. This was achieved by reading widely across mental health policies themselves, literature pertaining to the historical development of mental health policy in general, the prevention agenda in mental health policy, and broader contextual shifts, for example the financial crisis of 2008. The focus was primarily the UK context, however international movements that influenced this were included, such as the rise of community psychology and prevention discourses in the US in the 1960s. To facilitate this process, a historical timeline capturing influential documents from the rise of modern mental health policy was developed as a frame of reference (see Appendix 7.1. & 7.2.)

During this review of the literature, a sense of the prevention discourse was developed. Further documents, particularly in relation to contemporary developments in the prevention agenda, were identified through a 'snowballing' process whereby texts referenced in known policies were explored. The LTP was identified as a key document in this process. This was due to its current relevance and scope to influence mental health provision and prevention in the UK, and the cluster of other policies which elaborate on its message and further specify plans for the workforce, service structures, and funding arrangements.

In the later sections of the Historical Analysis that include the recent influx of policies that pertain to prevention and population health (beginning during the section 1997-2010 - Labour administrations), it becomes more focused on specific policies developed by or for the UK Government themselves, or by public bodies of the Government involved in the prevention of mental health difficulties in England. This is because such policies were to be the subject of the discursive analysis, and represent more direct evidence of the Government's prevention agenda. Documents relating specifically to Wales, Scotland or Northern Ireland as opposed to the UK in general were not included. This was in light of the unique policy contexts that would have shaped policy developed specifically for these

countries, which were beyond the scope of this study to explore in sufficient detail. As an example of the process by which documents from the contemporary prevention agenda were engaged with and the concepts that were explored, a table of notes from this process is included in Appendix 7.3.

Policies were considered up until the start of 2021. This was due to both the timeframe available for the writing of the current study, and the onset of a rapidly changing landscape for mental health service delivery, public health and the prevention agenda in the wake of the pandemic. From this point, upheaval from the disbandment of Public Health England, the creation of the UK Health Security Agency and Office for Health Improvement and Disparities, and the vision statements that framed these changes (Department of Health and Social Care, 2020; The Rt Hon Matt Hancock MP, 2020) were beyond the scope of the current study.

The findings are outlined in the Historical Analysis section below. This process informed the selection of documents to be included in the Discursive Analysis section, the procedure for which will be discussed next.

2.2.2.2. Discursive Analysis

Once the policy documents were selected, the discursive analysis was conducted in line with Fairclough's Stage 2, Part c, which outlines four aspects of discursive analysis including; structural, interactional, interdiscursive and linguistic elements. Policies were therefore assessed for the range of discourses they contained, and their relationship to each other in terms of the dominance of certain discourses over others (see Appendix 7.3. & 7.4 for examples of this process). It was considered how these discourses were used and combined together in order to achieve a particular function. This process can often result in contradictions as contrary concepts are merged together (Willig, 2001), and these were also attended to during the analysis. It also drew out the idiosyncratic ways in which discourses within the text were used to relate to the audience for a particular social purpose, and the

linguistic strategies that are drawn upon to achieve this. The linguistic analysis included the analysis of strategies such as word choice, framing of concepts, metaphors, explanations and types of argument within the policies (Fairclough et al., 2004).

3. ANALYSIS

3.1. HISTORICAL ANALYSIS

This section of the analysis is presented in chronological order, beginning with the historical context and the preconditions for the recent mass of policies relating to mental health prevention and population health. These particular policies will then be outlined in more detail, with reference to their rationale for prevention, the varying conceptualisations of mental health and prevention, the new emphasis that each document makes, and the actions they endorse. A supporting table with detail of this analysis can be found in Appendix 7.3. The paragraphs below will draw out the main features that distinguished key policy documents, but in reality each subsequent document had a high degree of commonality with those preceding it.

Over the course of the Historical Analysis, a number of themes will be drawn out which set the scene for the prevention and population health political agenda as it is today. It will begin with the growing commitment to prevention shown in the 19th and early 20th century. From here, the analysis will highlight the shifting dominance of different understandings of mental distress, including social and environmental conceptualisations, as well as those from more individual and biomedical frameworks. Narratives regarding individual versus collective responsibility for health and wellness will also be brought forward, alongside the

influence of interventionist and market-based government policies. The changing rationale for preventative action and its link to different political pressures will be covered.

Each of these themes are important given their implications for the preventative actions deemed appropriate throughout history. These include varying emphasis on changes to social policy, population level approaches, community interventions, investment in early intervention and primary care, and the provision of individual treatment, whether psychological or medical. Each development in the prevention narrative will be considered in terms of its relationship to key historical and political events, including the contribution of the World Wars, shifting economic conditions, population changes, the rise of different professional groups and mental health treatments, influential publications, and successive government administrations.

3.1.1. 19th and early 20th century

As noted in the Introduction section, mental health in the UK has not always been conceptualised in medical terms, and in the 19th century there was a tendency to consider those with mental health difficulties alongside those who had experienced hardship and marginalisation, for example those living in poverty (Turner et al., 2015). Those pushing for reform towards more humane mental health treatment, such as Phillippe Pinel in France and William Tuke in England, considered the cause of mental distress to have psycho-social elements, and believed that being treated with respect and held in high regard would be protective (Newton, 2013).

In 1908, Clifford Beers, in an attempt to raise awareness of the distress caused by the treatment of patients within mental health institutions, wrote a memoir of his own experiences in these settings (Beers, 1908). This captured the attention of an American psychiatrist, Adolph Meyer, who intended to work towards reform of the system through the combination of humane, socio-environmental and biologically informed understandings of mental health (Mandell, 1995). This resulted in the establishment of the National

Committee for Mental Hygiene in New York in 1909. The National Council for Mental Hygiene followed in London in 1923, whose founding principles included the prevention of mental distress. Newton reported one principle to be, "The improvement of the Mental Health of the Community. This involves a closer and more critical study of the social habits, industrial life, and environments of the people, with a view to eradicating those factors that lead to mental ill-health and unhappiness and to educating the public in all matters that mitigate for and against good mental health" (2013, p. 5).

Although setting out with a predominantly social emphasis, the Child Guidance Centres that took this intention forward in the US became gradually more individualised in their focus, shifting towards the treatment of middle class children in clinical settings rather than focusing on their environment (Horn, 1989). This coincided with an increase in the prevalence and influence of psychiatric professionals in the field. A similarly individualised approach was taken in the UK, with contributions from psychiatry, psychology, social work and church in establishing these organisations (Newton, 2013). Although the intention remained to prevent difficulties progressing into adulthood, their resource heavy focus on supporting individuals and families meant the influence of these centres was limited.

The role of mental health professionals and services was also heavily shaped by the context of the World Wars. Newton (1988) notes that psychiatric complaints became the most common reason for discharge in the Second World War for British servicemen, with similar patterns in the US. This led to a new demand for psychiatrists and psychologists in the assessment and classification of individuals on the basis of temperament and intelligence, diverting recruits to military tasks that they were deemed to be better suited for. This was reported to greatly reduce incidence of psychological 'breakdown'.

These contextual aspects indicate the importance placed on preventing mental distress in this period, and show the desire of individuals and organisations to address the social determinants of distress. However, it also highlights the influence of new professional roles and significant events such as the Second World War, which begin to set the scene for the psychiatric, biomedical and individualised elements of current preventative policy.

3.1.2. 1940-79 – Post-war and the welfare state

However, the post-war period also ushered in a social model of distress and prevention in the UK. Following the austerity brought about by the World Wars, the UK's welfare state was developed under Keynesian economic policy, which encouraged increased employment and expenditure on public services (Moth, 2020). It represented a compromise between capitalist and socialist ideals, with elements of market and collectivist values (Hawksley, 2013). The creation of the NHS was a central element of the welfare state, and was proposed by William Beveridge (1942) in what became known as the Beveridge Report, as part of the means to tackle the 'Giant Evils' of disease, want, squalor, idleness and ignorance. This founding document of the welfare state develops the idea of social insurance, and the collectivist notion that all should have access to support, with the needs of the less fortunate being provided for by those with means. However, alongside this is another side of the contract, by which the responsibility of individuals to play their part in alleviating society's evils is outlined (Rose & Miller, 1992). The influence of social as well as responsiblising narratives can be seen in present day policy relating to the NHS, and mental health policy is no exception.

The founding of the NHS in 1948 led to a rise in the power and preponderance of medical professionals in healthcare in general, but also in the management of mental distress. The Percy Report (Percy Commission, 1957) emphasised that mental health should be considered in the same way as physical health, with hospitals and treatments mirroring the physical health model. It followed that care should be provided in the least intrusive way, with minimal restriction. Alongside significant developments in psychotropic drug treatments for mental distress, sufferers were increasingly able to be treated in the community. This was deemed preferable from an economic as well as humanistic perspective, and resulted in a process of de-institutionalisation towards the care of those with mental health difficulties in the community (The Kings Fund, 2014). This meant increasing opportunities for psychiatrists to take positions of expert mental health practitioners in the community (Hawksley, 2013). The following Mental Health Act 1959 enabled this by consolidating the authority of psychiatrists. The profession was elevated

towards equality with physical health doctors, and the power to detain those in mental distress now rested with psychiatrists as opposed to the courts.

This process further embedded a biomedical and individualised perspective on mental distress. However, in the same post-war period, the psychologist Gerald Caplan in the US recognised the limitations of channeling resources into individual treatment, and aimed to renew a population level preventative model (Caplan & Grunebaum, 1967; Carrey, 2021). Caplan focused on training workers across the health field to support people during key moments of stress in their lives, aiming to prevent the intergenerational transmission of distress. Caplan took a public health approach, coining the terms primary, secondary and tertiary prevention, which were outlined in the Introduction section. These ideas were picked up in the UK by psychologists such as Douglas Bennett in the 1950s, who encouraged the rehabilitation of people in mental health institutions through vocational engagement (Newton, 2013). However, this can be seen to focus on the tertiary level of prevention. These themes progressed in the UK in the form of an interest in recovery from mental distress and social role valorisation, which became a goal for mental health services.

This section highlights the historical conditions that encouraged a tendency for UK mental health provision to turn towards tertiary prevention and recovery, rather than focus on primary, population wide preventative measures. This occurred alongside a growing assumption that mental distress should be viewed through a similar lens to physical health problems, with the implications that this had for individualising treatment and prevention. The consolidation of psychiatry's authority in the management of mental distress reinforced its conceptualisation as a biomedical issue, informing how preventative efforts could be thought about. This period also normalised the propensity for mental health policy to include both collectivist attitudes to supporting those who suffer disadvantage and inequality, alongside narratives that responsiblise individuals.

3.1.2.1. 1960s - The Community Revolution

Within this period, the process of de-institutionalisation led to increasing interest in the 'community' as the alternative to treatment in a hospital setting (Turner et al., 2015). In the 1960s, the negative impact of individualisation and the dominance of bureaucratic, controlling social institutions led a movement of activists to rally to the narrative of community as an antidote to these social ills (Burton & Kagan, 2003). This group showed solidarity with marginalised members of society, and in the US, community psychology developed with an intention to advocate for change to the social problems seen to contribute to mental distress (Tebes, 2016). Within this group, George Albee and other psychologists were instrumental in emphasising the role of social determinants in mental health and the need to take a population level approach to creating the conditions for people to thrive (Albee, 1996).

These movements were therefore important to the agenda for the prevention of mental distress. Their messages and action towards prevention didn't disappear, and have been taken forward in various forms by some services and initiatives in the UK more recently (*Community Psychology Section*, 2021; Hughes & Afuape, 2015). However, commentators suggest that their potential has been limited by the co-option of the community narrative by the range of expert professionals, practices and institutions that emerged to manage the distress of those living in the community (Ife, 1995). These involved networks of GPs, psychologists, psychiatrists, social workers, and community based teams, whose focus was arguably less on prevention, and more concerned with shaping the behaviour of individuals to allow them to exist alongside the dominant values of society. Burton & Kagan (2003) suggest that in the relatively collectivist ideological environment of the UK at this time, the activities of these workers filled the niche that community psychology was able to inhabit in other societies. The work of the psychologists among this network of professionals was influenced by the heavily individualistic focus of the academic field around psychology and mental health in the UK during this period (Burton et al., 2007).

The conditions covered in this section go some way to explain why, despite the activities in other countries, mental health policies in UK have often been characterised by an individual rather than a community level focus to prevention.

3.1.3. 1979-97 – The growth of neoliberalism

Beginning with economic downturn in the 1970s, the 1980s saw the reduced popularity of Keynesian economic policy, and a rise in alternative ideas. This occurred in the context of changes to the make-up of the UK's population, which made funding the welfare state and the NHS, and supporting those who were not within the labour market, increasingly difficult (Newton, 2013). In this setting, the economic and philosophical theories of Hayek (1944), who attested that individual freedoms should be paramount, were viewed with a fresh interest (Cosgrove & Karter, 2018). This saw the introduction of neoliberal values, resulting in interventionist government strategies such as the welfare state being scaled back, and replaced by the market as a means to regulate the economy (Rose & Miller, 1992). Increasing marketisation became a feature of Thatcher's Conservative Government of 1979-1997.

This administration's attitude to prevention through addressing the social determinants of distress was indicated by the treatment of the 'Black Report' (Department of Health and Social Security, 1980), commissioned in 1977 by the previous Labour Government. This report demonstrated that health inequalities had persisted since the development of the welfare state, and that rather than resulting from a failure of the NHS, these were due to inequality in other areas such as income, housing and employment conditions. It outlined wholesale changes to social policy to address these issues, however these were suppressed by the Secretary of State for Social Services of the time, with a limited number of copies made available for dissemination (Gray, 1982).

Later in the Conservative administration, the passing of the NHS and Community Care Act 1990 meant the NHS began to see market principles shape their day to day functioning. For

example, internal markets were introduced with the assumption that competition and entrepreneurialism would increase efficiency (Lewis, 2019). This was framed as an increase in choice and the empowerment of patients as consumers. However, the move was characterised by low levels of funding, competition between providers for contracts, patient throughput, and work that was increasingly target driven, with services focused on offering as low intensity, low cost intervention as possible. Neither of these qualities aligned well with a primary preventative agenda, which would require creativity and investment in challenging the broader determinants of mental health, without an immediate payoff for providers. Focus on prevention tended to be in reference to risk of harm to others, with the sensationalised coverage of a number of murders during the 1990s resulting in more restrictive and controlling means of managing those experiencing mental distress (Harper, 2004).

However, towards the end of this period, reports including the Global Burden of Disease study conducted with backing from the World Bank and World Health Organisation (Murray & Lopez, 1997) underscored the economic impact of mental distress. This contributed to renewed focus on prevention, as the impact of individuals' mental health on the nation's productivity, and the escalating cost of its treatment, became less and less tenable.

These events reinforced the need for mental health policies, including those relating to prevention, to be justified by an economic argument. Policies also began to reflect a reduction in government responsibility to intervene in producing the social conditions for health equality and positive mental health, and a corresponding shift in focus towards individual responsibility for the management of distress.

3.1.4. 1997-2010 - Labour administrations

Marketisation continued to be embedded, although in a diluted form, during the following Labour administration. Moth (2020) characterised this period as one of increased modernisation and centralised control, with emphasis on target setting and delineating

professional roles within mental health services. Preventative measures focused on reducing the number of people being treated through the most expensive services in the mental health system, i.e. secondary care teams and inpatient units, therefore represented tertiary approaches to prevention (Newton, 2013). This saw the focus of funds towards primary care as well as the IAPT initiative. IAPT was rolled out in 2006, with the express intention of reducing the economic burden of mental health difficulties by managing mild to moderate anxiety and depression, and encouraging people back into work (Layard, 2006). In return for their continued investment, ministers insisted upon evidence of the effectiveness and efficiency of this way of working. Therefore, a preoccupation with 'evidence based' therapies such as CBT, and accountability of services to deliver on nationally set targets, became the norm for services (Dalal, 2018).

It is also noted that the concern with risk prevention remained, both in terms of harm to the public, and the prevention of suicide (Turner et al., 2015). Turner notes that although increased spending for mental healthcare was announced, this was not proportional to the overall NHS budget, and the diversion of funds into specific areas limited the benefit to certain groups. For example, funds were channeled into secure and forensic units, and IAPT, rather than community teams that could feasibly have engaged in more preventative work.

On the international stage, the World Health Organisation (2008) acknowledged the impact of health inequalities and the role of social determinants of health, and pushed for governments to meet this challenge by taking a 'whole-of-government' approach to tackle them. In the same year, the 2008 banking crisis made it even more pressing to save resources by focusing on the prevention of mental distress and encouraging people back into work, while at the same time limiting the likelihood of genuine investment in primary preventative measures.

Newton (2013) suggests that the policy that followed, New horizons: Towards a shared vision for mental health (Department of Health, 2009), was one of the first examples of a specific interest in prevention along the vein of the contemporary prevention discourse. Prevention and public mental health were the first of the 'key themes' noted in the document. However, public mental health was then referred to only 6 times in the 150 page document, with an infographic of what this might entail and the promise that this

would be developed in the future. The need for primary prevention was specifically highlighted in the executive summary, but later in the document was linked to early intervention and the treatment of mental disorder, and was discussed in these terms. A pilot of Children and Young People's IAPT was given as a primary preventative strategy, despite this being a treatment service for those showing signs of mental distress, and therefore actually being an example of secondary or tertiary prevention.

This period established a tendency within policy to focus on secondary and tertiary prevention, and see treatment as an example of preventative action. The need to have a return on investment and show the economic benefits of policy made psychological therapies that lent themselves to a medicalised research paradigm, such as CBT, a popular choice for this treatment initiative. Policy that steered mental health provision in the direction of these therapies therefore became commonplace.

3.1.5. 2010-15 – The Coalition Government

During the Coalition administration, a number of publications made it difficult for policy makers not to acknowledge the impact of social determinants on mental health. The Spirit Level (Wilkinson & Pickett, 2010) indicated that even among wealthy countries, in societies with high levels of income inequality such as the UK, mental distress was greater. In addition, The Marmot Review (Marmot, 2010) further highlighted the social gradient of mental health in the UK. This document advised policy makers to prioritise primary prevention in the interest of improving people's wellbeing and preventing the economic burden of mental health difficulties. This was taken forward in the white paper HLHP (Department of Health, 2010), which claimed to be the first public health policy to show parity of esteem to both mental and physical health in terms of its actions.

HLHP also introduced the new Public Health England, which would move public health functions from primary care trusts to dedicated local authority teams. This was with a view to tackling the health inequalities outlined in the Marmot Review in a coordinated, managed

response with a ringfenced budget (Gregory et al., 2012). The stated aim was for this to target the wider determinants of health, for example housing, crime and employment, taking the onus away from the Department of Health alone. However, HLHP retained a heavy emphasis on individual people's choices and lifestyle as the underlying problem with heath inequality, and therefore focused on behaviour change as the solution. The policy's neoliberal principles extended from individualisation such as this, to localism at the level of service delivery. HLHP took pains to move away from 'nannying', and therefore did not compel local authorities to take any particular action against the social determinants of health. While existing under the justification of choice and a locally tailored approach, in a time of austerity this was likely to have limited the public health impact of the policy (Scott, 2015).

A following cross-government strategy, NHWMH, discussed mental health prevention as one of its six key aims. In similar style to other documents within this recent prevention agenda, its introduction explicitly referred to social inequality and the development of distress, and this policy went further to acknowledge the disproportionate impact this has on Black and minority ethnic groups and socially disadvantaged young people. NHWMH again refered to the future publication of public mental health guidance rather than outlining detailed primary preventative strategies. Nevertheless, it described the policy's work to guide the direction of mental health services as a public health strategy.

Following this, the NHS published a strategy document for mental and physical health. The FYFV discussed the rationale for prevention primarily in terms of reducing the burden of disease on the NHS, and the efficiency savings this would allow for. It framed the lack of preventative action as a threat to the prosperity of the country, necessitating 'hard hitting action'. Strong language was used to unsubtly responsiblise individuals, communities and local authorities for the preponderance of avoidable illnesses, which were seen to 'crowd-out' and divert funds from more worthy causes such as new treatments. The funding for preventative action was envisaged to come from efficiency elsewhere in the system, and increased volunteerism. Self-management through the provision of courses and information were seen as suitable preventative measures.

This period saw renewed focus on the social determinants of distress, and the need for government mental health policy to be seen to address this. However, this was held alongside narratives that responsiblised individuals, communities, NHS inefficiencies, and local authorities in the prevention of distress.

3.1.6. 2015-present - The Conservative Government

During the succeeding administration, the Five Year Forward View for Mental Health (FYFV-MH; Mental Health Taskforce, 2016) reviewed the FYFV's progress and drew attention to mental health specifically. It highlighted an ongoing shortfall in progress to address social determinants. Its language was notably less blaming, and there was greater recognition of processes involved in the development of mental health problems. Social determinants were implicated, however there was a struggle to consistently and coherently link these into the cause of mental distress in a way that took into account the complexity of this process. As such, focus on social determinants rarely influenced the FYFV-MH's preventative actions. The document focused instead on the need for further research into the causes of mental distress and local variations in need. Preventative actions included less variable access to treatment, increased screening, and early intervention, particularly perinatally and with children.

To take forward the FYFV-MH's preventative suggestions, the Prevention Concordat was developed (Public Health England, 2017). In line with a neoliberal agenda, this focused on the desirability of prevention as a means to improve individuals' capacity to deal with stress, be productive, improve their physical health, better their relationships, make use of their own abilities, and contribute to society, using the metaphor of health as an asset. The Prevention Concordat took a novel, public health approach, providing supportive resources to delegates who opted to commit to the pledge of prevention. This acknowledged the need for preventative action to happen outside of the healthcare system, and involve businesses, organisations and communities. However, the Government was criticised for

placing the onus for this action on external bodies during a time of cuts to local authorities, with no additional funding to make substantial changes or obligation to show a particular outcome (All Party Parliamentary Group on Mental Health, 2018).

The same aims as the Prevention Concordat were picked up by PBC and the corresponding speech (The Rt Hon Matt Hancock MP, 2018), and What Good Looks Like for Public Health (Public Health England, 2019). In PBC, prevention was framed as keeping people well and out of resource heavy settings such as hospitals. It was also conceptualised as considering the root causes of poor health and intervening there, however the possibility of preventing mental distress arising from adverse childhood experiences seemed to be questioned in the following quote, "Some diseases - such as those we are born with or inherit through our genes - cannot currently be prevented. Traumatic experiences in childhood can have a lasting impact on our mental health. But many causes of ill health are preventable." (PBC, p. 7). Each of these documents stressed whole population approaches and upstream working on wider social determinants to make this a reality, but operationalised their actions as access to evidence based, NICE recommended treatments, healthy lifestyles, increased mental health literacy, and improving the holistic working of existing mental health services. This was opposed to a movement towards primary prevention of mental distress.

This was also considered to be possible within existing funding arrangements, until the contribution of the LTP, which committed £2.3billion to mental healthcare. Prevention featured, particularly as a means to reduce the impact of common mental health problems on national productivity and mental health expenditure, and to intervene in a timely way to reduce the need for high intensity interventions such as hospital admissions. In the LTP, NHS England emphasised that the NHS is not an institution with full responsibility for prevention. This was a theme that was picked up by the mental health specific NHS strategy document, the MHIP. As a result this document included very little mention of prevention. Population level action was instead contrasted with a tailored approach to meet local need, the latter being framed as the more appropriate response. Personalisation, choice and control were also framed in a positive light, alongside increasing access to psychological therapies, employment support and physical health screening.

The prevention agenda continued to build at this time, alongside pressure from the international community. In a report by the United Nations Special Rapporteur (Alston, 2019), the UK Government was critiqued for its policies of austerity since 2010, and further implored to tackle social determinants of distress. In 2019 the Government produced the green paper AoH (Department of Health and Social Care, 2019). The document used language that acknowledged the damage caused by health inequalities and their additive effect on certain people and communities. The issue of primary prevention was discussed explicitly. However, while the previous documents produced by NHS England downplayed their role in prevention, AoH (as a Department of Health and Social Care policy) focused many of its actions for mental health prevention back on the NHS. These again prioritised increased access to early treatment within traditional mental health services. Despite stating the need for organisations and departments to work together for the sake of prevention, a cross-departmental commitment did not follow from AoH.

Shortly after AoH, NHS England commissioned the CMHF, a strategy document for adult and older adult community mental health services. This was characterised by very little mention of prevention. It did not give a rationale for prevention, other than to acknowledge this as a LTP requirement. The CMHF again gave allusions that prevention was not the remit of a CMHT, and referred to strengthening connections to local community groups and the voluntary sector, within whose remit the work on health inequalities and social determinants was located. Whole population approaches and 'rights based care' were condoned by the CMHF, but clarity was not provided as to what this would look like. Later in the text, population health approaches were considered to be about living well in the community alongside mental health difficulties, rather than preventing mental health problems, and NICE recommended psychological therapies were deemed to be service users' priority. Although social determinants of mental health were recognised in the CMHF, this was in the context of treatment being targeted towards disadvantaged populations, rather than the social determinants themselves being acted upon.

3.1.7. Historical Analysis Summary

The Historical Analysis outlines some of the conditions that led to the current interplay of discourses present in recent policies pertaining to prevention. These policies can be viewed as a sometimes uneasy blend of priorities and concepts. In some aspects, they held onto the collectivist approach that provided the foundation of the NHS, assuring the reader of the importance of equality for all, and the need to address the social aspects of health and mental distress. This message was reinforced in response to publications that shone light on health inequalities and the social gradient of mental health. The need for prevention, including through population health approaches, was also justified in policy through an economic argument for upstream approaches to alleviate mental distress.

These notions were combined, on the other hand, with the tendency for policies to represent the development, and prevention, of mental distress in individualistic rather than social terms. At times this was characterised by a biomedical approach, and on other occasions through moralistic insinuations about the personal responsibility for managing mental distress. In addition, policies often made use of narratives that stressed the importance of addressing wider determinants, while representing the retraction of intervention through state provision. These characteristics informed the preventative actions suggested. Rather than addressing wider determinants, NHS and government responsibility was regularly framed in policy as providing for secondary and tertiary prevention in the form of greater treatment provision. Often this was as low intensity and individual-led as possible, using therapeutic models which lend themselves to outcome measurement and medicalised research paradigms, so as to justify their investment. Personalisation, choice and control were concepualised as the priority when providing for peoples' needs. This was done in a way that responsiblised local authorities and communities, as well as individuals, for the management of mental distress, as opposed to the provision of wider population health approaches.

The contradictions inherent to these policies warrant further exploration. Close analysis of the rhetorical and discursive means by which the concepts of mental health, social

determinants, prevention, population health and responsibility are treated will add to the understanding of the obstacles that stand in the way of the prevention of mental health difficulties. This will be undertaken in the following Discursive Analysis section.

3.2. DISCURSIVE ANALYSIS

The Discursive Analysis section represents Stage 2 of Fairclough's (2001) 5 stage framework for conducting CDA outlined in the Method section, identifying obstacles to the social problem being tackled. It specifically relates to Part c, the analysis of the semiosis itself (see Table 1).

3.2.1. Selection of the texts

On the basis of the Historical Analysis, which concludes with a focus on the policies that form part of the recent prevention agenda, two texts were selected for inclusion into the Discursive Analysis. AoH, published in July 2019, is a recent green paper and as such is part of the Government's process of reform, whereby proposals for policy change are outlined and opened up to wider consultation. This is the stage of policy development prior to the publication of a white paper, which presents Government's proposals for legislation. After any final adjustments, the policy may then be presented as a Bill to Parliament and become enshrined in UK law. At the time of writing, the white paper to follow AoH had not yet been published. The second text was the MHIP. Published in the same month, it operationalises the LTP's actions towards mental healthcare within the NHS. It contains information relating to funding pathways, workforce planning, timeframes, and the transformation of services to meet the targets of the LTP.

The texts above were chosen for a number of reasons. AoH was considered informative given that it exemplifies the discursive themes that were highlighted repeatedly in the Historical Analysis section, for example the economic rationale for prevention, narratives of individual and community responsibility, social determinants and inequality, and self-management and access to treatment versus primary prevention. This representativeness avoids the risk of selecting a policy that is an outlier, or cherry picking a policy on the basis of a predetermined theory or bias (O'Reilly et al., 2021). There were other policies in the cluster which would have also met this criteria, given that similar discourses are to be found across this selection of documents. However, AoH was prioritised in line with its specific focus on prevention and its status as a green paper. As CDA is interested in social change, a green paper is of particular interest due to the power it holds to influence nationwide legislative change.

The second document, the MHIP, was selected as a suitable comparison with AoH. Both are likely to have been influenced by similar documents, for example the Government's vision paper PBC and the LTP, and therefore can be conceptualised as another facet of the same policy development process. Their timing of release in the same month may have indicated the Government's acknowledgment that both documents form part of the same strategy. They represent the progression of policy, one being the culmination of the Government's vision for future directions mental health prevention, and the other being the settling of this narrative into a strategic guide for the NHS. The analysis may shed light on the discursive methods by which this was achieved.

It is of interest, then, to consider the ways in which the discourses within each text differ. Given their temporal relationship, these variations are likely to be due to their distinct audiences and the work that each text is intended to deliver (Fairclough, 2001). Both also had the benefit of being relatively current, within the boundaries of the inclusion criteria for the study, and the fact that both remain active documents adds to the relevance of the analysis to clinical psychology practice. AoH will be considered first, given that it represents a stage of the policy making process prior to an NHS strategy such as the MHIP. The analysis of the MHIP will then compare and contrast discursive content in relation to the AoH.

3.2.2. Advancing our Health

3.2.2.1. Organisation of the text

The AoH is arranged as a narrative with a form of problem-solution structure, whereby the green paper justifies its solutions by the way in which it frames the problem to be tackled. It consists of an Executive Summary, Introduction, three chapters entitled Opportunities, Challenges and Strong Foundations, followed by a Conclusion. The chapter Challenges identifies the problems that face the NHS as; smoking, obesity, inactivity, mental health issues, wider factors, and prevention in the NHS. The solutions are framed as Opportunities and are cited as intelligent public health, predictive prevention, focused support and advice, predictive medicine, and tackling future and current threats. These are embellished in the chapter Strong Foundations, which adds further specifics and case studies to the Government's proposed plans for preventative reform. These include a focus on childhood, creating healthy spaces, prevention in older adulthood, national actions, research, and local actions. The argument is brought together into a final, concluding chapter. Each section includes consultation questions posed to the reader in separate text boxes.

This policy document incorporates both the prevention of physical health as well as mental health difficulties, and is therefore broader than the scope of the current study. However, an overarching discourse within AoH is that of parity of esteem, where the similarity between mental and physical health are emphasised, ostensibly as a rationale for both being given equal weight and priority in health policy. Parity of esteem has ties with medicalising discourses in which mental health difficulties are framed as illnesses like any other, and therefore understood to benefit from similarly individualised treatment situated firmly within a health framework (Timimi, 2014). In line with these assumptions, mental and physical health are regularly discussed interchangeably and in the same terms in AoH. Therefore, the following analysis will include sections of the policy that pertain to health and prevention in general, unless the subject is clearly that of physical health.

AoH uses a declarative, as opposed to a questioning or tentative, tone at times. This is indicated by its opening statement:

> The 2020s will be the decade of proactive, predictive, and personalised prevention. This means:
>
> • targeted support
>
> • tailored lifestyle advice
>
> • personalised care
>
> • greater protection against future threats (AoH, p.3).

The policy's modality regularly demonstrates a firm commitment to its chosen narrative and actions, in the style of an expert giving information:

> But for it to succeed, and for us to transform the NHS and improve the nation's health over the next decade, individuals and communities must play their part too (AoH, p.3).

The aim of a green paper is generally to outline a problem, offer proposals to address this, and then consult on these proposals. As a result, declarative statements can be expected. However, green papers may vary with regards to how problems are framed, the range of different proposals offered for consideration, and the style of language used. In a study of New Labour policy, Fairclough (2001) argues that, under neoliberalism, green papers have become a form of promotional literature designed to 'sell' a particular policy, limiting genuine debate on social and political issues. However, it is unclear if Fairclough bases this view on an empirical analysis of green papers over time. As their content is built on the authors', generally civil servants, understanding of the subject area, this will inevitably be influenced by the dominant discourses available to them at the time.

Either way, it is to be expected that AoH, although intended as a consultation around mental and physical health prevention and population health, may emphasise policy

directions from a circumscribed pool of possibilities. The following sections will consider the discursive methods by which these multiple functions of AoH are achieved.

3.2.2.2. The rationale for prevention: Improving quality of life or managing economic burden?

The multiplicity of intentions for AoH are visible in the text through the rationale given for prevention. In the introductory section, the intention is set for the document as a means to address the finding that increasing life expectancy in the UK is slowing, at the same time that people are spending a greater number of years living in poor health. In a text box entitled ‘The Mission’, the aims of the policy are linked to a separate Government strategy entitled the ‘Aging Society Grand Challenge’ which seeks to add 5 years to the proportion of people’s lives spent in good health, whilst reducing the discrepancy between the rich and the poor. These sentiments align with the social problem identified for this study; the advancement of the prevention agenda to reduce the human toll of mental (and physical) ill health across the population.

And yet, the ‘Aging Society Grand Challenge’ comes at a time where successive Conservative governments have faced criticism for economic policies of austerity and cuts to public services, with some commentators suggesting that they have set the conditions for the opposite outcome (Marmot et al., 2020; McGrath et al., 2016). This indicates that the quality of life discourse in AoH may be being utilised as a rhetorical strategy, obscuring the role that social and economic policy has had in the creation of the problem.

The quality of life rationale features alongside an economic rationale for prevention. This is not acknowledged as a topic in and of itself until page 61 of 76, when Value for Money is presented as a heading, suggesting that the economic rationale as a secondary, incidental benefit of work towards prevention. However, the issue of the financial impact of mental health difficulties on the economy, and the cost of mental health services to the NHS are alluded to throughout AoH, as these passages indicate:

> Mental health problems can have a broader impact on society. Poor mental health at work costs the UK economy between £74 billion and £99 billion per year (AoH, p.39).

> We are spending more on mental health services. The NHS Long Term Plan commits at least a further £2.3 billion a year by 2023 to 2024 (AoH, p.38).

These narratives demonstrate the wider intention for AoH as a solution to the problem of increasing pressures on the NHS and the burden of mental illness on the economy, rather than simply a moral drive to improve the health and quality of life of people in the UK. This can be understood in the context of escalating demand for mental health services and increasingly poor mental health of the nation, potentially as a result of rising inequality (Patel et al., 2018; Wilkinson & Pickett, 2010) and as a feature of post-industrial, neoliberal society (Newton, 2013; Roscher, 2020; Zeira, 2021).

3.2.2.3. Constructions of health: The responsibility for health as an asset

The primacy of the economic argument for prevention is repeatedly presented in AoH through an analogy for health itself; that of health as an asset. For example:

> Viewing health as our most precious asset, and not just a problem to fix when it goes wrong. Good health is the foundation of happy families, thriving communities, and a strong economy (AoH, p.12).

This has clear links to neoliberalism, which is associated with the belief in individual responsibility for the outcomes of one's life, and one's position in society (Cosgrove & Karter, 2018). Applied to health, the filter of this world view sees health as a commodity to be coveted, something that allows us to compete, and, importantly, an asset to be worked for. It has been noted that a neoliberal filter in the construction of mental health is linked to policies which put the onus on individuals and families to prevent and manage mental ill

health (Callaghan et al., 2017; Teghtsoonian, 2009). There are multiple examples of this type of responsibilising discourse throughout AoH, evidenced in the following passage:

> When our health is good, we take it for granted. When it's bad, we expect the NHS to do their best to fix it. We need to view health as an asset to invest in throughout our lives, and not just a problem to fix when it goes wrong. Everybody in this country should have a solid foundation on which to build their health (AoH, p.5).
>
> …focused support and advice to those who need it and choose to participate (AoH, p.13).

In these examples, the problem is seen as members of the public who are framed as expectant, over-reliant, burdensome, and have lacked the effort to maintain their own physical and mental health. The assumption within this responsiblising discourse is that all individuals have equal agency, opportunity and privilege to make the positive choices that influence their health. Constructing health in this way serves to downplay the role of contextual factors that lay outside of individual's control, such as ACEs, poverty, the environment they grew up or currently live in, and the broader socioeconomic policies that effect these (Callaghan et al., 2017). It also serves to suggest that the fault lies not in the lack of preventive action being undertaken by the Government, but the lack of uptake of support and advice by individuals (Teghtsoonian, 2009).

These discourses of asset and responsibility justify the particular preventative measures of AoH. Rather than focusing on overarching social determinants, the logical solutions to these discourses are health policies that focus on patient choice and self-management (Harper & Speed, 2012). This is evident in the passages below:

> In the 2020s, people will not be passive recipients of care. They will be co-creators of their own health. The challenge is to equip them with the skills, knowledge and confidence they need to help themselves (AoH, p.3).
>
> It can feel like the odds are stacked against us. This is particularly the case if you're living on a low income or have a serious mental illness or learning disability. This

> green paper is not about nannying, but empowering people to make the decisions that are right for them (AoH, p.24).

In the domain of mental health, this translates into individualised interventions that are often low intensity in nature and rely on the self-management of distress, such as the Every Mind Matters website and its self-help information, and improving access to IAPT for the guided self-management of anxiety and depression. For those with what AoH describes as serious mental health problems, the individualised solutions are to provide greater access to psychological therapy, employment support, and physical health screening. It is of note that all of these interventions represent treatment as opposed to prevention.

This section highlighted the construction of health as an asset, and its links to responsiblising discourses. The following section will look beyond constructions of good health, to consider the various discourses relating to the causes of mental distress within AoH.

3.2.2.4. What are mental health problems?

To understand AoH's position on the causes of mental distress, it is relevant to consider what the policy means when it alludes to difficulties with mental health. However, this is changeable throughout the document, and at times isn't clearly defined. Anxiety and depression are the only mental health difficulties listed by diagnosis in AoH, and are described as 'common mental health problems'. These difficulties tend to be referenced in the policy when stressing the deleterious impact of the high volume of mental health cases, for example:

> Poor mental health is the second most common cause of years lived with disability in England. The most common conditions are depression and anxiety, which make up the majority of mental health cases. Approximately 1 in 4 people report living with a mental health issue (AoH, p.9).

The other type of mental health difficulty AoH refers to is 'serious mental illness', although what is meant by this isn't clearly specified. However, AoH does not always distinguish between common and serious mental health problems, and more commonly conflates the two or uses 'mental health' as a generic term. This ambiguity can be seen as a strategic choice, in that solutions that may aid the management of anxiety and depression, for example the provision of self-help information, can be cast as preventative measures for all mental health difficulties, as evidenced in the following statement. In reality, there is no evidence to suggest that these actions could constitute prevention or treatment for more severe and enduring experiences of mental distress.

> We will launch the Every Mind Matters campaign nationally in October 2019 with the goal of making 1 million adults better informed and equipped to look after their mental health and support others. The campaign will include a new tool that asks a series of questions and then recommends simple, personalised actions to improve individuals' mental health (AoH, p.40).

In fact, AoH is unclear about whether it sees the prevention of serious mental illness as a possibility. These types of mental health difficulty were alluded to twice, both times alongside learning disabilities, as in the example below:

> In the 2020s, home adaptations, assistive technology and supported housing will be more important than ever; helping people to stay independent for longer and supporting those with complex needs including serious mental illness, learning disabilities and autism to lead good quality lives in communities (AoH, p.55).

This statement is reminiscent of the following passage, which distinguishes between courses of action for ill health that can and cannot be prevented. Although the following quote doesn't specifically allude to mental health, the reference to quality of life in contrast to prevention in both instances could indicate that AoH sees 'serious mental illness' as something which is not preventable.

> The good news is that much premature ill-health and disability can be prevented, and there are actions we can take to increase our chances of living longer, healthier

> lives. Some health conditions we are born with and cannot avoid. Where this is the case, the priority is supporting people to enjoy a good quality of life and to live well (AoH, p.10).

This is of relevance to the current study, as framing a difficulty as unpreventable and instead shifting the focus to maintaining quality of life has consequences for the actions that AoH is then able to justify. For example, if there is no possibility of preventing serious illness, it becomes reasonable to advocate for treatment services to alleviate the impact on a person, rather than implement policies that target the determinants of mental ill health at a population level. The use of the narrative of argument in this way also relates to what AoH assumes to be the cause of mental distress, which will be discussed in the following section.

3.2.2.5. What causes mental health problems?

Across society, policy, and even the discipline of clinical psychology, the causes of mental distress are debated, and different discourses of varying dominance exist in relation to this debate (Craddock & Mynors-Wallis, 2014; Read et al., 2009). As Albee points out, what those in power attribute the cause of mental distress to influences what measures they will deem appropriate in preventing it (Albee, 1996). It is therefore particularly relevant to consider the discourses around the cause of mental distress in AoH. The two most apparent are social determinants and biomedical discourses.

Social determinants discourse

As with the quality of life discourse, AoH takes pains to explicitly outline its position on the social causes of mental distress. Following damning findings of influential reports such as the Marmot Reviews into the impact of inequality on health (Marmot, 2010; Marmot et al.,

2020) and critiques of the biomedical narrative by the United Nations (United Nations, 2017), this is necessary for the credibility of policies considering the prevention of mental and physical ill health. The following example serves to reassure readers that AoH intends to take these social determinants seriously:

> But we know that some people find this easier than others. Not because of innate differences in their decision-making, skills or values, but due to differences in the circumstances they are born into and the conditions in which they live (AoH, p.49).

Biomedical discourse

However, as has been discussed, AoH assumes that some mental health problems are illnesses that we are born with that are unavoidable. This idea aligns more strongly with a biomedical discourse about mental health, which, although strongly contested, is currently dominant within society in the UK. As aforementioned during the discussion of parity of esteem, from a biomedical standpoint, mental health is analogous to physical health. Both are discussed within a health metaphor, in terms of illness, disease or disorder. Assumptions are made that both have a clear, linear causal process, and therefore similarly a clear, linear treatment process (Mollon, 2009), as illustrated in case study below:

> Anxiety and depression at work: Helen’s story
> Helen was first diagnosed with a mental health condition 15 years ago. After speaking to colleagues at work, Helen now receives the help and support she needs to continue in her role (AoH, p.9).

Of note is how this biomedical, individualised framing of mental health influences ideas as to the types of actions that might be preventative. The selective narrative account of the statement only contains the fact that she had a mental health condition, spoke to colleagues, and now has the help and support needed to return to work. It paints a straightforward process, in which speaking to colleagues is a positive experience, and the

help and support is readily accessed, sufficient and successful in resolving her mental distress. From this perspective, the desirability of returning to work is treated as self-evident, and providing 'help and support' a common sense approach to mental health. Other information absent, for example the conditions of her employment and the context that may have influenced her mental distress at work.

Newton (2013) points out the risks to a public health approach that a medical analogy for mental heath can have. They suggest that belief that a single cause leads to a single outcome can conflate visible, proximal causes of distress with more distal, underlying causes. This serves to individualise people like Helen's mental health difficulty as something inherent to her rather than her environment, closing down other potential avenues for alleviating distress. In a real world example, these might include advocating for better conditions of work or choosing to leave that role. This limits our perspective on preventative measures to the provision of individual support, rather than broader interventions to improve working conditions across the nation. It is also another example of treatment being advocated for rather than prevention.

How biomedical discourses come out on top

Of interest to the present study is how social determinant and biomedical discourses are held simultaneously by AoH, and how these methods relate to the actions towards prevention that the policy recommends. These shall be considered in turn.

Passive voice: Although AoH reassuringly draws attention to social determinants of mental distress, its use of passive language does so in a way that does not necessarily take responsibility for the role of policy in influencing these. This is an example of (Fairclough et al., 2004) notion of nominalisation, whereby focusing only on the effect of a social process serves to obscure the process itself and the involvement of social agents within this. For example, in the passage below, 'inequalities also exist', and 'cluster together' has the effect

of framing social determinants of mental distress as inevitable, obscuring the role of government and policy.

> Inequalities also exist across a range of other dimensions, including ethnicity, gender, sexuality and having a disability. The underlying causes of these inequalities often cluster together, with people experiencing 'multiple disadvantage' (AoH, p.7-8).

Other contributors to mental health on the other hand, for example sleep, are framed as resolvable and therefore legitimate targets for intervention. This process allows particular strategies to dominate AoH's suggested actions, for example sleep interventions and Every Mind Matters.

Active voice, but without committed action: In other areas of AoH, tackling social determinants is covered in a more active way. And yet, this also falls short of commitment to amend policy and target the root social causes of mental distress. For example, in the consultation question below, the wording is structured in such a way as include only health and social care policies. This closes down discussion of the influence of wider policy on mental health, including employment, housing and welfare.

> Q - Which health and social care policies should be reviewed to improve the health of people living in poorer communities , or excluded groups? (AoH, p.8).

In a section of AoH entitled 'Tackling risk factors and strengthening protective factors' on page 39, commendable preventative actions are listed. However, these are not always followed up with a clear plan of action. Or, when a plan is outlined, it can be individualised along with a biomedical discourse in a way as to fall short of meaningfully engaging with social determinants. For example, ACEs and violence are cited as a risk factor that requires urgent action. However, the suggested action refers to a Reducing Parental Conflict Programme, an ill-defined initiative which aims (at some point in the future) to gather evidence and resources for 'practitioners' working with parents who experience conflict. This initiative problematises parents and singles out workless parents as the most detrimental to childhood outcomes (Department for Work and Pensions, 2020). This is an

example of how language can be used to give the impression of constructive action on social determinants of mental distress, while delivering the opposite.

Social determinants or health inequalities?: Another way that the social determinants discourse is undermined in favour of a biomedical discourse is through AoH's treatment of the term 'inequality'. In some areas of the policy this is used as one might expect, to denote the cumulative, unequal life experiences that disadvantage certain social groups and constitute the social determinants of mental distress. An example of this is quoted in the 'Passive Voice' section of this study.

However, later in the document, rather than referring to the underlying causes, the term 'inequality' denotes unequal outcomes. It focuses on disproportionate representation of certain groups in services, or succumbing to a particular problem or disease, rather than the underlying experiences that lead to differences in outcome. The example below is discussed in AoH as an inequality:

> Although smoking rates are falling overall, they remain stubbornly high in certain groups, including: […] among people living with mental health conditions (AoH, p.26).

Applying the term 'inequality' to both these instances allows AoH to use phrases such as 'reducing these inequalities' to infer commitment to preventing social determinants. However, its actions actually focus on the second definition of inequality, and are therefore preoccupied with increasing access, assessment and screenings for disorders among underrepresented groups. These actions fit with a biomedical explanation of mental health, and do nothing to prevent the experiences that make people from certain groups more likely to smoke, for example, or develop mental health difficulties in the first place.

Representing cause and effect: There are other examples of the confusion of cause and effect that serve a similar function within AoH. The biomedical, straightforward, linear pattern of cause and effect is drawn on regularly, for example in describing mental ill health as a cause of physical health problems, as in the following passage:

> When it comes to preventing health problems, much of our focus is still on people's physical health. Less attention is given to the steps we can take to improve our mental health and wider sense of wellbeing. This is despite our physical and mental health being closely related – physical health problems increase the risk of poor mental health, and vice versa (AoH, p.38).

This allows the notion of prevention and mental health to coexist in the same statement, and appears to advocate for preventative action for both mental and physical health. However, 'steps we can take to improve our mental health' suggests secondary or tertiary rather than primary prevention, therefore early treatment for existing mental health problems to alleviate their impact on physical health. In this case, despite alluding to parity of esteem, AoH prioritises primary prevention only in relation to physical health.

The causal link between mental and physical health is also oversimplified in the quote above. This occurs in other areas of AoH, such as the following statement which considers early intervention in preventing mental distress:

> Children are also affected by the wellbeing of their parent or primary carer. We need to recognise the impact that parental mental ill-health, parental drug and alcohol addiction and domestic abuse can have on a child's life chances (AoH, p.49).

Although this comment shows some useful ideas in relation to prevention by considering people's early life experiences, it utilises a biomedical discourse to individualise the causes of mental distress, locating the fault solely with parents. The impact of parenting shouldn't be downplayed, and parents hold responsibility to provide care that meets their child's physical and emotional needs. This is not always forthcoming, as reflected in the significant rates of childhood abuse and neglect present in the UK (Office of National Statistics, 2020). Research suggests that parents and children can benefit from interventions that focus on strengthening the relationship between them (Barlow et al., 2016), and that perinatal mental health service provision can improve child outcomes (NICE, 2020).

And yet, by highlighting a linear relationship between parental mental health, addiction and abusive behaviours on child's mental health, AoH obscures variables that might underly

these ‘risk factors’, such as stress or intergenerational trauma arising from wider social determinants like discrimination and poverty. This leaves AoH free from the responsibility to act on these, and instead limits suggestions to increasing access to traditional mental health or substance misuse services. Again, this constitutes treatment as opposed to prevention. This is likely to produce less positive impact on rates of mental distress in the population than offering parental support in addition to addressing the structural causes of distress. A summary of the actions that AoH does endorse will be brought together in the following section.

3.2.2.6. What the discourse achieves: The actions of AoH

The sum of the discursive strategies highlighted enables AoH to justify a particular direction in terms of its preventative measures for the nations mental health. Although at times conflicting, discourses relating to economics, individual responsibility and biomedical explanations are textured together with those pertaining to quality of life and social determinants of mental health. The result is an image of AoH as a document which values equality in health, wellbeing and quality of life, but is required to balance this with pragmatism in the face of a critically strained NHS. The cause of this burden are the mental and physical health problems that arise from lack of information, reluctance to take onboard help and advice, poor choices and worklessness within the population. The solutions to this are straightforward, obvious and necessary.

However, on closer inspection, the given solutions are at times contradictory to AoH’s explicitly stated aims. Through the neoliberal, individualizing standpoint of the policy, the target of intervention is moved away from social determinants and changes to wider socioeconomic policy, onto secondary or tertiary preventative strategies focused on a local level. This is highlighted by the conflict between the following two statements, which are spaced 8 lines apart from each other:

> These measures will help to shift the health system away from just treating illness, and towards preventing problems in the first place (AoH, p.4).
>
> [We are] Launching a mental health prevention package, including the national launch of Every Mind Matters (AoH, p.5).

Physical health prevention is primary, mental health prevention is secondary or tertiary

One characteristic of AoH's actions are that while primary preventative strategies are sometimes highlighted for physical health, for example renewing water fluoridation schemes to tackle problems with childhood dental health, these are uncommon in the strategies for mental health. The discursive devices discussed in previous sections explain why, instead, preventative action for mental health difficulties are individually focused and limited to secondary and tertiary measures. These include increased screening and assessment of mental health problems to facilitate early intervention, increased provision of traditional services and one to one therapy, and efforts to encourage those with existing mental health problems to return to work or manage their physical health differently. Interventions are characteristically low cost, low intensity and quick to deliver. These include interventions for sleep, and the provision of information and self-help, for example the Every Mind Matters website, and information to parents to take responsibility for their children's self-harming behaviour.

Local over population level action

Related to this point, AoH also tends to suggest local rather than population level solutions for mental health prevention. On a number of occasions, traditional public health approaches were framed as outdated in comparison to what the policy describes as

‘intelligent public health’. An example of traditional public health used was the primary prevention strategy to ban smoking in public places. This is contrasted with ‘proactive, predictive and personalized’ (p. 3) intelligent public health strategies, which advocates the use of big data and genomics to tailor preventative strategies to local areas.

This occurs in AoH, despite the evidence for the benefit of widescale population level changes in improving health. As Albee pointed out, ‘Individual psychotherapy is available to a small number only. No mass disorder has ever been eliminated by treating one person at a time’ (Albee, 1999, p. 133). The policy itself is obliged to acknowledge this, and yet still seeks to persuade readers of the benefit of an alternative approach:

> The new personalised prevention model offers the opportunity to build on the success of traditional public health interventions and rise to these new challenges (AoH, p.4).

AoH achieves this through the use of vocabulary that alludes to a modern, sophisticated, almost science fiction approach to prevention, as in the following statement:

> New technologies such as genomics and artificial intelligence will help us create a new prevention model that means the NHS will be there for people even before they are born (AoH, p.3).

Traditional public health measures, on the other hand, are not only described as dated, but also intrusive and poor value for money:

> There will always be a place for interventions that improve everyone’s health. But it can be less intrusive and better value for money to offer people more personalised and tailored support. Many are already opting in to this kind of approach (AoH, p.13).

This is not to say that there is no role for the creative use of local level, nuanced data and new technologies in the management of mental distress, and increased choice in the modality in which people engage with mental health services can be valued by clients and clinicians (National Institute of Mental Health, 2019). And yet, traditional or longstanding

ways of doing things are also not inherently negative or problematic. However, framing them as outdated is a strategy that can serve to discredit existing approaches in favour of the writer's chosen alternative (Harper, 2004). In this instance, disputing population level interventions and opting for localised, targeted, secondary or tertiary preventative approaches allows a cheaper solution to prevention that negates the need to change broader social and economic policy.

In addition, emphasising data driven, locally tailored approaches taps into the 'promissory note' of big data. This is a rhetorical device, where a desired research outcome is positioned just around the corner, in order to persuade people of its imminent materialisation (Soyland, 1994). In this way, AoH frames the solutions to mental health prevention as mysterious and unknown by focusing on the need for further research into individual populations before any interventions can be implemented. This obscures the fact that the social causes of mental distress, and therefore the solutions to them, are actually well established (McGrath et al., 2016; Patel et al., 2018; Wilkinson & Pickett, 2010). This avoids the need to immediately act and deliver on primary preventative approaches.

The following section of the discursive analysis will move on to consider the MHIP, comparing and contrasting its content with that discussed above.

3.2.3. The Mental Health Implementation Plan

3.2.3.1. Organisation of the policy

The MHIP is an NHS strategy document organised across an introduction, two main sections, and two annexes. 'Section 1 – Overview' summarises the mental health commitments of both the FYFV-MH and the LTP and outlines service planning, implementation targets, workforce considerations, and the financial transparency of LTP funding. It also has a

section dedicated to 'Advancing mental health equalities', followed by opportunities for the voluntary, community and social enterprise (VCSE) sector. In 'Section 2 – The Implementation Plan for Mental Health', each of the LTP commitments are addressed in turn by service area, for example there is a section for adult severe mental illness and community care, a perinatal mental health section, and so on. Annex A includes a breakdown of mental health expenditure by service area for the upcoming 5 year period, while Annex B contains a workforce plan for the 5 years, broken down by professional group and service area.

3.2.3.2. Prevention discourse: Conspicuous by its absence

Initial readings of the MHIP highlighted a marked reduction in focus on prevention between this document and AoH. As an illustration of this, the word 'prevention' and derivatives of this were mentioned 153 times across the 76 pages of AoH, and 15 times over the 56 pages of the MHIP, almost entirely in relation to the prevention of suicide and rough sleeping rather than mental health problems themselves. While an element of this pattern is to be expected given the specific preventative focus of AoH, it still indicates a sharp difference in priorities between the two.

This is reinforced by the lack of recognition of prevention as an important aspect of the LTP by the MHIP, despite it featuring regularly alongside discussion of health inequalities in the LTP. Although there is a section of the MHIP dedicated to "Alignment with other priority areas in the NHS Long Term Plan" (MHIP, p.16), prevention is not featured. This highlights that while mental health prevention was included in the more rhetorical sections of the LTP, it was not specifically included in its operationalised actions, which the MHIP takes forward. This is relevant to the social problem under study, given that the MHIP has the power to shape mental health service delivery for the foreseeable future.

It is perhaps not surprising that the MHIP does not go over and above the explicitly mandated sections of the LTP in order to include prevention, given the under-resourcing of

mental health services at the time of its publication (Afuape, 2020). This also raises questions about AoH's ability to deliver on action towards prevention where the LTP has not.

So what happened to the prevention discourse? It is proposed that three discursive themes allow prevention to be almost absent from the MHIP, despite its priority in the LTP and AoH. These include the assertion that social determinants are outside of the remit of the NHS, questions as to the preventability of serious mental illness, and prevention not being stakeholders' choice when it comes to mental healthcare. These themes will be discussed in turn.

Social determinants are, "beyond the remit of the health system alone"

Related to this theme were the MHIP's use of prevention and population health discourses, the focus on health inequalities rather than social determinants of mental health, and the MHIP's actions towards local rather than population level interventions.

Drawing on prevention and population health discourses: The prevention discourse is not the only one to be noticeably absent from the MHIP. Related to the 'passive voice' on social determinants in AoH, this cause of mental distress is barely featured in the MHIP. This is made possible through the following passage:

> Mental health inequalities are often linked with wider cultural and societal systems of disadvantage which impact a person's wellbeing, including (but not limited to) adverse childhood experiences, stigma, discrimination, and one's environment, such as housing security. These can have significant impacts on an individual's wellbeing, and many of these enablers are beyond the remit of the health system alone. The shift towards more integrated, population-level health systems will support more localised and personalised responses to health inequalities across the prevention and treatment spectrum to be rolled out (MHIP, p.14).

Firstly, this statement reassures the reader that some social determinants are important and being taken into consideration, through vocabulary drawing attention to their ‘impact’ and ‘significant’ nature. However, the use of the narrative of argument and delineations of the ‘remit’ of the NHS draw the conclusion that despite this awareness, there is little that can reasonably be done by NHS services to alleviate these. This point is made firmly, with definitive modalising expressions such as ‘are beyond’ placing prevention of the causes of mental distress categorically beyond the power and responsibility of the MHIP and the NHS. Other modalising expressions such as ‘will support’ and ‘to be rolled out’ demonstrate commitment to the alternative path that the MHIP has chosen, namely to provide treatment on a localised and individual level, leaving little room to question this approach. It is of note that this path is a contradiction to AoH, which makes the statement below. It seems that this is considered an approach for physical health, but not mental health:

> The next step is to move from a national treatment service (focused on illness) to a national 'wellness' service (focused on creating good health) (AoH, p.47).

Although the second sentence suggests some responsibility for the NHS in addressing social determinants by use of the word ‘alone’, this isn’t followed up in the actions of the MHIP. For an implementation plan designed to address the nation’s mental health provision, it is problematic that the MHIP does not offer suggestions as to the governmental departments or institutions that *are* responsible for addressing social determinants and preventing mental distress.

This also deflects from the fact that possibilities for NHS services to impact the social determinants of mental distress outlined in this passage do exist and are widely written about. For example, drawing on theories of community psychology, liberation psychology and anti-racism, traditional mental health services can adjust their structures and practices to actively challenge discrimination and stigma, engage communities and strengthen cohesion (Afuape, 2020; British Psychological Society, 2018). This has the potential to reduce the incidence of ACEs and improve the environments people inhabit. Clinical psychologists within NHS mental health services have the capability to become more politically focused, utilising their position of power to advocate for social change, and potentially engage individuals and communities therapeutically in this process (Aherne et

al., 2019). Moreover, the NHS is one of the largest employers in the UK, and so there is substantial scope for the NHS to influence 'one's environment' through the implementation of employment conditions that facilitate mental wellness.

For obvious reasons, the MHIP does not draw attention to another possibility; for funding to be diverted away from a treatment based healthcare system and towards other government departments and local authority services that more directly influence the wider determinants of distress. However, it could advocate for the preventative priorities of the LTP and AoH to be taken forward through the allocation of some of the additional £2.3billion ringfenced for mental health provision by the LTP.

The power of this single statement to obscure all of these possibilities therefore has a profound and limiting effect on the preventative actions of the MHIP. The third line suggests where these efforts will be directed instead. It is reiterated in both the introduction and Section 1 of the policy to add emphasis, and yet is one of the few occasions that the prevention of mental health difficulties is acknowledged in the MHIP. It is a confusing sentence that holds a number of apparent contradictions, which relate to its word choice. For example, in common use, the phrase 'population-level health' would bring to mind notions of population heath and the application of broad, national policies to target the causes of poor health upstream. However, the sentence actually proposes 'localised and personalised' responses to health inequality, to be acted upon separately by each area of the country. This relates to AoH's distinction between 'traditional' and 'intelligent' public health.

The passage also frames prevention and treatment as part of a spectrum to be 'rolled out', possibly drawing on ideas about the primary, secondary and tertiary levels of prevention (Caplan & Grunebaum, 1967). This prepares the reader to broaden their understanding of what prevention entails, enabling the MHIP to propose primarily treatment, but frame this as preventative action.

Drawing on prevention and population health discourses in these ways serves to suggest that the MHIP is acting on all of these levels, however analysis in later sections will indicate

that only individual treatments and localised approaches are being proposed. A similar point could be made about the MHIP's reference to inequality.

Social determinants or health inequalities?: As in AoH, the MHIP considers work on inequalities in a specific way. The vocabulary of 'inequalities' suggests work to alleviate the causes of inequality and the cumulative, unequal life experiences that disadvantage certain social groups. However, the MHIP uses 'health inequalities' instead to denote access to and outcomes of traditional mental health services which vary across, for example, different ethnic groups. Below is an example of the typical context in which inequalities are discussed:

> We know there is still a lot of work to do to provide quality and timely mental health care for everyone who needs it, and to tackle inequalities in access, experience and outcomes (MHIP, p.3).

It is towards this direction that the MHIP focuses its attention. This, again, results in the narrowing of preventative action in favour of localised treatment options. This is underlined by the passage below, which suggests that resolving inequalities is about local systems taking responsibility, and straightforward, easily actionable steps that will result in reduced inequality. This is opposed to the complex, national, cross departmental, policy level drive that would be required to impact the causes of health inequalities in a genuine way (McGrath et al., 2016; United Nations, 2017), which it obscures.

> All systems are expected to set out how they will specifically reduce health inequalities by 2023/24 (MHIP, p.14).

Local over population level action: Having managed expectations as to the remit of NHS mental health services, the MHIP moves away from population level preventative action towards localised, targeted approaches, as indicated in the following example.

> Further, local areas will also be expected to plan to meet the needs of their local population to address inequalities in access (for example, to improve access for older people by promoting initiatives in care homes)… (MHIP, p.23).

> As mental health inequalities are varied and contextual, local health systems are ideally positioned to co-produce localised solutions with communities experiencing mental health inequalities (MHIP, p.14).

Scott (2015) points out that localism discourses can contain a contradictory array of meanings. These can range from ideas around empowering local communities and being responsive to the nuances of these, to responsiblising local communities for managing the challenging context they find themselves in, but have little control over. Both of these narratives are evident in the examples above. The allusion to the 'varied and contextual' nature of mental health inequality and the 'ideally positioned' local systems frames the MHIP's localised actions as responsive and necessary. On the other hand, the phrase, 'local areas will also be expected to' belies the hand-over of responsibility to local systems. Scott highlights that in a neoliberal political context where local communities and services do not have the resources to thrive (which are also likely to be those with most mental health need), localism can be an imposition on local systems. This discourse does, however, relieve national bodies such as NHS England of responsibility if local services fall short of their goals.

In addition, a tailored and contextual local plan for mental health may land positively with those who endorse neoliberal values of individual innovation and entrepreneurialism, and reject a high degree of intervention from the state. However, the drive towards localism without additional population level policies that focus on reducing the social determinants of mental distress can be seen as at odds with a primary prevention agenda.

The preventability of serious mental illness

A second narrative that impacts upon the MHIP's possible actions towards prevention relates to its construction of mental health. As in AoH, the common mental health problems/serious mental illness split is also present in the MHIP, with different services commissioned for the treatment of each. In AoH, there were indications that serious

mental illness was not considered to be within the Government's power to prevent, and this idea may be subtly reflected by the following statement of the MHIP:

> In this context 'SMI' covers a range of needs and diagnoses, including but not limited to; psychosis, bipolar disorder, 'personality disorder' diagnosis, eating disorders, severe depression and mental health rehabilitation needs – some of which may be co-existing with other conditions such as frailty, cognitive impairment, neurodevelopmental conditions or substance use. New and integrated primary and community services should remove thresholds to ensure people can access the care, treatment and support at the earliest point of need, so that they can live as well as possible in their communities (MHIP, p.26).

In AoH, the aim to help people 'live as well as possible' was reserved for those illnesses for which prevention was not an option. In focusing on this, as well as accessing 'care, treatment and support at the earliest point of need', the suggestion is that the only available actions for serious mental illness are tertiary prevention.

The idea that there is limited scope for preventing serious mental illness is reinforced by its biomedical framing. The heavy use of diagnostic illness categories are immediately apparent in this passage, regardless of the choice to qualify one of the more controversial categories of 'personality disorder' with inverted commas. As in the analysis of AoH, this results in a decontextualised construction of mental health, which is framed as discreet, individualised illnesses that happen to occur, without a known social cause. From this perspective, it is perhaps unsurprising that the suggested actions that follow are to increase the provision of treatment within traditional mental health services, rather than focus on prevention through tackling social determinants.

Secondary and tertiary, rather than primary prevention: Specifically, the MHIP's actions are operationalised as integrated community models for people with severe mental illness (in particular eating disorders and personality disorders), early intervention for psychosis, individual placement and support to assist people into employment, physical health checks for those with severe mental illness, suicide prevention and support for rough sleepers.

Improving access, and early screening and assessment are further prioritised within these service areas.

The way these actions are discussed reinforces their legitimacy as appropriate interventions, despite there being many more possible options for both treatment and prevention, as discussed in previous sections. One way this is done is to describe the move in this direction as part of a self-evident, necessary and desirable journey towards improving access to treatment. In the examples below, the phrases 'move closer' and 'on track' are used. The first passage also draws on the consensus of 'staff, patients, carers and supporters across the country' in emphasising that this is the correct path to be on.

> Together, we can build on the achievements of dedicated staff, patients, carers and supporters across the country to move closer over the coming years to ensuring every child and adult who needs mental health support can get access to it (MHIP, p.4).

> Access to children and young people's mental health services is continuing to expand and all other standards are being achieved or on track for delivery in 2020/21 (MHIP, p.3).

This is related to the framing of this journey as new and revolutionary, as in the following statement:

> At the beginning of the year, the NHS Long Term Plan renewed our commitment to pursue the most ambitious transformation of mental health care England has ever know (MHIP, p.3).

However, the transformative nature of the MHIP's plans is somewhat contradicted by the fact that its suggestion is to continue to provide very similar community mental health services, just with increased funding and breadth of access. This is despite indications that this model hasn't successfully managed the level of mental distress within the population (The Kings Fund, 2014). This is apparent in the plans for the initial years of the implementation plan, in which increased funding is needed just to:

> Stabilise and bolster core community mental health teams (MHIP, p.25).

Another discourse that legitimises the MHIP's direction towards treatment is that of evidence based practice, as used in the example below:

> With this Implementation Plan, a ringfenced local investment fund worth at least £2.3 billion a year in real terms by 2023/24 will ensure that the NHS provides high quality, evidence-based mental health services to an additional 2 million people (MHIP, p.3).

This discourse has the effect of drawing on ideas of mental health services as scientific, modern and effective course of action suggested by experts. Evidence based practice does have some beneficial aspects, including its emphasis on research, therapist accreditation, therapeutic rigor, and standardisation across services. This can safeguard against a postcode lottery in provision and quality, and against dishonest or harmful treatments being provided to vulnerable service users. Evidence based guidelines such as those developed by NICE are also likely to offer some protection against the provision of ineffective treatments, which is primarily positive for service users, and also services which are then able to make more effective use of their finite resources.

However, it has come under critique for its narrow view of 'evidence' which privileges particular types of knowledge about mental health and its treatment (Mollon, 2009). For example, this might be limited to treatments that lend themselves to the positivist, Eurocentric tools of experimental science, such as randomised controlled trials. These treatments, for example cognitive behavioural therapy, have the opportunity to demonstrate their efficacy, which results in the provision of further funding, then a greater evidence base, in turn leading to a self-fulfilling prophecy by which these therapeutic models have a monopoly within mental healthcare.

Other types of knowledge and evidence, such as understanding derived from population level studies, for example the Marmot Reviews into the social determinants of distress (Marmot, 2010; Marmot et al., 2020), are not necessarily captured in this notion of evidence. The availability of studies into the causes and prevention of mental distress is

limited by the diversion of funds towards treatment (MQ: Transforming Mental Health Through Research, 2018). The privileging of evidence based practice in this way results in mental health services being diverted towards individual treatments for mental health difficulties, and away from more contextual and socially focused approaches that might be preventative.

Contexts in which prevention is *acknowledged – the prevention of suicide*: Suicide prevention is the main context in which prevention is a stated aim of the MHIP. However, it is given a specific meaning in this case, relating to prevention of the actual act of suicide, rather than upstream work to alleviate the causes of suicidality. This is evident in the actions that the MHIP suggests. Other than allusions to a multi-agency plan to prevent suicide, these centre around the provision of services for those who are already suicidal, including crisis services and an expectation of mental health services to have a 'zero suicide ambition' (although how this will be achieved is not elaborated). The passage below is an example of this:

> Suicide prevention is a complex system-wide challenge which requires close working between the NHS, public health and partner organisations, tailoring evidence of what works to local need and determinants. This commitment will be delivered in close partnership with public health and local authorities, Public Health England and Department of Health and Social Care. It is also important to recognise the suicide reduction ambition sits within the context of other improvements to mental health services in the NHS Long Term Plan which will support preventing suicides, most notably: 24/7 crisis care for all ages available via 111; integrated community models for SMI which will include meeting needs for those who self-harm and with co-morbid substance use; and improving the therapeutic environment in inpatient settings (MHIP, p.38).

Firstly, this statement emphasises the complexity of suicide and the need for local tailoring, which suggests that the causes of suicide are mysterious and must be specifically researched for each area before action can be taken. This results in a lack of specific preventative action forming part of this national policy, yet it belies the availability of research that exists in relation to the causes of suicide. The Samaritans indicate that preventative work aimed at

increasing social connections and purposeful activity, particularly among middle-aged men who have low income could be an effective solution (Samaritans, 2020).

In the second sentence, the statement suggests that the relevant government departments for managing suicide are Public Health England and Department of Health and Social Care. This obscures the potential for broader cross-departmental work that could alleviate the social determinants of suicide, for example input from the Department of Work and Pensions in supporting fulfilling and stable employment. Instead, those seen as having greatest responsibility for the prevention of suicide are crisis teams and other mental health teams.

This has obvious limitations from a humanitarian point of view, given that the majority of the suggested provisions only come into effect at the very end of someone's journey towards deciding to end their life, and do not seek to prevent the distress experienced prior to this point. This also means that the people who do come into contact with services at this stage are likely to be met with the more restrictive practices, such as sectioning under the Mental Health Act. However, a greater number of people are likely never to access these interventions. This is due to findings which suggests that a large volume of those who end their own life do not seek crisis intervention, and either are not part of mental health services, or have not accessed them in the months preceding suicide (Appleby et al., 2019). This means that not only does the provision of crisis support and mental health services fall short of preventing the wider causes of suicide, it is also likely to be ineffective at meeting its aim of preventing suicidal acts themselves.

Prevention is not stakeholders' choice

Previous sections considered how passages of the MHIP frame the alleviation of social determinants of mental distress as outside the remit of the NHS, and query the possibility of preventing rather than treating serious mental illness. A third narrative that undermines the prevention agenda within the MHIP centres around stakeholder choice.

A consensus on treatment: The MHIP makes the following statements that suggest there is a consensus among stakeholders that treatment, in the way that it has traditionally been delivered, is the right way forward for mental health services:

> NHS England and NHS Improvement received written submissions from over 145 organisations, capturing the views of over 27,000 people from across the age spectrum. These views shaped the proposals to transform mental health services laid out in the NHS Long Term Plan (MHIP, p.3).
>
> We heard from stakeholders that a continued focus on high quality care in the community is the right thing to do for patients… (MHIP, p.3).

Given the widely acknowledged positivity of co-production and service user involvement in shaping service delivery, this makes a powerful statement in favour of the MHIP's proposals. It frames treatment in the community as the consensus reached through democratic processes, with the views of stakeholders presented as homogeneous. This is reinforced by the use of persuasive statistics. The prevention agenda, on the other hand, does not appear to have been emphasised as a priority by stakeholders.

However, there are reasons to question the reliability of this singular preference for treatment as usual. For example, there is no further information as to the process of stakeholder involvement; the methods by which information was sought, who was consulted, or which questions that were asked of them. We have seen from AoH that the framing of consultation questions has the potential to enable certain answers and close down others, and NHS service user involvement and co-production has been criticised for being tokenistic and limited in its genuine redistribution of power to shape services (Kalathil, 2015).

Even if these statements on the consensus of stakeholder preference for community treatment could be corroborated, it may not be a surprise for certain groups to prioritise treatment over prevention. For example, service users who are currently living with mental distress may justifiably seek to prioritise the availability of services to support them, as might those who work in existing mental health teams. This is especially likely if service

users’ or clinicians’ conceptualisations of mental distress have been shaped by the biomedical discourse that dominates society and mental health services. This is an example of hermeneutical injustice, the suffering of oppression based on the limited availability of concepts to understand one’s experience (Fricker, 2006). This is because biomedical discourses obscure the contextual causes of mental distress from those who experience it, reducing their power to advocate for change.

This limited will from stakeholders to prioritise prevention also touches upon a fundamental difficulty of this agenda; that in a stretched system with limited allocated funds, primary prevention often means redistributing resources away from initiatives to support the cohort with existing mental health difficulties, in order to provide preventative measures for future generations (Department of Health and Social Care, 2013). An alternative option would be for additional funding to be utilised to further both treatment and prevention agendas simultaneously. This isn’t beyond the realms of possibility, given that the UK falls below the European average for healthcare expenditure (Rocks & Boccarini, 2021). However, this is not the solution suggested by the MHIP. This is despite the aforementioned indications that continued focus on treatment rather than prevention is not sustainable, and not preferable from a position of population health.

The above use of stakeholder choice in the MHIP has links to the idea of localism, in that it endorses co-production, rather than rolling out of plans dictated by central institutions. Developing plans based on stakeholder choice also relates to themes of individualism and personal responsibility. This will be explored in the following section.

Offering choice and control: The MHIP makes regular reference to personal choice within mental health care, with the following prominent text box as an example:

By 2023/24

370,000 adults with severe mental illness

will have greater choice and control over their care.

(MHIP, p. 26).

In a similar style to the treatment of localism in the section on AoH, this is framed as unquestionably positive, and undoubtably those accessing mental health treatment should have power over their care. However, focus on individual choice over treatment has been a feature of neoliberal policy (Harper & Speed, 2012). It accentuates the individual's responsibility to control and navigate their own care, a process which is underpinned by values around self-management. At the same time, state intervention is stepped back, leaving the management of distress to the individual. This is reflected in the interventions that are endorsed, which are commonly low intensity, for example the provision of online self-help.

There will be a proportion of people, perhaps more so among those identified as having 'common mental health difficulties', who will be able to self-manage their treatment and would welcome greater flexibility and choice, for example in the modality in which they engage with services, such as being able to access online content from home. Also, those economically better off are likely to be in a better position to exercise choice. However, the focus on individual choice and control is more likely to disadvantage those living with severe and enduring distress or those who are struggling financially, for whom this added responsibility of co-ordinating their care might pose a significant barrier.

Having highlighted the limited actions for mental health prevention that are endorsed by AoH and the MHIP, and the discursive processes that allow for this, the Discussion that follows this section will explore these points in relation to previous literature.

4. DISCUSSION

The Discourse Analysis section, which represented Stage 2, Part c of Fairclough's (2001) stages of CDA, demonstrated how prevention and population health discourses are woven into AoH alongside other, often competing discourses (see Table 2 below for a summary of the 5 stages framework for CDA). Their treatment at different times allows them to function in particular ways, for example various assumptions as to what can and should be prevented are drawn on at different times and justify certain preventative actions. The result is that despite the inclusion of prevention and population health in AoH, the policy falls short of instigating actual commitments to primary preventative work. This is further demonstrated in the actions recommended by the MHIP, which are predominantly treatment based rather than preventative.

The Discussion section will relate these findings to the literature on policy and prevention. It will consider how these findings fit with wider research pertaining to the social problem of preventing mental distress, and what is added by the present study. Following this, the obstacles to this problem being tackled will be considered from a different perspective, considering the intransitive features standing in the way of prevention. This will be combined with consideration as to whether aspects of the social order 'need' this problem to continue, by drawing attention to social groups who either benefit from the problem, or have an interest in it continuing. This represents Stage 2, Part a, and Stage 3 of Fairclough's (2001) model. Following this, Stage 4 will be addressed by identifying the possible ways past the obstacles, relating these to the implications for clinical psychology. The Discussion will end with a critical review of the analysis, in line with Stage 5.

Table 2

5 Stage Framework for CDA

Stage	Description
Stage 1	Focus upon a social problem that has a semiotic aspect
Stage 2	Identify obstacles to the social problem being tackled. You can do this through analysis of: d) The network of practices it is located within e) The relationship of semiosis to other elements within the particular practice(s) concerned f) The discourse (the semiosis itself) by means of: o Structural analysis: the order of discourse o Interactional analysis o Interdiscursive analysis o Linguistic and semiotic analysis
Stage 3	Consider whether the social order (network of practices) 'needs' the problem
Stage 4	Identify possible ways past the obstacles
Stage 5	Reflect critically on the analysis

Note. From "The discourse of New Labour: Critical Discourse Analysis" by Fairclough, N., 2001, in M. Wetherell, S. Taylor, S. J. Yates, & N. Fairclough (Eds.), *Discourse as Data: A guide for analysis*. Sage.

4.1. RELATING THE FINDINGS TO THE LITERATURE

The aim of the current study was to attend to the social problem of the prevention of mental distress, and the role that policy plays in the maintenance of the problem, or its solution. Selecting this focus represented Stage 1 of Fairclough's (2001) model of CDA. The intention behind the study was to produce new knowledge for clinical psychologists to draw upon in understanding the problem, to facilitate genuine progress towards prevention. Specifically, it aimed to shed light onto the finding that prevention and population health were increasingly the focus of policy discourse, but had not consistently translated into preventative action at a service level. The reasons for this discrepancy are summarised below in reference to existing theory and research. They are grouped under three key ideas; what one assumes needs preventing affects the preventative actions taken, who is seen to be responsible for prevention also has an impact on this, and the malleability of the term prevention underscores some of the discrepancy between prevention discourses and their outcomes.

4.1.1. What one thinks needs preventing affects actions

AoH and the MHIP were shown to include a variety of conceptualisations as to the nature of mental health problems, the interplay of which impacted upon the preventative actions operationalised by the policies. Both alluded to social determinants of mental distress, reflecting research that has demonstrated their role in the development of both mental and physical health inequalities (Marmot, 2010; Marmot et al., 2020; Wilkinson & Pickett, 2010). This responds to a marginal but increasingly present discourse within broader society and the clinical psychology profession that demands to appreciate mental distress within its social and cultural context (Richard et al., 2011). However, ever present within AoH and the MHIP were implicit and explicit biomedical narratives as to the cause of mental distress, which dominated the social determinants discourse though the passive way the latter were

discussed, the lack of commitment to actions in relation to these, the shifting of the narrative onto health inequalities in access and outcomes, conflictual assumptions made in relation to cause and effect around mental distress, and the framing of biomedical solutions as desirable.

These findings are in line with those of (Moth, 2020), whose ethnographic study within a community mental health team found evidence of reliance on biomedical frameworks within the practices of the organisation, despite policies purporting to endorse a more social conceptualization of mental health. The term 'bioresidualism' was coined to describe this process. Bioresidualism was present when intensive workloads and performance management, the result of neoliberal priorities within the system, reduced the space for skilled and discretionary work. This left the social context unattended to, and the biomedical model as the remaining framework.

This biomedical framework is criticised in in its application to preventative practices. Rose et al. (2008) point out that a medical model is designed to attend to why a particular person develops a particular condition at a particular time, and therefore consider the risk and vulnerability factors that are proximal to the individual. However, Rose suggests that this process actually targets factors that moderate the risk of developing a condition, rather than the underlying causes. Relating this to mental health, this could mean that the 'cause' of a period of anxiety is determined as a stressful situation at work. Subsequently, an intervention to teach coping skills and provide employment support would seem appropriate (Newton, 2013). However, this negates wider factors that have left someone susceptible to experiencing anxiety in particular situation, which relate to social determinants of distress.

This process is reflected in AoH and the MHIP in their framing of interventions that actually constitute treatment as a preventative strategy, as opposed to encouraging primary preventative measures. This also makes sense of the narrative within AoH and the MHIP that some mental distress, namely 'serious mental illness' is beyond the reach of preventative measures. This perspective is logical if our notion of prevention is limited to the proximal moderating factors of distress. This is another example of how biomedical discourse exerts limitations on preventative action.

Instead, the biomedical model directs us towards evidence based treatments as the focus of mental health provision. Conceptualising mental health as discrete disease categories, each with a distinct treatment, results in treatment being seen as analogous to a medical prescription. This is reflected in the adoption of NICE guidelines for the treatment of mental health difficulties, as opposed to just the physical health conditions for which they were initially developed. In line with this, NICE recommended interventions such as CBT are endorsed by AoH and the MHIP as the gold standard for mental health provision.

Mollon (2009) highlights the draw of this approach for clinical psychologists, who benefit from the promise of a coherent, scientific resolution to mental distress, in which they are central to its delivery in the form of psychotherapy. It should also be acknowledged that NICE guidelines of evidence based treatments also improve the standardisation of mental health provision across the country, reducing the postcode lottery in the volume and quality of care provided. They commonly endorse CBT as a treatment, which has an accredited training pathway and robust set of competencies (Roth & Pilling, 2008), potentially improving the rigour and minimum standards of practice within mental health services and reducing the use of dishonest or unregulated treatments among vulnerable client groups. In addition, NICE guidance focuses on scientific research to justify psychological interventions such CBT. This limits the pharmaceutical industry's ability to monopolise the arena of 'evidence based' mental health treatment, and acts as a counterweight against its lobby for the prescription of expensive drugs.

However, this approach relies on valid and reliable diagnostic criteria for mental health, the existence of which have been heavily questioned (Boyle, 1999; Thomas et al., 2018). Mollon (2009) also argues against the biomedical model for its reductive oversimplification of the development of mental distress, and the effect of obscuring measures that might address social determinants. There is evidence that despite these criticisms, research into biomedical causes of distress and treatments that follow this conceptualisation is engaged in to a much greater degree than research into prevention (MQ: Transforming Mental Health Through Research, 2018). This creates a vicious cycle in which these interventions are seen as the only legitimate and scientific courses of action.

An evidence based, biomedical approach curbs preventative strategies for mental health in other ways. AoH draws upon a parity of esteem discourse, which, although claiming to position mental health on an equal footing with physical health, has been noted instead to further instill the illness metaphor within mental healthcare (Callaghan et al., 2017; Timimi, 2014). Parity of esteem is not achieved in AoH, as despite statements to the contrary, given that primary preventative measures are reserved for physical health conditions, whereas the interventions for mental health are limited to treatment, as discussed above. Mental health is framed as a risk factor for physical health problems, and so prevention was viewed as valuable predominantly in its capacity to improve physical health. This was evident in preventative efforts focusing on actions such as screening for mental health, and providing low intensity mental health treatment to those with long term conditions. This was at the detriment of considering the social factors that result in both poor mental and physical wellbeing (World Health Organisation, 2014). In a policy analysis of child mental health services, (Callaghan et al.) similarly concluded that, “By conflating mental health with other health problems, we risk increasing medicalization, and further obscuring complex and intertwined family, community and socioeconomic contexts that produce and maintain distress” (2017, p.12).

This section outlines how the framing of mental health and the targets for prevention contribute to the limited preventative action endorsed by AoH and the MHIP. This was found to be further hampered by where the policies placed the responsibility for mental health prevention.

4.1.2. Who is responsible for prevention?

AoH and the MHIP held various messages about where the responsibility for prevention lies. One of the most outright was the statement in the MHIP which stressed that social determinants were “beyond the remit of the health system alone” (MHIP, p. 14). This confirms the voice of various institutions who have argued that not enough is being done to

act on mental health prevention in NHS services and beyond (British Psychological Society, 2019a; Centre for Mental Health, 2019; Mental Health Taskforce, 2016). The analysis indicated towards economic concerns in relation to prevention policy, and the idea of the NHS being stretched by its responsibility towards treating mental health difficulties. It was also suggested in AoH that funding for prevention was to be found within the resources already allocated to services, and in the MHIP that the additional funds of the LTP were firstly needed to stabilise existing services before any additional goals around access and treatment could be met, let alone prevention. It is perhaps unsurprising that the MHIP declined responsibility for wider preventative action, despite these being within the capabilities of the NHS (Afuape, 2020).

The MHIP points beyond the NHS to the Department of Health and Social Care and Public Health England for responsibility for suicide prevention. However, many of the social determinants they mention earlier in the document are under the remit of wider departments still, for example the Department for Work and Pensions, the Department for Education and the Department for Levelling Up, Housing and Communities. This reflects the Kings Fund's and the Mental Health Foundation's concern that too little funding had been committed, and not enough has been done to hold other departments to account for prevention (Gregory et al., 2012; Mental Health Foundation, 2019).

Rose and Day suggest that instead, "what is needed is acceptance of a collective responsibility for the population's health and social wellbeing" (1990, p. 1034). However, in contrast to this, the focus of responsibility within AoH and the MHIP is directed towards the individuals experiencing mental distress themselves. This has come to be expected from neoliberal policy, which has been found to responsiblise individuals and communities through focus on lack of mental health knowledge as a cause of distress, self-management as a solution, and medicalised discourses (Moth, 2020; Teghtsoonian, 2009). This is not to say that individuals cannot take control of their wellbeing, or that being supported in the self-management of distress is not valuable for some. There are many, particularly those with more mild forms of distress, who would be able to benefit from this approach. However, Rose et al. (2008) argue that the preoccupation with individual wellbeing and simply providing advice to encourage individuals to behave differently and make different

choices cannot have the desired effect on population health. This is given that traits, for example behaviours or symptoms associated with poor mental health, have a normal distribution which is supported by the kind of society the population is situated within. Those who fall on the outer extremities of that distribution might be viewed as deviant, but they are responding to the wider context that influences us all.

Linked to responsiblisation, localism and discourses around individual choice and control are also drawn upon as a way to positively frame the transition of responsibility for mental health from state to communities (Scott, 2015), a process which is likely to hit local areas with the most need and least resources the hardest. This represents a withdrawal from the state in taking responsibility for tackling wider social determinants of distress through national policy, which are absent as solutions in both AoH and the MHIP. This mirrors the outcomes of a Canadian policy analysis, which found recurrent examples of discursive strategies masking the harmful aspects of neoliberal policy from the conversation as to the causes of mental distress (Teghtsoonian, 2009). These points go some way to explain why, although present in the rhetoric of current policy, mental health prevention is not occurring at a population level.

4.1.3. Prevention as a flexible concept

Finally, as Scott (2015) attests, the malleability of particular terms can be useful politically, in that they can be drawn on in particular ways to suggest, justify, and persuade the reader in a number of directions. The direction stated may therefore be at odds with the action that is actually taken. This is especially true of the term prevention, which has a number of levels; for example the primary, secondary and tertiary definitions outlined by Caplan and Grunebaum (1967). AoH and the MHIP draw on the concept of tertiary prevention regularly in the context of mental health, more so than for physical health. However, Gordon (1983) argues that tertiary measures, those which intervene to prevent relapse or the worsening of existing difficulties, actually constitute treatment as opposed to prevention. They advocate

for this to be dropped as an aspect of prevention, and instead suggested that levels of prevention should be structured with regard to the target of their intervention, for example universal (population wide approaches that include and have the potential to benefit everyone), selective (those which target a high risk social group) and individual (targeting those whose individual characteristics lead to increased risk).

This differential use of the term prevention answers one of the questions posed by the current research, which was why the small amount of preventative work done centres around early intervention for psychosis. This does not constitute primary prevention, and is rather an example of secondary prevention, but as both fall under the heading of prevention, they constitute action towards the prevention agenda. This is an aspect of prevention that can fall within traditional service structures, without the challenge of engaging wider departments or overhauling social and economic policy.

As well as prevention, population health has also been conceptualised differently in AoH and the MHIP for different ends. The general understanding of this is of wide reaching, national approaches that intervene upstream, before the development of mental health difficulties, to prevent the conditions that result in distress (Buck et al., 2018; The King's Fund, 2019). This marries up with both primary and universal definitions of prevention. However, in the MHIP, population discourse is drawn upon while the actions endorsed are in fact local and individual in focus.

Each of these points again demonstrate how prevention and population health can be such a feature of policy, without necessarily leading to substantial progress towards primary prevention of mental distress. Instead, at the level of service delivery outlined by the MHIP, what is provided is in fact more coverage by the same traditional mental health services. This is in support of the literature summarised in the introductory section of the study which suggest that low levels of funding (Mental Health Foundation, 2019) and demoralisation within mental health services (Townley et al., 2018) are some of the reasons for lack of preventative action in services. But it adds to the explanation as to how, through policy discourses, this is able to occur. The following sections will progress the analysis through Fairclough's (2001) stages.

4.2. NETWORKS AND STRUCTURES THAT CONTRIBUTE TO INERTIA

Fairclough (2001) proposes that in identifying the obstacles to the social problem being tackled (Stage 2 of the framework), in this case the prevention of mental health difficulties, it is critical to look beyond policy discourses to consider the wider contextual factors that uphold the problem. This links the intransitive social practice with the transitive knowledge represented by the discourse. The process was begun in the introductory section of the current study, which highlighted historical policy context that produced AoH and the MHIP. This section will expand this to consider the network of practices that the policies are situated within (Stage 2, Part a), and will incorporate consideration as to whether the social order 'needs' to retain the status quo with regards to the inertia of the prevention agenda (Stage 3). Firstly, the Discussion will briefly highlight what the social causes of distress are, and the preventative measures that would be required to alleviate them. From this perspective, the barriers to these actions being taken can be explored. Given the scope of this Discussion, one preventative action will be taken as an example to highlight these barriers to change.

4.2.1. The preventative actions required for the social causes of distress

An indication as to the social determinants of distress was shown by the most recent Adult Psychiatric Morbidity Survey, a nationally representative survey of exploring mental health in England (McManus et al., 2016). Elevated levels of common mental health problems, self-harm, bipolar disorder and post-traumatic stress were found among women compared with men, a trend that has grown since the last iteration of this survey. Among most of the diagnoses explored, those who experienced poor physical health, lived alone, were not employed, and received Employment and Support Allowance due to poor health or disability were more likely to have poor mental health. Research indicates that men living in the most economically deprived areas on low incomes were 10 times more likely to die by

suicide than those from more affluent areas (Samaritans, 2020). In relation to economic factors and mental distress, Wilkinson and Pickett (2010) indicate that mental health has a social gradient within a population, and that outcomes are worse the greater the inequality between the rich and poor within a society. In a systemic review by Patel et al. (2018) a significant relationship between risk of depression and income inequality in nearly two thirds of all studies, and this was even higher when the studies were longitudinal in nature.

The British Psychological Society (2019b) summarised evidence in relation to ACEs, which included experiences such as abuse, parental separation, and substance misuse, mental distress and domestic violence in the household. It was found that experiencing 4 or more of these was then associated with poor health outcomes, substance use, and being a victim and perpetrator of violence. The impact of the ACEs above was reinforced by a report by the United Nations Special Rapporteur (United Nations, 2017), who also pointed to poverty, gender based inequalities and violence, and social exclusion including experiences of racial discrimination as contributory factors to the development of mental distress.

In terms of preventative action, the United Nations Special Rapporteur (United Nations, 2017) highlights the need for rights-based, population level interventions in which mental health is considered across all policies and services. This would need to include violence prevention, poverty reduction, health and education in order to strengthen the protective factors and mitigate risks to individuals and families. Marmott (2010) suggests that tackling social inequalities might include factors such as access to fair employment, healthy physical environments, strengthening communities, and maximizing the control that people have over their lives across the lifespan. Graham et al. (2011) suggests racial inequalities in mental health would require interrogating each prominent social institution for their values, cultural orientation and principles, to identify structural ways in which these reflect and reinforce the interests of dominant cultural groups.

In order to address the economic inequalities outlined by Wilkinson and Picket (2010), one might advocate for strategies such as using the tax system to redistribute wealth among the population and the instigation of a universal basic income. This is the position of the organisation Psychologists for Social Change, which originated as a collective advocating against austerity measures across the UK since 2008 (Griffin et al., 2017). In preventing the

psychological toll of austerity, the organisation advocate for the following principles to underpin future policy drives in the UK; agency, security, connection, meaning and trust (McGrath et al., 2016). Among their recommendations are the following:

- "Social policy that works towards a more equitable and participatory society, to facilitate individual wellbeing, resilient places and strong communities.
- Policy makers to take into account the psychological impacts of macro social and economic changes.
- A social security system that empowers and supports, rather than punishing people in times of need.
- Public services to increase focus on preventing distress, improving citizen participation and social justice, as well as help facilitate the five positive indicators above.
- Co-production to be one such model of public service reform. This approach harnesses individuals' and communities' assets and expertise, rather than viewing them just as passive recipients of and burdens on services.
- A community-led approach to mental health and emotional wellbeing that develops collective responses to individual needs and by doing so works to strengthen communities and build on communal resources" (2016, p. 52).

With reference to some of these ideas, the following section takes the social determinant of income inequality as an example and considers the barriers to change in this area.

4.2.2. What are the barriers?

The barriers to reducing income inequality operate on a number of interrelating levels. At one level are barriers to government action in policy changes in this direction. Carey and Crammond (2015) and Stevens (2011) write about the structure of Government and the process of policy making. Rather than being based in evidence and research, this is more of an iterative process that hinges upon relationships among civil servants, hierarchies of

influence within Whitehall, the driver of self-interest, the fit that policies have with the Government's narrative at the time, and so on. Given this network of practices, the Government isn't necessarily structured to instigate radical social change to reduce income inequality.

This would only be able to come about with buy in from the highest levels of Government. One difficulty with this is the lack of a strong lobby for preventative action. While there are organisations and think tanks with a particular interest in advocating for mental health treatments, given the visibility of this difficulty and the resonance with people's personal experiences of mental distress, there is less drive in support of practices that effect those who haven't yet been impacted by distress. This is evidenced by the little impact that Public Health England has been able to make in this area, despite the backing of high profile reports such as the Marmot Reviews (Marmot, 2010; Marmot et al., 2020), which advocate for cross departmental efforts to reduce income inequality. This is likely to be exacerbated by the lack of training provided to public health officials in the area of mental health (Frenken, 2021). There are, on the other hand, powerful organisations able to lobby *against* policies that promote income inequality. Industry groups are more likely to advocate for less tax and regulation in order to encourage innovation and entrepreneurialism, and large corporations will resist tax increases in order to protect profits.

Some argue that there is no clear evidence base for preventative measures for mental health (Department of Health and Social Care, 2013). There are also critiques of Wilkinson and Picket's (2010) research, for example, that this represents evidence of correlation between the two factors, rather than a causative link (Snowdon, 2010). However, this is unsurprising, given the difficulty in setting up an experimental study that could gauge the impact of policy level changes on future mental health. Also, the dearth of spending on preventative mental health research is likely to negatively impact the development of this evidence base (MQ: Transforming Mental Health Through Research, 2018).

Nevertheless, these factors do not provide Government with the confidence it might need to advocate for income equality. This is exacerbated by the lack of clarity around even the concepts of prevention, mental health and health inequality, as demonstrated by the current study. McMahon (2021) argues that preventative thinking and action is hindered by

these concepts. For example the metaphor of working 'upstream', was shown to poorly fit with participants' understanding of how inequality works, did not easily translate into specific actions or ways of working, and was problematic in its varied interpretation by wider audiences. It is perhaps no wonder that the Government produces policies infused with contradictions around prevention. This issues is likely to impede the developing a clear vision and route towards prevention through increased income equality.

In addition to political backing, initiating policies in relation to income equality would also require public backing. There is evidence that the public's attitudes to this topic are mixed. A study by the Joseph Rowntree Foundation indicated that although people believe the gap between the richest and the poorest is too wide, they are more likely to believe that the most wealthy are overpaid, rather than the poor being underpaid, and do not necessarily endorse redistribution (Orton & Rowlingson, 2007). These seem to be related to narratives around self-reliance, and that those who are well off deserve their position due to hard work. It is indicated that those in the highest earning income brackets are the least accurate in their understanding of where they fall on the spectrum of wealth (Lansley, 2009), with this lack of perspective potentially impeding their view on the necessity of redistribution policies.

With regards to concerns around specific policies such as universal basic income, arguments of varying credibility exist against this proposal. These include critique of the economic foundation of its argument, the removal of the incentive to work, the reliance of individuals with poor financial literacy to manage monthly payments, and the notion that it would actually take funding from the most needy by distributing funds across the board (Ezrati, 2019). Regardless of the legitimacy of such arguments, such fears are likely to be sensationalised by parts of the press, either in the interests of selling stories, or the interests of the billionaire owners of certain media outlets who may benefit from the status quo with regards to income inequality. This is likely to further sway public opinion with regards to income inequality.

Finally, on the more proximal level of clinical psychology practice, there are barriers to bringing about support for preventative action such as the reduction of income inequality. Clinical psychology training currently includes little focus on public health and prevention,

with the focus being predominantly on models of treatment and therapeutic competencies (British Psychological Society, 2019c; Rahim & Cooke, 2020). This hampers the potential for clinical psychologists to contribute towards the development of models that might inform a cohesive, integrated, cross society, psychologically informed prevention strategy. It is also a missed opportunity for clinical psychologists to inform the work of NHS services to take a more preventative approach that draws attention to the role of social determinants.

Instead, psychologists continue to benefit from their role in individualised, medicalised mental health settings. Mollon (2009) highlights the draw of this arrangement. For example, the structuring of services around NICE guidance puts psychologists in a powerful position within mental health services through the primacy it places on psychotherapy, lending legitimacy to the clinical psychology profession. Changing from a treatment to a prevention model would inevitably result in a vast proportion of staff in existing mental health services becoming deskilled, and would require an upheaval in terms of service structure and training.

4.3. IMPLICATIONS FOR CLINICAL PSYCHOLOGY: OVERCOMING THE BARRIERS

However, there is potential for clinical psychology to have a role in overcoming the barriers to preventative action, and the findings from this piece of research can inform this in a specific way. This section will draw on Patel et al.'s (2018) three levels through which practitioners can target the effects of income inequality, at an individual, local and national level.

Actions at an individual level could include changes within an individual clinical psychologist's practice. Moth (2020) found evidence of professionals utilising their power to resist the policy agendas that they felt were at odds with their ethical obligations to reduce mental distress. This was achieved through the use of professional discretion, for example promoting practices despite them being contrary to the economic priorities of neoliberal policies. Critical policy analyses such as the current study can influence this by drawing

clinical psychologist's attention to discourses being utilised and the contradictions at play, helping to inform a critical stance on the key policies that shape mental health services.

The knowledge developed in the current study would encourage clinical psychologists to critically interpret mental health prevention and population heath policy using specific questions such as;

- Who is the policy by and who is its target audience? Is it solely for the attention of health departments or does it have a broader remit? This would indicate whether or not the policy has the scope to influence primary prevention through targeting broader social determinants of distress.
- How does it define concepts such as prevention and population health? Are these consistent throughout the policy, or do they change depending on the aims of a particular section of the text?
- What does the policy suggest, either implicitly or explicitly, are the causes of mental distress, and where the target for prevention should be? The current study suggests that clinical psychologists should be watchful for policies containing narratives of individual responsibility and blame, as these are unlikely to sufficiently acknowledge the role of inequality and the social determinants of distress.
- What are the proclamations in the introductory section of the policy relating to its plans for mental health prevention? Is additional funding allocated and is this being diverted in line with the direction and scope of this rhetoric? This would indicate whether these proclamations are realistic, given what this study indicates about the common contradictions between the rhetoric and the actions operationalised by prevention policy, and the level of investment and social change that would be needed to facilitate primary prevention.
- Are other rhetorical devices evident? For example, are promissory notes being used to suggest that future preventative action is just around the corner? Or are important topics being discussed in a passive voice that does not invite action?
- What does it imply for a clinical psychologist's role and does this align with a preventative agenda? If the role of psychologists and mental health services is to

continue to offer individualised and treatment based interventions, this is unlikely to be able to have a significant impact on primary prevention and population health.

In the process of conducting the current CDA, some of the answers to these questions were explored in relation to AoH and the MHIP. It was found that these policies made effort to present a vision for prevention, which involved improving the quality of life of the nation, primary prevention, and reducing health inequalities by tackling the social determinants of mental distress. This was particularly the case in the introductory sections of AoH, which presented the Government's intentions for the policy. However, this was not backed up by the actions operationalised in AoH, or the MHIP. Instead, resources were earmarked for predominantly secondary and tertiary level prevention and the provision of individualised treatment.

This occurred discursively through a number of means. For example, health was framed as an asset for individuals to maintain. The problem faced by the NHS became people's lack of responsibility for their wellbeing, rather than the Government's responsibility to provide the right conditions for this. Although both social and biological causes of mental distress were noted, the latter dominated through the passive voice by which the existence of social determinants was discussed, the simplification of cause and effect in the development of mental distress, and the primary prevention of physical health difficulties taking precedence over the primary prevention of mental distress. Inaction towards this was also enabled by the shifting conceptualisations of prevention and health inequalities throughout both policies, and questions as to the preventability of mental distress in the first place.

With this in mind, consideration needs to move beyond the implications for individual psychologists towards Patel et al.'s (2018) local and national levels of action, if change to facilitate primary prevention is to be seen. At the local level, for example within mental health services, clinical psychologists can form networks with other psychologists, service users, commissioners, and mental health professionals to commit to primary preventative action. Clinical psychologists' understanding of policy, the discursive strategies employed and the structural barriers to change might be used to facilitate conversations about what keeps primary prevention off the agenda within mental health services.

From this position of pooled resources, local networks may then organise to influence primary preventative action at a national level. An example of this in a related area of concern includes the organisation Psychologists for Social Change. Originally named Psychologists Against Austerity, this collective formed to steer public debate about the impact of austerity on mental distress, and the ways in which psychological understanding could be used to inform more preventative social policy (*Psychologists for Social Change*, 2021). The findings of the current research indicate that clinical psychologists could advocate for policy that secures sufficient funding to a coherent, cross-departmental strategy which addresses wider determinants of mental distress, including, for example, the Department for Work and Pensions, the Department for Education, the Department for Levelling Up, Housing and Communities, and the Office for Health Improvement and Disparities.

For this to be achieved, lobbying groups would need to be formed among the stakeholders and actors involved in mental health provision. This would need to include professional organisations, for example the Royal College of Psychiatrists, the British Association of Social Workers, the British Psychological Society, and the Association of Clinical Psychologists UK. It would also necessitate the engagement of service user groups and lobbying groups for social change beyond the mental health arena, such as the Joseph Rowntree Foundation and the New Economics Foundation.

However, for lobbying groups to be successful, they need to be able to deliver a coherent message to government. It is sometimes assumed that clinical psychologists and those advising mental health policy makers agree on what is preventable and how this can be achieved, but this is not necessarily the case. Clinical psychologists are liable to fall prey to the same assumptions made by policy makers, given the contradictory discourses surrounding these topics. Therefore, debate needs to be encouraged between psychologists, their organisational bodies, and those of other mental health professionals, to establish coherent concepts and models with regards to mental health prevention.

The current research indicates that these models should include agreement as to the causes of mental distress, taking into account the complexities of this process and the impact of social determinants, among other influential factors. It should also address clinical

psychology's position as to the relationship between mental and physical health, beyond simple linear patterns of cause and effect. Clarity around terms such as social determinants, health inequalities, and different levels of prevention needs to be reached, so that these are not conflated. Lastly, the study shows that models for preventative action at each level need to be developed, in a way that prioritises primary prevention rather than almost solely focusing on treatment.

The impact of this may be that clinical psychologists need to be equipped with new knowledge and skills to transition from primarily delivering individual treatments, to additionally being able to influence national, population level change. Clinical training courses will need to more consistently centre topics of population health and primary prevention. There may also be those who feel deskilled and resistant towards this path towards prevention, and it would be the responsibility of professional organisations such as the British Psychological Society and the Association of Clinical Psychologists UK to provide a strong rationale and adequate support to facilitate a broadening of attitudes around prevention.

This work to develop a cohesive model of prevention within clinical psychology also needs to intersect with the actions of research institutions. In previous sections of this study it has been noted that the spend on research into biomedical causes of distress significantly outweighs that of prevention (British Psychological Society, 2019a; MQ: Transforming Mental Health Through Research, 2018). Research institutions therefore need to prioritise the exploration of models and interventions relating to prevention. A stronger evidence base could be used to campaign for the policy changes endorsed earlier in this section, and would add to policy makers' confidence in taking the prevention agenda forwards.

Greater clarity as to the concepts and evidence base may also influence public opinion with regards to prioritising the prevention of mental distress. However, (Newton, 2013) warns that changes to social policy that effect the freedoms and privileges of powerful, majority groups within society are likely to be met with resistance. This encourages the government to endorse more palatable, and less effective, solutions to social problems. Yet, guidance does exist for addressing public attitudes, for example in relation to income inequality, which might aid psychologists in campaigning for public engagement with policy change

(Peacock-Brennan & Harper, 2015). These include recommendations for framing one's argument, drawing out specific issues, providing evidence of positive change and linking this to benefits for the person you are addressing.

Further implications from the current research have been considered, which don't arise specifically from the analysis, but are consistent with it. For example, prevention could be kept in the forefront of the work of clinical psychologists and mental health services by considering the impact that issues such as poverty, social exclusion and racism have on distress. Patel et al. (2018) advocate for spaces to focus on managing the psychological distress and experience of social defeat engendered by an economically unequal society. In the social care arena, poverty-aware social work has been endorsed (Saar-Heiman, 2019). This goes beyond paying lip service to understanding the impact of poverty, but encourages practitioners to take further steps to align themselves with their clients and facilitate their voices to be heard in the struggle against it.

Clinical psychologists may choose to engage with community and liberation psychology approaches. Taking the example of racism as a cause of distress, given its consequences for mental health highlighted earlier in the current study, there are examples of work where connections are forged with communities who experience racialised exclusion and discrimination, drawing on their existing strengths to co-produce preventative interventions. Afuape (2020) outlines a radical systemic model in response to a request for Child and Adolescent Mental Health Service (CAMHS) input at a local secondary school. Although the proposed target of the intervention was a group of children expressing behaviour that challenged the school staff, the process involved aligning with and listening to this group of marginalised individuals, who were the subject of internal exclusion. Spaces were created to speak about how they understand their experience of trauma and oppression within their school environment, including experiences of racism. Then, with a focus on action, plans were made as to how they wanted to be supported to change the situation, prompting the management team to consider the conditions that affected the whole school's emotional wellbeing. This led to tangible preventative actions, such as children helping to co-produce an anti-racism policy that could more effectively protect them from future harm.

Carrying on this illustration, there are also national, primary preventative actions that could tackle the racism in schools that contributes to mental distress. For example, a reassessment of the extent of institutional racism in the UK could be conducted through an independent report. This is needed following the widespread criticism of the report of the Commission on Race and Ethnic Disparities (HM Government, 2021) by organisations such as the United Nations (2021) for the denial of data, contemporary theories of racism, and the accounts of those with lived experience of racism. This could focus on providing genuine advice for education institutions in addressing institutional racism, followed up with policies that mandate, and importantly, adequately fund, changes within schools. These might include instating an anti-racist curriculum (Anna Freud National Centre for Children and Families, 2022), addressing disproportionate exclusion among global majority students (Psychologists for Social Change, 2019), and introducing an adequately resourced member of staff to support schools with their anti-racist agenda.

4.4. CRITICAL REFLECTIONS

In line with Stage 5 of Fairclough (2001), this section will include critical reflections on the analysis. Firstly, CDA has been criticised on the basis that it is defined by its ideological position, with regards to its critical stance on social hierarchies and power, positioning in favour of those seen to suffer in relation to this, and focus on political action (Meyer, 2001). Widdowson (1995) questions CDA's claims to be a form of analysis given these a priori judgements, which do not allow for multiple interpretations of the text to be considered. Widdowson suggests CDA is biased in its selection of texts and the interpretation of these, which confirm its predetermined standpoint. Fairclough (1996) responds to these criticisms by pointing out that CDA at least makes its stance explicit at the outset, as opposed to other research where assumptions and biases are at work, but are unacknowledged.

As Meyer points out, this relates to the unresolved discussion as to whether any research can be value free, or, “without using any pre-framed categories of experience” (2001, p. 5). Therefore, the current study will proceed in line with epistemic humility and be, “cautious about our knowledge at all times because it is partial and fallible, we don’t understand and may never understand much of what is real” (Pilgrim, 2020, p. 4). The following comments will instead focus on the steps that have been taken to add to the quality of the current research, drawing on the stipulations of contribution, credibility and rigour outlined by Spencer and Ritchie (2011). As the former is covered in the implications section above, this section will be focused on credibility and rigour.

Credibility refers to the plausibility and defensibility of the claims made in the research. With regards to the selection of policies, to avoid Widdowson' s (1995) critique about cherry picking, the Historical Analysis of the recent development of prevention and population health discourses was conducted (See Appendices 7.1., 7.2. & 7.3. for examples of this process). This allowed me to select representative policies that epitomised the culmination of these discourses, rather than focusing on an isolated narrative on the basis of a predetermined bias (O’Reilly et al., 2021). This process allowed the study to evolve, and on the basis of this, AoH and the MHIP were selected instead of the policy that I had expected to focus on (the LTP).

Once the policies were chosen, the discursive analysis went through a series of stages which involved reading and re-reading the texts, familiarising myself with the points and themes that came up regularly or were heavily emphasised (see Appendices 7.3. & 7.4. for examples of the process). The write up of the analysis was therefore anchored to these discourses, rather than representing spurious or cherry picked ideas. Quotes from the raw data were used to evidence these key themes, rather than selecting isolated passages that confirmed a preset notion. Negative cases were also highlighted, and consideration of these was used to add nuance and deepen the analysis. Supervision was regularly used to facilitate this process, and this additional perspective was useful in questioning areas of the analysis that demonstrated obvious bias or were poorly evidenced. Each of these attempts to improve credibility anchored on the personal reflexivity highlighted in The Researcher’s Position part of the Epistemology and Methodology section. An example of how my values and

assumptions may have influenced the outcome of the research, and how personal reflexivity was used to mitigate the impact of this on its credibility, will be outlined here.

An area of the analysis that required particular reflection was the topic of social determinants of distress within AoH. As previously alluded, I hold critical views about the effectiveness of policies that de-contextualise and individualise distress. I also aim to consider the workings of power, the mechanisms by which power imbalances are maintained, and the vested interests that policy makers might have in minimising the existence and impact of social factors. It became apparent that I had not expected sections of AoH to acknowledge the existence of social inequalities, or their contribution to mental distress, anticipating instead the individualising and responsiblising narratives that have been a theme of neoliberal policies. However, through maintaining awareness of my biases and attending to negative case examples, I noted that these did exist, and that the cumulative disadvantage and exclusion of certain groups was alluded to.

I therefore needed to revise my analysis of AoH, coming to a more nuanced position that took this evidence into account. Upon further analysis of the text, I noted that although social determinants of mental distress were included, the way they were treated within the text meant that this awareness rarely impacted upon the preventative actions endorsed by AoH, or taken forward by the NHS in the MHIP. This related to the findings of the Historical Analysis, which highlighted a shift in policy since the 1980s. While discussion of social inequalities and their impact on health was suppressed along with the Black Report under the Thatcher administration (Department of Health and Social Security, 1980; Gray, 1982), current policy such as AoH is now able to discuss social inequalities and their impact. But this is not necessarily taken forward by planning or funding commitments to address them. When outlining evidence for this in the text, I went beyond reporting examples by including detail as to the specific discursive strategies that were visible, for example the use of passive voice in AoH's discussion of the role of social determinants. I included multiple accounts of this over a full subsection of the analysis to limit the likelihood of reporting a spurious finding. This process meant that the research retained credibility, while also allowing me to take a critical stand on the policy. This was in line with both judgmental rationalism and the tenets of CDA.

In addition to credibility, rigour was attended to through documentation of the research process (see Appendix 7.3. & 7.4.), and by selecting a robust structure by which to conduct CDA. CDA is known for not having a fixed methodological process, and draws on a multitude of procedures that are matched to the research question at hand (Jager, 2001). Where the researcher is new to the discourse analytic process, this has the potential to result in analysis which lacks structure and rigour. Therefore, the staged process outlined by Fairclough (2001) was utilised.

5. CONCLUSION

Prevention and population health have been gathering momentum as a feature of UK mental health policy for over a decade. The current study attributes this to the economic drive for efficiency savings (Newton, 2013), influential reports that implicate social determinant as integral to the population's experience of wellness and distress (Marmot, 2010; Marmot et al., 2020), and international pressure by the organisation such as the United Nations (Alston, 2019) and the World Health Organisation (World Health Organisation, 2008). This is also mirrored by calls from within the clinical psychology profession to address the social and political causes of mental distress (Richard et al., 2011).

And yet despite this, cross departmental, population wide preventative measures have not been forthcoming, and there is little evidence of revolutionary changes to the mental health provision within the UK in line with this agenda (Centre for Mental Health, 2019). A number of other contradictory features of policy were also noted, which warranted further exploration. The current study outlined the case for the clinical psychology profession's engagement with these issues, given its ethical obligation towards acting to improve the population's mental health (British Psychological Society, 2021; McGrath et al., 2016; Rahim

& Cooke, 2020). It was acknowledged that clinical psychology training does not currently emphasise this, and instead treatment is seen as the primary role for clinical psychologists (British Psychological Society, 2019c).

Therefore, the need to support the critical appraisal of policy documents informing mental health provision, and specifically its prevention, was proposed. The current study aimed to facilitate new understandings as to the structural and discursive barriers to mental health prevention, by exploring the underlying conceptual frameworks present in the selected policies, and their impact on preventative action.

A 5 stage framework for CDA was utilised (Fairclough, 2001), and an initial historical analysis led to the selection of two policies to focus upon, AoH and the MHIP. A further discursive analysis indicated that how mental health and health in general are conceptualised, and therefore what the target of prevention is deemed to be influences a policies stance on preventative action. Different positioning of groups, institutions and Government departments in roles of responsibility for prevention also impacted whether policies took up the call for mental health prevention. In addition, the concept of prevention was shown to be a malleable one, and its differential framing within and between policies was noted to influence the preventative actions endorsed by the policy.

These findings were discussed in terms of their relationship to social structures and networks of practices which may have a vested interest in maintaining inertia with regards to mental health prevention, and the example of income inequality was considered to highlight the barriers to change. The implications for clinical psychology in overcoming these barriers were considered in relation to individual work with clients in mental health services, community level engagement, and work at a policy level to contribute to a cohesive model for preventative action.

6. REFERENCES

Afuape, T. (2020). Radical systemic intervention that goes to the root: Working alongside inner-city school children, linking trauma with oppression and consciousness with action. *Journal of Family Therapy*, *42*(3), 425–452.

Afuape, T., & Hughes, G. (2015). *Liberation practices: Towards emotional wellbeing through dialogue*. Routledge.

Aherne, C., Moloney, O., & O'Brien, G. (2019). Youth mental health and the Power Threat Meaning Framework: Jigsaw's systems perspective. *Clinical Psychology Forum*, *313*, 3–7.

Albee, G. W. (1996). Revolutions and counter-revolutions in prevention. *American Psychologist*, *51*(11), 1130–1133.

Albee, G. W. (1999). Prevention, not treatment, is the only hope. *Counselling Psychology Quarterly*, *12*(2), 133–146.

All Party Parliamentary Group on Mental Health. (2018). *Progress of the Five Year Forward View for Mental Health: On the road to parity*. https://www.rethink.org/media/2579/on-the-road-to-parity-final-report.pdf

Allwood, L., & Bell, A. (2020). *Covid-19: Understanding inequalities in mental health during the pandemic*. Centre for Mental Health. https://www.centreformentalhealth.org.uk/sites/default/files/2020-06/CentreforMentalHealth_CovidInequalities_0.pdf

Alston, P. (2019). *Report of the Special Rapporteur on extreme poverty and human rights on his visit to the United Kingdom of Great Britain and Northern Ireland* (Forty First Session; A/HRC/41/39/Add.1). United Nations General Assembly. https://undocs.org/A/HRC/41/39/Add.1

Anna Freud National Centre for Children and Families. (2022). *Anti-racism and mental health in schools: A briefing*. Anna Freud Centre. https://www.annafreud.org/media/15716/briefing-paper_final.pdf

Appleby, L., Kapur, N., Shaw, J., Hunt, I., Ibrahim, S., Turnbull, P., Bojanić, L., Rodway, C., Tham, S.-G., & Richards, N. (2019). *National confidential inquiry into suicide and safety in mental health: Annual report: England, Northern Ireland, Scotland and Wales*. University of Manchester. https://www.hqip.org.uk/resource/national-confidential-inquiry-into-suicide-and-safety-annual-report-2018/#.YoUNVHXMI2x

Bambra, C., Gibson, M., Sowden, A., Wright, K., Whitehead, M., & Petticrew, M. (2010). Tackling the wider social determinants of health and health inequalities: Evidence from systematic reviews. *Journal of Epidemiology and Community Health*, *64*, 284–291.

Barlow, J., Sembi, S., & Underdown, A. (2016). Pilot RCT of the use of video interactive guidance with preterm babies. *Journal of Reproductive and Infant Psychology*, *34*(5), 511–524.

Beers, C. W. (1908). *A mind that found itself: An autobiography*. Longmans, Green and Co.

Beveridge, W. (1942). *Social insurance and allied service report*. The Stationery Office.

Bhaskar, R. (1997). *A realist theory of science* (Third Edition). Verso.

Blommaert, J. (2005). *Discourse: A critical introduction*. Cambridge University Press.

Boyle, M. (1999). Diagnosis. In C. Newnes, G. Holmes, & C. Dunn (Eds.), *This is madness: A critical look at psychiatry and the future of mental health services* (pp. 75–91). PCCS Books.

British Medical Association. (2018). *Lost in transit? Funding for mental health services in England*. https://www.bma.org.uk/what-we-do/population-health

British Psychological Society. (2018). *Guidance for psychologists on working with community organisations*. https://www.bps.org.uk/sites/www.bps.org.uk/files/Policy/Policy%20-%20Files/Guidance%20for%20psychologists%20on%20working%20with%20community%20organisations%20%28Sep%202018%29.PDF

British Psychological Society. (2019a). *British Psychological Society response to the Department of Health and Social Care Advancing our health: Prevention in the 2020s*. https://www.bps.org.uk/sites/www.bps.org.uk/files/Policy/Policy%20-%20Files/BPS%20Response%20-%20DHSC%20Advancing%20Our%20Health%20%28Prevention%20in%20the%202020s%29.pdf

British Psychological Society. (2019b). *Evidence Briefing—Adverse Childhood Experiences (ACEs)*. https://www.bps.org.uk/news-and-policy/adverse-childhood-experiences-aces

British Psychological Society. (2019c). *Standards for the accreditation of Doctoral programmes in clinical psychology*. British Psychological Society. https://www.bps.org.uk/sites/www.bps.org.uk/files/Accreditation/Clinical%20Accreditation%20Handbook%202019.pdf

British Psychological Society. (2021). *Code of ethics and conduct*. https://www.bps.org.uk/sites/www.bps.org.uk/files/Policy/Policy%20-%20Files/BPS%20Code%20of%20Ethics%20and%20Conduct.pdf

Brodie, M. (2021, October 1). *Public health system reforms: Location of Public Health England functions from 1 October*. https://www.gov.uk/government/publications/location-of-public-health-england-phe-functions-from-1-october-2021/public-health-system-reforms-location-of-public-health-england-functions-from-1-october#:~:text=At%20this%20point%20Public%20Health,to%20PHE%20%27s%20formal%20closure.

Bronfenbrenner, U. (1992). *Ecological systems theory*. Jessica Kingsley Publishers.

Browne, N., Zlotowitz, S., Alcock, K., & Barker, C. (2020). Practice to policy: Clinical psychologists' experiences of macrolevel work. *Professional Psychology: Research and Practice*, *51*(4), 371–382. https://doi.org/10.1037/pro0000301

Buck, D., Baylis, A., Dougall, D., & Robertson, R. (2018). *A vision for population health: Towards a healthier future*. The King's Fund.

Burton, M., Boyle, S., Harris, C., & Kagan, C. (2007). Community psychology in Britain. In S. Reich, M. Rieme, I. Prilleltensky, & M. Montero, *International community psychology: History and theories* (pp. 219–237). Springer.

Burton, M., & Kagan, C. (2003). Community psychology: Why this gap in Britain? *History and Philosophy of Psychology*, *4*(2), 10–23.

Burton, M., & Kagan, C. (2006). Decoding *Valuing People*. *Disability & Society*, *21*(4), 299–313. https://doi.org/10.1080/09687590600679899

Callaghan, J. E., Fellin, L. C., & Warner-Gale, F. (2017). A critical analysis of Child and Adolescent Mental Health Services policy in England. *Clinical Child Psychology and Psychiatry*, *22*(1), 109–127. https://doi.org/10.1177/1359104516640318

Caplan, G., & Grunebaum, H. (1967). Perspectives on primary prevention: A review. *Archives of General Psychiatry*, *17*(3), 331–346.

Carey, G., & Crammond, B. (2015). Action on the social determinants of health: Views from inside the policy process. *Social Science & Medicine*, *128*, 134–141. https://doi.org/10.1016/j.socscimed.2015.01.024

Carrey, N. J. (2021). Gerald Caplan, then and now: Public mental health applications to the current psychological challenges of the pandemic. *Canadian Medical Association Journal*, *193*(42), 1635–1635.

Center on the Developing Child. (2022). *How racism can affect child development*. Harvard University. https://developingchild.harvard.edu/resources/racism-and-ecd/

Centre for Mental Health. (2017). *Adult and older adult mental health services 2012-2016: An analysis of Mental Health NHS Benchmarking Network data for England and Wales*. https://www.centreformentalhealth.org.uk/publications/briefing-52-adult-and-older-adult-mental-health-services-2012-2016

Centre for Mental Health. (2019). *A vision for prevention: Priorities for the Government's green paper on health prevention*. https://www.centreformentalhealth.org.uk/publications/vision-prevention

Community Psychology Section. (2021). British Psychological Society. https://www.bps.org.uk/member-microsites/community-psychology-section

Cosgrove, L., & Karter, J. M. (2018). The poison in the cure: Neoliberalism and contemporary movements in mental health. *Theory & Psychology*, *28*(5), 669–683. https://doi.org/10.1177/0959354318796307

Cowen, E. L. (1977). Baby-steps toward primary prevention. *American Journal of Community Psychology*, *5*, 1–22.

Craddock, N., & Mynors-Wallis, L. (2014). Psychiatric diagnosis: Impersonal, imperfect and important. *The British Journal of Psychiatry*, *204*(2), 93–95.

Dalal, F. (2018). *CBT: The cognitive behavioural tsunami: managerialism, politics, and the corruptions of science*. Routledge.

Department for Work and Pensions. (2020). *Reducing Parental Conflict programme and resources*. https://www.gov.uk/government/collections/reducing-parental-conflict-programme-and-resources

Department of Health. (2009). *New horizons: Towards a shared vision for mental health*. https://www.nhs.uk/NHSEngland/NSF/Documents/NewHorizonsConsultation_ACC.pdf

Department of Health. (2010). *Healthy lives, healthy people: Our strategy for public health in England*. The Stationery Office. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/216096/dh_127424.pdf

Department of Health. (2011). *No health without mental health: A cross-government mental health outcomes strategy for people of all ages* (Grande-Bretagne, Ed.). The Stationery Office.

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/213761/dh_124058.pdf

Department of Health and Social Care. (2013). *Chief Medical Officer Annual Report 2013: Public Mental Health*. https://www.gov.uk/government/publications/chief-medical-officer-cmo-annual-report-public-mental-health

Department of Health and Social Care. (2018a). *Independent Review of the Mental Health Act 1983*. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/778897/Modernising_the_Mental_Health_Act_-_increasing_choice__reducing_compulsion.pdf

Department of Health and Social Care. (2018b). *Prevention is better than cure: Our vision to help you live well for longer*. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/753688/Prevention_is_better_than_cure_5-11.pdf

Department of Health and Social Care. (2019). *Advancing our health: Prevention in the 2020s: Consultation Document*. https://www.gov.uk/government/consultations/advancing-our-health-prevention-in-the-2020s

Department of Health and Social Care. (2020). *The future of public health: The National Institute for Health Protection and other public health functions*. https://www.gov.uk/government/publications/the-future-of-public-health-the-nihp-and-other-public-health-functions

Department of Health and Social Care. (2021). *COVID-19 mental health and wellbeing recovery action plan*. https://www.gov.uk/government/publications/covid-19-mental-health-and-wellbeing-recovery-action-plan

Department of Health and Social Security. (1980). *Inequalities in health: Report of a research working group*.

Durose, C. (2011). Revisiting Lipsky: Front-line work in UK local governance. *Political Studies*, *59*(4), 978–995. https://doi.org/10.1111/j.1467-9248.2011.00886.x

Easterlin, R. A., Angelescu McVey, L., Switek, M., Sawangfa, O., & Smith Zweig, J. (2010). The happiness–income paradox revisited. *Proceedings of the National Academy of Sciences*, *107*(57), 22463–22468.

Eriksson, M., Ghazinour, M., & Hammarström, A. (2018). Different uses of Bronfenbrenner's ecological theory in public mental health research: What is their value for guiding public mental health policy and practice? *Social Theory & Health*, *16*(4), 414–433. https://doi.org/10.1057/s41285-018-0065-6

Ezrati, M. (2019, January 15). *Universal Basic Income: A thoroughly wrongheaded idea*. Forbes. https://www.forbes.com/sites/miltonezrati/2019/01/15/universal-basic-income-a-thoroughly-wrongheaded-idea/?sh=ad92ac345e1c

Fairclough, N. (1995). *Critical Discourse Analysis: The critical study of language*. Longman.

Fairclough, N. (1996). A reply to Henry Widdowson's' Discourse analysis: A critical view'. *Language and Literature*, *5*(1), 49–56.

Fairclough, N. (2001). The discourse of New Labour: Critical Discourse Analysis. In M. Wetherell, S. Taylor, & S. J. Yates (Eds.), *Discourse as data: A guide for analysis*. Sage.

Fairclough, N. (2009). *Discourse and social change*. Policy Press.

Fairclough, N. (2013). Critical discourse analysis and critical policy studies. *Critical Policy Studies*, *7*(2), 177–197.

Fairclough, N., Jessop, B., & Sayer, A. (2004). Critical Realism and Semiosis. In J. Joseph & J. M. Roberts (Eds.), *Realism, discourse, and deconstruction* (pp. 23–42). Routledge.

Fisher, P., & Lees, J. (2016). Narrative approaches in mental health: Preserving the emancipatory tradition. *Health:*, *20*(6), 599–615.

Fotaki, M. (2014). *What market-based patient choice can't do for the NHS: The theory and evidence of how choice*. Centre for Health and the Public Interest.

https://d1wqtxts1xzle7.cloudfront.net/84425951/What-market-based-patient-choice-cant-do-for-the-NHS-CHPI-libre.pdf?1650330784=&response-content-disposition=inline%3B+filename%3DWhat_Market_Based_Patient_Choice_Can_T_D.pdf&Expires=1664974257&Signature=MSlGZOrrIr8qB~QyzY-JB7TYgsxQpyKTYXZ0x~YikKiYw1LWbXeCVDzVxRSbzm-0V-o230sjqw2MDkfZ1a-98yI5y~4gc~0-VFBoC5M4MWQsVbvizt5iQ6~IilSKSsV3hAeO3-9EleyyJAw2asKEHxJo44OUwXxbAl1Qnty6~~o-KJFh1y73CVcgYVNnqCHGxY5K1JTNW-6reRFyBz6vZABN6zclt2j7~3Xa5JIcnRLVlgErJWEP0AUfStqZ0AiBnK78s8sT6L99iQ6JUlgVgJY-8lFdue17wvgVxsyizRdd3iEhYCiplJ0gbcZt-H0HLeczVRNkymR-YnLHEgk-eg__&Key-Pair-Id=APKAJLOHF5GGSLRBV4ZA

Frenken, H. (2021). *Mental health teaching in the training of public health professionals: A thematic analysis of interviews with key stakeholders* [University of East London]. https://repository.uel.ac.uk/download/1f6fd4f3f996fc33f53099a284410ac797e357b83b42c24f8c1cd7aaef499213/1218334/2021_ClinPsychD_Frenken.pdf

Fricker, M. (2006). Powerlessness and social interpretation. *Episteme*, *3*(1–2), 96–108.

Gordon Jr, R. S. (1983). An operational classification of disease prevention. *Public Health Reports*, *98*(2), 107.

Graham, L., Brown-Jeffy, S., Aronson, R., & Stephens, C. (2011). Critical race theory as theoretical framework and analysis tool for population health research. *Critical Public Health*, *21*(1), 81–93. https://doi.org/10.1080/09581596.2010.493173

Gray, A. M. (1982). Inequalities in health. The Black Report: A summary and comment. *International Journal of Health Services*, *12*(3), 349–380.

Gregory, S., Dixon, A., & Ham, C. (2012). *Health policy under the coalition government: A mid-term assessment*. The King's Fund. https://www.kingsfund.org.uk/sites/default/files/field/field_publication_file/health-policy-under-the-coalition-government-kingsfund-nov2012.pdf

Grier, W. H., & Cobbs, P. M. (1968). *Black Rage*. Basic Books.

Griffin, D. V., Zlotowitz, D. S., McLoughlin, E., & Kagan, P. C. (2017). Universal basic income: A psychological impact assessment. *Educational Psychology Research and Practice*, *3*(1), 86–111.

Harper, D. J. (2003). Developing a critically reflexive position using discourse analysis. In L. Finlay & B. Gough (Eds.), *Reflexivity: A practical guide for researchers in health and social sciences* (pp. 78–92). Blackwell Science.

Harper, D. J. (2004). Storying Policy: Constructions of Risk in Proposals to Reform UK Mental Health Legislation. In B. Hurwitz, T. Greenhalgh, & V. Skultans (Eds.), *Narrative Research in Health and Illness* (pp. 397–413). Blackwell Publishing Ltd. https://doi.org/10.1002/9780470755167.ch23

Harper, D. J., & Speed, E. (2012). Uncovering recovery: The resistible rise of recovery and resilience. In E. Speed, J. Moncrieff, & M. Rapley (Eds.), *De-medicalizing misery II* (pp. 40–57). Palgrave Macmillan.

Hawksley, J. (2013). *A Genealogy of the Care Programme Approach in Mental Health Services* [University of East London]. https://repository.uel.ac.uk/download/204b4136ef3e5cae3b69c812d54c577adb3e00c23358773e4435c8746cb1a1c2/884537/2013_DClinPsych_Hawksley.pdf

Hayek, F. A. (1944). *The road to serfdom*. Routledge.

HM Government. (2021). *Commission on Race and Ethnic Disparities: The report*. HM Government. https://www.gov.uk/government/publications/the-report-of-the-commission-on-race-and-ethnic-disparities

Horn, M. (1989). *Before it's too late: The child guidance movement in the United States, 1922-1945.* Temple University Press.

Hughes, G. (2017). New models of care: The policy discourse of integrated care. *People, Place and Policy Online*, *11*(2), 72–89. https://doi.org/10.3351/ppp.2017.6792867782

Hughes, G., & Afuape, T. (2015). ‘What’s our story?’: Centralising young people’s experiences of ‘gangs’, crews and collectives to promote wellbeing. In T. Afuape & G. Hughes, *Liberation practices: Towards emotional wellbeing through dialogue* (pp. 84–97). Routledge.

Ife, J. W. (1995). *Community development: Creating community alternatives-vision, analysis and practice*. Longman.

Jager, S. (2001). Discourse and knowledge: Theoretical and methodological aspects of a critical discourse and dispositive analysis. In R. Wodak & M. Meyer (Eds.), *Methods of critical discourse analysis* (pp. 32–62). Sage.

Johnstone, L., & Boyle, M. (2018). The power threat meaning framework: An alternative nondiagnostic conceptual system. *Journal of Humanistic Psychology*, 1–18.

Joseph, J., & Roberts, J. M. (2004). Introduction: Realism, discourse and deconstruction. In J. Joseph & J. M. Roberts (Eds.), *Realism, discourse, and deconstruction* (pp. 1–19). Routledge.

Kalathil, J. (2015). Hard to reach? Racialised groups and mental health service user involvement. In P. Staddon (Ed.), *Mental health service users in research* (pp. 121–133). Policy Press.

Keys, C., Nanayakkara, G., Onyejekwe, C., Sah, R., & Wright, T. (2021). Health inequalities and ethnic vulnerabilities during COVID-19 in the UK: a reflection on the PHE Reports. *Feminist Legal Studies*, *29*(1), 107–118.

Lansley, S. (2009). *Life in the Middle: The Untold Story of Britain’s Average Earners*. Trades Union Congress.

Layard, R. (2006). *The depression report: A new deal for depression and anxiety disorders*. Centre for Economic Performance, LSE.

Layard, R., Clark, D. M., Knapp, M., & Mayraz, G. (2007). Cost–benefit analysis of psychological therapy. *National Institute Economic Review*, *202*, 90–98.

Lewis, J. (2019). *Government and NHS reform since the 1980s: The role of the market vis à vis the state, and of political ideas about the ‘direction of travel’*. LSE Department of Social Policy.

Mandell, W. (1995). *Origins of mental health: The realization of an idea*. John Hopkins, Bloomberg School of Public Health. https://publichealth.jhu.edu/departments/mental-health/about/origins-of-mental-health

Marmot, M. (2010). *Fair society, healthy lives: Strategic review of health inequalities in England post 2010*. The Institute of Health Equity. https://www.instituteofhealthequity.org/resources-reports/fair-society-healthy-lives-the-marmot-review/fair-society-healthy-lives-full-report-pdf.pdf

Marmot, M., Allen, J., Boyce, T., Goldblatt, P., & Morrison, J. (2020). *Health equity in England: The Marmot Reivew 10 years on*. Institute of Health Equity. https://www.instituteofhealthequity.org/resources-reports/marmot-review-10-years-on

McGrath, L., Griffin, V., & Mundy, E. (2016). The psychological impact of austerity: A briefing paper. *Educational Psychology Research and Practice*, *2*(2), 46–57.

McMahon, N. E. (2021). Working 'upstream' to reduce social inequalities in health: A qualitative study of how partners in an applied health research collaboration interpret the metaphor. *Critical Public Health*, 1–11. https://doi.org/10.1080/09581596.2021.1931663

McManus, S., Bebbington, P., Jenkins, R., & Brugha, T. (2016). *Mental health and wellbeing in England: The Adult Psychiatric Morbidity Survey 2014*. NHS Digital. https://files.digital.nhs.uk/pdf/s/5/adult_psychiatric_study_executive_summary_web.pdf

McWade, B. (2016). Recovery-as-policy as a form of neoliberal state- making. *Intersectionalities: A Global Journal of Social Work Analysis, Research, Polity, and Practice*, *5*(3), 62–81.

Mental Health Foundation. (2019). *Mental Health Foundation Consultation Response: Department of Health and Social Care: Prevention Green Paper, October 2019*. https://www.mentalhealth.org.uk/sites/default/files/MHF_Prevention%20Green%20Paper%20response.pdf

Mental Health Taskforce. (2016). *Five year forward view for mental health*. https://www.england.nhs.uk/wp-content/uploads/2016/02/Mental-Health-Taskforce-FYFV-final.pdf

Meyer, M. (2001). Between theory, method, and politics: Positioning of the approaches to CDA. In R. Wodak & M. Meyer (Eds.), *Methods of critical discourse analysis* (pp. 14–31). Sage.

Mollon, P. (2009). The NICE guidelines are misleading, unscientific, and potentially impede good psychological care and help. *Psychodynamic Practice*, *15*(1), 9–24.

Moth, R. (2020). 'The business end': Neoliberal policy reforms and biomedical residualism in frontline community mental health practice in England. *Competition & Change*, *24*(2), 133–153. https://doi.org/10.1177/1024529418813833

MQ: Transforming Mental Health Through Research. (2018). *UK mental health research funding: 2014—2017*. https://www.mqmentalhealth.org/wp-content/uploads/UKMentalHealthResearchFunding2014-2017digital.pdf

Murray, C. J., & Lopez, A. D. (1997). Global mortality, disability, and the contribution of risk factors: Global Burden of Disease Study. *The Lancet*, *349*(9063), 1436–1442.

National Health Service and Community Care Act, no. 19, Act of Parliament of the United Kingdom (1990). https://www.legislation.gov.uk/ukpga/1990/19/introduction

National Institute for Health and Care Excellence [NICE]. (2020). *Antenatal and postnatal mental health: Clinical management and service guidance [Clinical guideline No. 192]*. https://www.nice.org.uk/guidance/cg192/chapter/Recommendations#providing-interventions-in-pregnancy-and-the-postnatal-period-2

National Institute of Mental Health. (2019, May 9). Technology and the future of mental health treatment. *Health Topics*. https://www.nimh.nih.gov/health/topics/technology-and-the-future-of-mental-health-treatment

Newton, J. (1988). *Preventing mental illness*. Routledge.

Newton, J. (2013). *Preventing mental ill-health: Informing public health planning and mental health practice*. Routledge.

NHS England. (2014). *Five Year Forward View*. https://www.england.nhs.uk/five-year-forward-view/

NHS England. (2019a). *NHS Mental Health Implementation Plan 2019/20 – 2023/24* (p. 57). https://www.longtermplan.nhs.uk/publication/nhs-mental-health-implementation-plan-2019-20-2023-24/

NHS England. (2019b). *The NHS Long Term Plan*. https://www.longtermplan.nhs.uk/publication/nhs-long-term-plan/

NHS England. (2021). *Early Intervention in Psychosis*. NHS England and NHS Improvement South West. https://www.england.nhs.uk/south/our-work/mental-health/early-intervention-in-psychosis/

NHS England & National Collaborating Centre for Mental Health. (2019). *The community mental health framework for adults and older adults*. https://www.england.nhs.uk/publication/the-community-mental-health-framework-for-adults-and-older-adults/

Office of National Statistics. (2020). *Child abuse in England and Wales: March 2020*. https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/bulletins/childabuseinenglandandwales/march2020

Oliver, D. (2018). David Oliver: Is Matt Hancock really prioritising prevention over cure? *British Medical Journal*. https://www.bmj.com/lookup/doi/10.1136/bmj.k4712

Oliver, D. (2021). David Oliver: Renaming government agencies won't improve population health. *British Medical Journal*, n1004. https://doi.org/10.1136/bmj.n1004

O'Reilly, M., Kiyimba, N., Lester, J. N., & Edwards, D. (2021). Establishing quality in discursive psychology: Three domains to consider. *Qualitative Research in Psychology*, *18*(3), 406–425. https://doi.org/10.1080/14780887.2020.1810373

Orton, M., & Rowlingson, K. (2007). Public attitudes to economic inequality. *Joseph Rowntree Foundation*, *4*, 1–4.

Paradies, Y., Priest, N., Ben, J., Truong, M., Gupta, A., Pieterse, A., Kelaher, M., & Gee, G. (2013). Racism as a determinant of health: A protocol for conducting a systematic review and meta-analysis. *Systematic Reviews*, *2*(1), 1–7.

Parkin, E. (2021). *Mental health policy in England* (Briefing Paper CBP 07547). House of Commons Library.

Patel, N. (2020). Critical Human Rights-Based Approach to Applied Psychology: Context and Power. In P. Hagenaars, M. Plavsic, N. Sveaass, U. Wagner, & T. Wainwright (Eds.), *Human Rights Education For Psychologists* (pp. 1–15). Routledge.

Patel, V., Burns, J. K., Dhingra, M., Tarver, L., Kohrt, B. A., & Lund, C. (2018). Income inequality and depression: A systematic review and meta-analysis of the association and a scoping review of mechanisms. *World Psychiatry*, *17*(1), 76–89.

Peacock-Brennan, S., & Harper, D. (2015). *Improving public discussion about inequality: A briefing paper*. Psychologists Against Austerity. http://www.psychchange.org/uploads/9/7/9/7/97971280/talking-about-inequality.pdf

Percy Commission. (1957). *Report of the Royal Commission on the law relating to mental illness and mental deficiency 1954-1957*. The Stationery Office.

Pilgrim, D. (2020). *Critical realism for psychologists*. Routledge.

Psychologists for Social Change. (2019). *PSC support the moratorium on school exclusions in England*. Www.Psychchange.Org. http://www.psychchange.org/psychologists-for-social-change-support-the-moratorium-on-school-exclusions-in-england.html

Psychologists for Social Change. (2021). Psychologists for Social Change. http://www.psychchange.org/

Public Health England. (2017). *Prevention Concordat for Better Mental Health*. https://www.gov.uk/government/publications/prevention-concordat-for-better-mental-health-consensus-statement/prevention-concordat-for-better-mental-health

Public Health England. (2019). *What good looks like for public mental health*. https://www.adph.org.uk/wp-content/uploads/2019/06/What-Good-Public-Mental-Health-Looks-Like-Final.pdf

Public Health England. (2020). *Disparities in the risk and outcomes of Covid-19*. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/892085/disparities_review.pdf

Rahim, M., & Cooke, A. (2020). Should clinical psychologists be political. In W. Curvis (Ed.), *Professional Issues in Clinical Psychology: Developing a Professional Identity Through Training and Beyond* (pp. 81–91). Routledge.

Read, J., Bentall, R. P., & Fosse, R. (2009). Time to abandon the bio-bio-bio model of psychosis: Exploring the epigenetic and psychological mechanisms by which adverse life events lead to psychotic symptoms. *Epidemiology and Psychiatric Sciences*, *18*(4), 299–310.

Rethink. (2004). *Developments and trends in mental health policy.pdf*.

Richard, L., Gauvin, L., & Raine, K. (2011). Ecological Models Revisited: Their Uses and Evolution in Health Promotion Over Two Decades. *Annual Review of Public Health*, *32*(1), 307–326. https://doi.org/10.1146/annurev-publhealth-031210-101141

Rocks, S., & Boccarini, G. (2021). *Taxes and health care funding: How does the UK compare?* The Health Foundation. https://www.health.org.uk/news-and-comment/charts-and-infographics/taxes-and-health-care-funding-how-does-the-uk-compare

Roscher, K. (2020). *Neoliberal development: Capability deprivation and barriers for positive mental health* [International Political Economy]. University of Puget Sound.

Rose, G., & Day, S. (1990). The population mean predicts the number of deviant individuals. *British Medical Journal*, *301*(6759), 1031–1034.

Rose, G., Khaw, K.-T., & Marmot, M. G. (2008). *Rose’s strategy of preventive medicine: The complete original text* (New ed). Oxford University Press.

Rose, N., & Miller, P. (1992). Political Power beyond the State: Problematics of Government. *The British Journal of Sociology*, *43*(2), 173. https://doi.org/10.2307/591464

Roth, A. D., & Pilling, S. (2008). *A competence framework for the supervision of psychological therapies*. Research Department of Clinical, Educational and Health Psychology, University College London. https://www.researchgate.net/profile/Stephen-Pilling/publication/265872800_A_competence_framework_for_the_supervision_of_psychological_therapies/links/5727a25e08ae586b21e2963e/A-competence-framework-for-the-supervision-of-psychological-therapies.pdf

Saar-Heiman, Y. (2019). Poverty-aware social work in the child protection system: A critical reflection on two single-case studies. *Child & Family Social Work*, *24*(4), 610–618. https://doi.org/10.1111/cfs.12642

Samaritans. (2020). *Out of sight, out of mind: Why less-well off, middle-aged men don't get the support they need*. https://media.samaritans.org/documents/Samaritans_-_out_of_sight_out_of_mind_2020.pdf

Scott, K. (2015). Happiness on your doorstep: Disputing the boundaries of wellbeing and localism. *The Geographical Journal*, *181*(2), 129–137. https://doi.org/10.1111/geoj.12076

Snowdon, C. (2010). *The spirit level delusion: Fact-checking the left's new theory of everything*. Little Dice.

Soyland, A. (1994). After Lashley: Neuropsychology, metaphors, promissory notes. *Theory & Psychology*, *4*(2), 227–244.

Spencer, L., & Ritchie, J. (2011). In pursuit of quality. In D. Harper & A. Thompson (Eds.), *Qualitative research methods in mental health and psychotherapy: A guide for students and practitioners* (pp. 225–242). John Wiley & Sons, Ltd.

Stevens, A. (2011). Telling Policy Stories: An Ethnographic Study of the Use of Evidence in Policy-making in the UK. *Journal of Social Policy*, *40*(2), 237–255. https://doi.org/10.1017/S0047279410000723

Tebes, J. K. (2016). Reflections on the future of community psychology from the generations after Swampscott: A commentary and introduction to the Special Issue. *American Journal of Community Psychology*, *58*(3–4), 229–238.

Teghtsoonian, K. (2009). Depression and mental health in neoliberal times: A critical analysis of policy and discourse. *Social Science & Medicine*, *69*(1), 28–35. https://doi.org/10.1016/j.socscimed.2009.03.037

The Kings Fund. (2014). Service transformation: Lessons from mental health. *Service Transformation*, 24.

The King's Fund. (2019, March 29). *What does improving population health really mean?* The King's Fund. https://www.kingsfund.org.uk/publications/what-does-improving-population-health-mean

The Rt Hon Matt Hancock MP. (2018, November 5). *Prevention is better than cure – Matt Hancock's speech to IANPHI* [Interview]. https://www.gov.uk/government/speeches/prevention-is-better-than-cure-matt-hancocks-speech-to-ianphi

The Rt Hon Matt Hancock MP. (2020, August 18). *The Future of Public Health* [Interview]. https://www.gov.uk/government/speeches/the-future-of-public-health

Thomas, F., Hansford, L., Ford, J., Wyatt, K., McCabe, R., & Byng, R. (2018). Moral narratives and mental health: Rethinking understandings of distress and healthcare support in contexts of austerity and welfare reform. *Palgrave Communications*, *4*(1), 39. https://doi.org/10.1057/s41599-018-0091-y

Tilley, S., & Cowan, S. (2011). Recovery in mental health policy: Good strategy or bad rhetoric? *Critical Public Health*, *21*(1), 95–104. https://doi.org/10.1080/09581591003694987

Timimi, S. (2014). *Pathological child psychiatry and the medicalization of childhood*. Routledge.

Townley, G., Brown, M., & Sylvestre, J. (2018). Community Psychology and Community Mental Health: A Call for Reengagement. *American Journal of Community Psychology*, *61*(1–2), 3–9. https://doi.org/10.1002/ajcp.12225

Turner, J., Hayward, R., Angel, K., Fulford, B., Hall, J., Millard, C., & Thomson, M. (2015). The History of Mental Health Services in Modern England: Practitioner Memories and the Direction of Future Research. *Medical History*, *59*(4), 599–624. https://doi.org/10.1017/mdh.2015.48

United Nations. (2017). *Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health: Mr. Dainius Pūras*. https://www.ohchr.org/en/statements/2017/04/special-rapporteur-right-everyone-enjoyment-highest-attainable-standard-0

United Nations. (2021). UN Experts Condemn UK Commission on Race and Ethnic Disparities Report. *United Nations Media Centre*. https://www.ohchr.org/en/press-releases/2021/04/un-experts-condemn-uk-commission-race-and-ethnic-disparities-report

Widdowson, H. G. (1995). Discourse analysis: A critical view. *Language and Literature*, *4*(3), 157–172.

Wilkinson, R. G., & Pickett, K. (2010). *The spirit level: Why equality is better for everyone*. Penguin Books.

Willig, C. (2001). *Introducing qualitative research in psychology: Adventures in theory and method*. Open University Press.

Willig, C. (2016). Constructivism and 'The Real World': Can they co-exist? *QMiP Bulletin*, *21*, 1–9.

Willig, C. (2019). Ontological and epistemological reflexivity: A core skill for therapists. *Counselling and Psychotherapy Research*, *19*(3), 186–194.

Wodak, R. (2001). What CDA is about: A summary of its history, important concepts and its development. In R. Wodak & M. Meyer (Eds.), *Methods of critical discourse analysis* (pp. 2–12). Sage.

World Health Organisation. (2008). *Closing the gap in a generation: Health equity through action on the social determinants of health*. https://www.who.int/publications/i/item/WHO-IER-CSDH-08.1

World Health Organisation. (2014). *Social determinants of mental health*. https://apps.who.int/iris/bitstream/handle/10665/112828/9789241506809_eng.pdf

Zeira, A. (2021). Mental Health Challenges Related to Neoliberal Capitalism in the United States. *Community Mental Health Journal*, *58*, 205–212. https://doi.org/10.1007/s10597-021-00840-7

7. APPENDICES

7.1. HISTORICAL OVERVIEW OF POLICY DEVELOPMENTS

Draws on: (Burton & Kagan, 2006; Durose, 2011; Hawksley, 2013; Moth, 2020; Newton, 2013; Rethink, 2004; The Kings Fund, 2014; Turner et al., 2015)

1890 - Lunacy Act – terms for certification for compulsory incarceration

1923 – National council for mental hygiene set up in 1923, non-governmental, aimed to critically look at underlying social/environmental causes of unhappiness and mental health so it could be eradicated, and to scientifically study acquired mental disease with a view to prevention

1930 – Mental Treatment Act – no need for certification to forcibly treat, Board of Control

Development of antipsychotic drugs means more people can be helped in community

Beveridge report (1942) "'Social Insurance and Allied Service Report', proposing the expansion of National Insurance and the creation of the NHS. Formed the basis for the post-War welfare state, stablished by the 1945 Labour government. Outlined the five "Giant Evils", created a form of contract between the state and the people, in which needs and responsibilities would be clearly marked out and separated. The introduction of social insurance would attempt to establish collectivist mentality at large" (Hawksley)

1940 – post-war until late 1970's, consolidation of the social model. Welfare state developed as a compromise between capitalism and socialism, market values and collectivist values. Keynes, welfare state

1948 – NHS founded, preponderance and power of medical professionals

1957 – The Percy Report – MH should be considered in the same way as physical health, and treatment/hospitals for MH should mirror physical health. Care should be provided, but with as limited restriction as possible

1959 – Mental Health Act – as a result of the Percy Report (1957), repeals the Lucacy Act and Board of Control abolished. Have to be certified 'insane' to be admitted to an asylum, not 'morally defective'. The community is the most appropriate and cheapest place to care for people. Elevated role of psychiatry; doctors rather than the courts had the authority to detain people, psychiatrist could work in the community. Psychaitry afforded equal footing with other areas of medicine. Increased opportunities for professional experts. Reduce long term detentions in favour of short term and voluntary treatment

1959 – Advisory Committee for Management Efficiency set up by ministry of health – health economists, promoted centralized planning, technologies of management

1960s – groups of political activists against outcomes of individualization and mass society - faceless, bureaucratic, controlling, exploitative. Picked up narrative of Community as an antidote. Mental health an aspect of the community. Professionalisation, mental health subject to greater research, domain of experts

1961 – the Plowden Report – the use of maths and stats in the running of the NHS advocated for by ministry of health. Government push to take control of management of NHS back from medical professionals

1961 – Enoch Powel Water Tower Speech and signals the closing of large asylums. Psychiatry gains traction as made it possible to treat people in the community. Some psychiatrists saw this move as progressive, others noted the little evidence for the treatments.

1962 – Hospital Plan – specialist acute units attached to general hospitals, other people should be seen by local authority in the community. Uses statistical methods to forecast the savings of closing asylums

1968 – Seebolm Report – leads to the creation of an integrated social work profession

> 1970's until 1990's – Keynesian economics - government could relieve unemployment, increasing economic activity through taxation and public spending. Inhumane aspects of markets must be controlled. "Nationalization and comprehensive state provision/welfare. The number of professions working in mental health grew with the move to community care" (Moth). High degree of discretion in professional practice

1971 – creation of the Royal College of Psychiatrists from the Royal Medico-Psychological Association (

> Early service user movements, dissatisfaction re. medical authority, poor treatment by psychiatry, experimental/unevidenced procedures, lack of resources in community care, lack of civil rights. Some clinicians began to respond and note the need for services to respond to social devaluation of their users. MIND lobbies for change to Mental Health Act (1959)

> Evolution from welfare state towards neoliberalism, regulatory state as opposed to the welfare state, new public management culture in the NHS, consumerist discourses, transition from de-institutionalisation to community care, emergence of risk discourse, targets, market values, control, compliance, 'government at a distance', individualist rather than collective assumptions

1974 – NHS reorganization integrates mental health services with general hospital/medical services, NHS organized in districts alongside Local Authority boundaries. Disruption, poor funding, increased managerialism

> Numerous repots and allegations of ill treatment within MH hospitals

1975 – Report of the Committee on Mentally Abnormal Offenders (Butler Report). Not yet the public outcry around risk, even though risk existed. Instead called for more cooperation between justice system and mental health services. Formed the basis of forensic psychiatric NHS services

1975 – Better Services for the Mentally Ill

1983 – Mental Health Act, strengthening civil rights of those with mental health problems. In practice, was still hard to make decisions about treatment. Voluntary inpatients detained if they said no to treatment

1983 – Grifiths report – embedded New Public Management – top down control spread though NHS, hierarchical, 'government from a distance'. Establishes todays organisation of the NHS.

Conservative Government reorganization of NHS, imposed general management and new structures for health authorities.

1988 – The Griffiths Report led to the NHS Community Care Act (1990). Responsibility for community care placed on local authorities. Redefined the role of health authorities and social care authorities. More managerialism, creating purchaser and provider split. Community care seen by practitioners as positive but allusive, poor funding and lack of direction given, faulty public policy, practitioners left to own devices, often poor outcomes in the community for service users. This report also promoted private practice.

1990 – 1997 – "NHS and Community Care Act 1990 (NHSCCA) introduced by a Conservative administration. Framed in terms of increased choice, empowerment and consumer rights, operationalised through creation of internal and external markets to promote service commodification and marketization" (Moth). Managerialist reform.

1990 – Global burden of disease study (WHO, World Bank)

1990 – DoH Care Program Approach – move towards CMHTs began. Specialist teams. NHS or local authority in charge of coordinating an individual's care. Another step towards managerial configuration of the NHS, but still some room for discretion of professionals. Care planning done to people rather than with them, element of control and enforced treatment to mitigate risk and repercussions

1991-96 – introduction of NHS Trusts including separate mental health Trusts

1992 – killing of Johnathan Zito by Clunis

> Preoccupation with community care, narrative of people with mental health difficulties as being dangerous rather than for better care. Low spending. Political pandering to public opinion, increased control and restrictions. Funds diverted to forensic and high/medium secure institutions, new asylums. Focus on risk management

1992 – The Reed Report, reviewing health and social services for mentally disordered offenders

1992 – The Health of the Nation, includes mental health targets. Lots of focus on suicides and reducing this, seen by practitioners as a way to push for more funding in general

1997-2010 Labour Government

Increased spending, but not by as much as increase in general NHS spending. Also increased it in specific areas, didn't help minority groups or certain areas of the country, and funneled funds into secure units rather than community teams, low preventative work. Increasing managerialism. Service users movements sometimes feel 'hijacked' by policy makers. Increased focus on evidence based treatment. Clinicians became accountable. Centralisation alongside rhetoric of empowering frontline workers. Modernisation, use of targets embed market norms, professional identities challenged. Continued preoccupation with threat to public and risk.

1998 – Modernising Mental Health Services, white paper. Spending increase executed as target driven NHS reforms. £700m pledged

1998 – Human Rights Act

1999 – National Service Framework for adult mental health. Outlined specific objectives/standards of care, only for adults of working age (severe MH, suicide, carers, **mental health promotion**, primary care. New service models: Assertive Outreach, Crisis Resolution/home treatment team, Early Intervention. Large scale of change, somewhat prescriptive, no flex to local need.

Drug treatment still predominated, low access to psychological interventions

2000 – Race Relations Act

2000 – NHS Plan – named mental health as one of three clinical priorities. Extra £300m pledged to speed up National Services Framework actions

2001 – Mental Health Policy Implementation Guidelines. DoH promised unprecedented funds and gave a lot of specific guidance. Focus on risk management fragments care, development of assertive outreach/home treatment teams, serves the social control function of psychiatry. Policy makers saw this as positive national leadership, clinicians felt it constrained the development of locally appropriate services

2001 – DoH mental health policy implementation guide – tight referral criteria for assertive outreach, services started to shift the goalposts, discretionary work

2002 – National Suicide Prevention Strategy – DoH. Guidance to modify inpatient environments to reduce risk.

2003 – Inquest and report into death of Rocky Bennett leads services to show they are working in line with the Race Relations Act

2003 – "introduction of NHS Foundation Trusts as service providers. Corporate entities with independence from government control, expected to produce surpluses through competitive activity in health care markets, reshaped professional practice to align with market principles, towards neoliberal restructuring of the NHS" (Moth), managerialist reform

NHS Partnership Trusts developed, local authority/social services combined with NHS. Also Third Sector providing innovative services in addition to core services, NHS commissioned these, awarding block contracts for a particular need. Not free

to patients but subsidised. The NHS dictated what the need was and what they would pay for, and what would be provided

2003-09 – New Ways of Working, initiative for mental health professionals (Turner)

2004 – National Service Framework for children and young people and maternity

2005 – DoH - New ways of working for psychiatrists. Positions them in MDTs, in service development, training up nurses

2006 – Everybody's Business, integrated mental health services for Older Adults, first integrated policy statement for older adults (Turner)

2006 – IAPT, specific focus on reducing economic burden of mild/moderate mental health, rationale to reduce burden on society. Ministers demanded 'evidence of efficacy' before funding and continuing to fund

2007 – Mental Health Act, after long battle between the Government and the Mental Health Alliance. Labour, trying to 'extend and clarify powers of compulsion' and partly reverse what had been overhauled in the 1983 MH act. Seen as means of social control rather than to benefit wellbeing of service users. Focused around risk as a justification. Leaves too much scope for 'professional judgement' disempowering service users.

2007 – Creating Capable Teams Approach – DoH. Teams given a way to assess their skills requirement, dictate from above. More CPs and social workers followed

2008 – NHS operating Framework - IAPT made priority

2009 onwards, end of New Labour to start of coalition, welfare retrenchment, austerity, discourse of personalization, individualization, self-management, market engagement. Increased private and voluntary sector provision, new mental health payment system

2009 – DoH New horizons: towards a shared vision for mental health - with priorities including: personalised services, tackle stigma, tackling inequality, improving physical health of people

2010 – Conservative/Lib Dem Coalition Government, Cameron, Clegg

2010 – Marmot Review. Led to…

2010 – DoH – Healthy Lives, Healthy People. White Paper Healthy Lives, claims to be the first public health strategy to give parity between mental and physical health. Public health and behaviour change shifted from NHS to local government. Public Health England set up to provide support and leadership, co-ordinated public health response. Health and wellbeing to assess local population needs, to jointly agree strategies with clinical commissioning groups. Focus on localism, liberal approach, helping people help themselves, in the interests of business

2011 - No Health Without Mental Health – coalition Government, DoH. Cross Government strategy. Reflected in NHS Outcomes Framework. Allowing more flexibility for services to adjust to local conditions, localism

2012 – Health and Social Care Act – Coalition Government, first Government commitment to parity of esteem. Opened the doors for privatisation. Build on the New Horizons 2009
The reframing of service provision as a priced commodity, market values within NHS, opposed by healthcare trade unions, executive, non-departmental public body created - NHS Commissioning Board (renamed NHS England), and the transformation of hospitals into Foundation Trusts (FTs), has to be viable or face closure

2013 – Payment by results/Mental Health Payments System - further shift to market values. Block contracts reduced mental health specific funding, clustering based on diagnostic categories Shift away from mental health service funding via block contracts. Instead, service users are allocated to a new classification system known as a cluster, based on their diagnostic characteristics, service provision as a priced commodity (Moth)

7.2. REVIEW OF RECENT POLCIY DEVELOPMENTS

Key

Key policies relating to prevention agenda highlighted in red

Policies beyond the scope of the current study highlighted in grey

2014 – NHS - Five Year Forward View

2015 – Conservative Government, Cameron, May

2016 – review of the Five Year Forward View from the independent Mental Health Taskforce- made recommendations for improving mental health. Referenced tackling inequality and poverty, discrimination, worse experience of minority groups

Aug 2017 – Prevention Concordat for better mental – DoH policy paper - different signatures - brings together a wide range of organisations that have committed to preventing mental health problems and promoting good mental health. The organisations that join the Concordat agree to work together to take local and national action to achieve the aim of better mental health for all.
What are they doing in the name of prevention, what is their actual commitment, outcomes measured, are they accountable? Local authorities 'encouraged' to sign up but don't need to

Dec 2017 – Impact of Brexit on health and social care: government response

Nov 2018 – Prevention is better than cure: our vision to help you live well for longer – DoH. Matt Hancock's speech

Jan 2019 – NHS -Long Term Plan

Jan 2019 – Suicide prevention: cross-government plan - DoH

May, 2019 – The Government's revised mandate to NHS England for 2018-19

Jun 2019 - What Good Looks Like for Public Mental Health. PHE.

Jul 2019 – Advancing our Health, Prevention in the 2020s. DoH green paper

Jul 2019 – NHS - Mental health implementation plan

Sep 2019 – NHS - Community mental health framework for adults and older adults

Dec 2019 – Conservative Government, Johnson

Mar 2020 – COVID

Aug 2020 – Matt Handcock Future of Public Health speech. Alludes to the importance of prevention and population health, mentions John Snow. Announces National Institute for Health Protection – mandate to protect against external threat to the country. "External

threats like biological weapons, pandemics, and of course infectious diseases of all kinds". Unclear as to public health and mental health. Mentions need to link with private sector innovation and reduce bureaucracy

Sep 2020 – Mental health policy in England – House of commons briefing paper – priorities to manage after Covid

Sep 2020 - The future of public health: the National Institute for Health Protection and other public health functions.

Feb 2021 – Integration and Innovation: Working together to improve health and social care for all - DoH white paper setting out legislative proposals for a Health and Care Bill. Sold as NHS that is integrated, less bureaucratic and more accountable. Condones integrated care e.g. between health and social and for those with multiple LTCs, flexibility to local populations, shift away from focus on competition/tendering that 2012 coalition government condoned.

March 2021 - Transforming the public health system: reforming the public health system for the challenges of our times. DoH Policy Paper. Post Covid, we need a focus on both health security (analysis, genomic surveillance, test and trace, lead by UK health Security Agency) and health improvement (cross Government prevention agenda, lead by new Office for health Promotion, under the Chief Medical Office, within the DoH, proactive, predictive, personalised).
"At the heart of our proposals in the forthcoming Health and Care Bill is the concept of population health: using the collective resources and strengths of the local system, the NHS, local authorities, the voluntary sector and others to improve the health of their area"

March 2021 - COVID-19 mental health and wellbeing recovery action plan – DoH

July 2021 – second reading of Health and Care Bill. Concerns it will allow for reduced responsibility for the Government to provide for our care needs, justified by the NHS being stretched after Covid.

7.3. TABLE OF PREVENTION THEMES

Key

Initial reflections on the documents highlighted in blue

Selected texts for discursive analysis highlighted in yellow

Date	Policy	Brief Description	Target Audience	Rationale for Prevention	How Prevention is Conceptualised (how defined, metaphors)	Changes from previous policies	Recommended Actions
Sep 2020	Mental health policy England	House of Commons Briefing Paper. Summarising information relating to Mental health and Covid-19, historical mental health policies, the use of force, the of the MH act, crisis care and waiting time standards	The House of Commons and the House of Lords	Discussed in reference to previous policies – LTP and FYFV (see columns below)	Mental health preventions discussed in reference to previous policies – LTP and FYFV (see columns below) Prevention also discussed in relation to suicide. Prevention of act of suicide rather than upstream causes.	Little change from narrative of LTP and FYFV	References actions taken by previous policy including – FYFV-MH, LTP, AoH Specifically mentions Every Mind Matters and Online Harms (consultation for tackling harmful online content) initiatives as prevention action for mental health. Refers to cross-gov suicide prevention workplan
Sep 2019	The Community Mental	Commissioned by NHS England and developed	Community mental health providers	Not mentioned, other than as a LTP requirement;	Allusions that prevention is not the remit of CMHTs; Population health approaches are about living	Almost no mention of prevention	CMHTs should move towards whole population approaches (doesn't say what);

	Health Framework for Adults and Older Adults	by the National Collaborating Centre for Mental Health and an expert reference group. A framework for community mental health provision			well in the community (not preventing mental health problems); NICE recommended psychological therapies is what people want and how they will get better and stay well (not prevention); Social determinants -> mental health problems, support needs to be maximised for the people who need it in a population (not saying to act on the social determinants, but once they have a mental health problem resources need to be funnelled towards them); Communities (? BAME) need to be engaged with early and proactively to address racial disparities (it is the community where the problem lies, not suggesting unpicking why certain communities have a worse experience) However, promoting mental and physical health,		Provide rights based care and choice to those from communities with racial disparities (ideas for what this might look like?) Need to follow the LTP with greater investment in prevention (no mention of how this will be done); By strengthening connections to local community groups and voluntary sector, whose remit health inequalities and social determinants are; Not just individual therapy, but also support around advocacy, housing, linking people to community support, help with alcoholism, finances, physical health, etc - not preventative as people with MH problems already, but tertiary prevention;

					and preventing ill health are stated as the number 1 aim of the framework; Language unrelated to MH, e.g. smokers, seeing them as 'stubborn' and that they should be liable to pay for treatment		
Jul 2019	Advancing our health: Prevention in the 2020s	Green paper/consultation document Presented to Parliament by the Parliamentary Under Secretary of State for Public Health and Primary Care	Parliament, those responsible for the delivery of health services	Mental health a risk factor for poor physical health; MH leading cause of disability; Depression and anxiety are the biggest concerns; Aging Society Grand Challenge – 5 extra healthy years, narrow gap between rich and poor, this green paper will contribute; Cost to the economy of poor MH at work;	Prevention is about targeted support, lifestyle changes, personalised care and protection from future threats; Prevention is cutting edge science/genomics; People are co-creators of their own health; People need to help themselves; People take their **health for granted**; Health is an asset to invest in; Some children aren't born into loving homes that help them thrive (and some aren't, blame to families); Prevention is not just what we have done in the past;	Future threat now used to describe the consequences of no prevention, escalation; Genomics stressed Same huge individual responsibility message; Disadvantage clusters together, new level of acknowledgement; New inclusion of behavioural sciences – telling us which evidence base now; **Public health measures that help everyone are dated;** Increasing focus on the use of data as key to prevention, predicting	Equip people with knowledge and confidence to self-manage; Launching Every Mind Matters as preventative - asks a series of questions and then recommends simple, personalised actions to improve individuals' mental health.; Focus on prevention in all areas of government; PHE social marketing campaigns are modern, efficient, focused prevention (but are they successful in smoking and in MH? But in this case it was the smoking ban that actually helped, less the

					Organisations have the responsibility to work together, individuals and communities need to play their part; We need to promote conditions for good health; Inequalities cluster together into multiple disadvantage; Early diagnosis is needed, but doesn't always happen; Mental health as a diagnosis; Case study – help was to get her back to work despite panic attacks; Some conditions we are born with, then it is about quality of life (do they think MH comes under this?); What effects health; services, choices, conditions we live, genes; Selected pie charts to suggest that the biggest cause is choices; Prevention is happy families, thriving communities, strong economy;		social media campaign alone); Personalised prevention, not broad scale change that improves everyone's health is the way forward; 'Predictive prevention' agenda needs progressing through finding an evidence base (not scientific), building trust with the public on data use; Accelerated Detection of Disease challenge – research using biomarkers to detect disease, including mental illness (bioreductionsim, medical analogy too far, shows what they think about MH causes); Reiterates LTP's actions towards more psychological therapy, perinatal, children and young people; Time to change employer pledge;

					Intelligence, technology and data and behavioural sciences is the way forward; Proactive, predictive, personalised; This (e.g. targeted social media campaigns) are better and cheaper than traditional public health measures that help everyone; Focused support is only **for those who 'want' and 'need' it** (neoliberal, paternalistic); Predictive algorithms delivering evidence based self-management, screening; accelerated Decection of Disease will; Mental health need bringing closer in line with physical health in terms of prevention, closing 'prevention gap' between them (presumably taking the analogy so far as to treat them exactly alike –		Increase mental health 'literacy' across society so people more confidence to know signs of distress and where to seek help (not upstream because they are already distressed); Provide advice to children in Rise Above programme at school, teaching about stress, self-harm and bullying (also not primary prevention); Sign up to prevention concordat; Suicide prevention; Giving information and advice to parents about children's MH; Breathing Space scheme – respite while people seek debt support; Training new teachers to spot signs of MH and mandating teaching about MH (MH already started if they are spotting signs, nothing about reducing the conditions in schools that lead to this. What does this

					actually different and need a different approach); Less attention is given to steps we can take to improve our mental health (behaviour change strategies controversial in terms of how effective they are generally, but especially for MH. Shows what they think causes MH – poor choices) We need to tackle wider social determinants - ACEs, violence, poverty, problem debt, housing insecurity, social isolation, bullying and discrimination (limited suggestion as to how); Attachments, secure homes, green spaces, income, social connections; Case study of Prevention Concordat signature in Bristol says what it aims and who signed up, but not what was actually done; Action on alcohol and drugs seen as part of prevention action, (not asking why		teaching look like – bio/CBT/decontextual); Provide schools with expert information and materials; Connect people to green space (not create more of it near them). Supporting children with alcohol dependant parents (good, although it is not in action yet, just exploration of how harm can be prevented); Reducing alcoholism through providing information on effects, nudging, making alcohol free alternatives more present (not acknowledging why alcoholism is a problem, assuming individual locus of contro). Raise awareness of cannabis harms and link to MH; Review evidence between sleep and health; Set up a social prescribing academy;

					people take alcohol or drugs and preventing that); Sleep has health consequences (assuming a very linear causation in a particular direction. Not the complexities of poor sleep as an outcome of something else, third variable. Acknowledges this in words, but not actions); Acknowledges that people don't always invest in their health because of the conditions they are in and circumstances they are born into, not different values/decision making/skills (good to finally acknowledge, but actions don't fit with this acknowledgement, e.g. give more information); Parents and carers have the fundamental role for baby's development (but not the wider conditions?); Parental mental health, addiction, domestic violence have negative		Reducing parental conflict program Healthy Children Program Hungry Little Minds campaign;

					impacts on children (they also have a complex causation and complex solutions that involve wider determinants, not individualising drug awareness or parental conflict program); Invest in support during childhood (is good prevention); Lack of language rich home environment a problem (not considering why; poor educational opportunities for parents, limited emotional/time/material resources. Solve – give more information and advice. Sold as a prevention measure, but not actually preventing the problem)		
Jul 2019	NHS Mental Health Implementation Plan	NHS England strategy and planning document.	Primarily leaders of local Sustainability and Transform	The Long Term Plan has set a president for it;	Population level health systems are those which are **integrated, localised and personalised** through **choice and control.** That is	Mention of prevention almost lost by this point	High quality care in the community is what stakeholders want; Prioritise CYP services, crisis services, eating disorder, personality

	2019/20 – 2023/24	A policy framework for the coming five years. To translate the approach of the FYFV and LTP into mental health specific policy sets out information on funding, transformation activities and indicative workforce numbers to support the development of local plans, which are	ation Partnerships and Integrated Care Systems.		what will reduce health inequalities; Population level approaches only discussed in terms of differing local need; Prevention will be 'rolled out' along with treatment, that line is used twice and is the only mention of preventing mental ill health; Mental health inequalities are often linked to **societal and cultural systems of disadvantage** (ACEs, stigma, discrimination, environment). These are **beyond the remit of health services** (actually there is a lot that could be done re. preventing all of those happening within the health system); These are so locally specific that guidance here wouldn't be helpful; Search of 'prevention' only really results in suicide or homelessness prevention. No guidance given re.		disorder, perinatal and suicide prevention, early intervention for psychosis, gambling, mental health provision for rough sleepers (work towards equity of access to the same levels as non-rough sleepers, not do something different for this population to prevent); Largest workforce into CYP mental health and severe adult mental health; **Local health systems set out their own plans** for how they will reduce inequalities (not given firm/clear guidance); **Data, information and tools** are what NHS England need to provide local services to reduce inequalities; Key indicators of equality need to be settled on before work can be done; Example of tackling inequalities in local population – improve

		due to be completed by the end of 2019			homelessness prevention, waiting for NICE; Population health is about **intelligence about a local population** and changing commissioning of services based on this (not many examples, and not about upstream approaches delivered to the whole population that are preventative); Public health only mentioned in reference to linking with PHE; Includes a table of 'alignment with other priority areas in the long term plan', and the prevention/population health element is absent; Adult services for severe mental health difficulties are about people getting **better and staying well - treatment**		**access** for older people by doing IAPT interventions in care homes; **Increased psychological therapies** for those with diagnoses, **employment support**, physical **health checks**, medication

Jun 2019	What good looks like for public mental health	PHE and the Association of Directors of Public Health. Aims to support the efforts of local organisations and wider society towards improved population health	"Public health practitioners, mental health commissioners, local authority planners and system leaders with a public mental health portfolio"	Preventing mental distress to benefit us all. Through people being able to manage stress, work productively and contribute. Prevention reduces absenteeism from work Mental health problems are common The statistic about those with serious mental health problems having 15-20 years lower life expectancy, due to preventable physical health problems	Prevention should be evidence based From a population health basis Considers primary, secondary and tertiary prevention, and their links Mental health acknowledged not to be a static state Prevention involves the reduction of health inequalities Prevention is: - the promotion of good mental health - preventing the development and escalation of mental distress across the population - preventing this for an individual - preventing suicide - improving the lives of those living with mental health problems Wellbeing is realising one's own **assets, coping** with normal stress, **working productively, contributing**	**Acknowledgement of levels of prevention** – explicit about aim for both population level prevention and preventing individual's existing distress worsening Prevention as the **promotion of good** mental health Focus on the **alleviation of distress**, re. mental health and suicide Includes **psychosocial element -** belonging, social connection, identity and purpose, faith, social capital Intergenerational Focus on **systems understanding prevention better**	**Good system leadership** will bring these disparate groups together Four areas: Core mental health services well delivered System understands why prevention is important Prevention embedded across policies and systems Policies and systems promote resilience in communities

					to community, having emotional skills, relationship skills. Wellbeing helps people recover from illnesses Wellbeing is protective against risky health behaviours. Healthy places are safe, pleasant and pro-social Prevention involves **individual and community resilience** Prevention involves socioeconomic/environmental factors: poverty, financial insecurity, discrimination, access to education, employment, transport, housing Prevention in terms of disorders – CMHP Mental health problems develop early in life – mostly before 14 or 24 y/o. **Stigma and disproportionate disadvantage** need tackling Requires whole person and social context		

					Requires focus on needs and strengths Belonging, social connection, identity and purpose are crucial. Involves social capital Some communities face greater adversity and barriers Needs action from a wide range - public, private, voluntary, community and social enterprise - including faith groups Requires data, local tailoring, outcome measurement, adequate resources, operationalised goals Mental heath is a culmination of protective and risk factors Prevention requires a lifespan, and an intergenerational approach Prevention needs to shift towards upstream/wider determinants		

Jan 2019	NHS Long Term Plan	NHS England strategy and planning document. A policy framework for the coming decade. NHS wide rather than specific to mental health (E)	NHS stakeholders including commissioners and managers. Potential members of Integrated Care Systems, including local authority, voluntary sector, community groups, private organisations	There is concern about **funding**, staffing, pressures from a growing and **ageing population**, and increasing i**nequalities**. Action on prevention is to help people stay healthy and **moderate demand on the NHS**; One element of prevention is to **reduce hospital admissions** through investment in community and primary care. This is likely to have financial and capacity payoffs; Reducing common MH problems is to increase **national income and productivity**;	The NHS has a contribution to make, but is **not an institution with full responsibility** for prevention, and is not a substitute for the work of others. **Individuals and communities are primary** among the groups responsible, followed by government, and businesses; The prevention programmes to be funded are **evidence based**; Health inequalities and prevention are related. If NHS services set out **measurable goals and mechanisms** this will narrow health inequalities; **Prevention is about avoiding frustration** from inefficiencies in the **timing of treatment** and reducing use of more expensive inpatient services, e.g. someone in crisis presenting at A&E because	Less overtly critical, blaming, inflammatory and dramatic language to the FYFV. **More examples are mental health related**. More examples of mental health issues alongside other areas, e.g. perinatal. Otherwise very similar	Preventative actions are mostly for physical health – mental health actions are all treatment. Cut smoking by people with long term mental health problems by providing **health checks**; Of the ways the NHS supports wider social goals, the first is to help people with severe mental illness **find and keep a job** through IPS/IAPT; £2.3billion ringfenced funding for mental health should go towards **service expansion** (rather than novel services); Funding should be prioritised for **primary and community** services; Funding should go toward faster access to community services **and crisis services**; People who are clinically **judged to benefit most should be prioritised** for community support;

					a community crisis team isn't available; Work on prevention and population health is to supplement existing NHS work, an add on; Prevention is about being proactive and **predicting illness** so that treatments can be targeted before people get unwell, or before they get words. This is how population health management can be achieved; **Health inequalities** are due to **people not having enough individual choice** in treatment leading to failure to engage them in the **management of their own wellbeing**. Prevention is achieved through having more individual choice and managing one's own mental wellbeing; Preventative strategies for physical and mental health are equivalent;		**Children** and young people's access to these services should be a priority; Extent current services to 0-25; Prevention requires action on workforce, innovation and efficiency, technology and 'system architecture' of the NHS; **Integrated Care Systems** will help decision making around population health; Case finding, tailored screening and early diagnosis are opportunities to be taken; Increase choice to meet individual preferences; Local NHS services to focus more on population health through ICSs (how isn't specified); Increase funding for areas high health inequalities based on **needs assessment;** Provide information in the form of 'top tips' to

					Good mental health is supported with **apps and online resources**; Population health and ICS are synonymous; **Individual trusts are accountable** for their poor performance re. inequalities, and outcome measures will solve this; Prevention is working **'upstream' to avoid illness**; There are wider threats to health that the NHS is not able to rectify/compensate for, linked to **social and economic policy.** These are costly to the NHS; **Local authorities have greater responsibility** and funding for prevention; **Social enterprises** are better placed to tackle with wider determinants of health and can be partnered with; **The role of the NHS is secondary prevention** – detecting early and preventing deterioration;		prevent mental distress in young carers; **Increased geographical coverage** of services for severe gambling; Also improve inpatient care in terms of availability and physical environment; **Partner with social enterprises who address the wider determinants** of health; Being an **employer that supports the mental** health of its workforce (but doesn't say how); Increase access to existing services that are evidence based is what is needed to reduce perinatal mental health. Also increase services for fathers/partners. Aim to make the experience less stressful by increasing parental involvement and providing accommodation; We need to fund eating disorder services for

					Our environments have a bigger impact on health than healthcare alone – deprivation, poverty, ethnicity, intellectual ability; It is **the responsibility of local teams** to decide how they will reduce health inequality. NHS England advice on how is coming in the future; **Health checks** are the way to prevent ill health in those with serious mental health problems; **'Top tips' and increased information** will prevent young carers from developing mental health problems; The problem with mental health problems during perinatal period and pregnancy is its cost; **Increased access to existing services** is what is needed; Prompt access to services is what children need to prevent worse distress;		children and young people in particular; Fund **services in schools**, supervised by the same as the services in the community, CYP IAPT, focus on digital interventions, better information sharing (not make the school a more mentally healthy environment); Improve access to psychological therapies for students, especially in vulnerable groups; **Increase IAPT provision** to greater numbers; Need new services and work towards reducing racial disparities (but not how); Place based, information sharing, **more choice and control**; Offer intensive home treatment for crisis rather than admission, will be less expensive;

					Mental health viewed through language of **disorder and diagnosis**; Children's crisis services need funding to reduce pressures on A&E; Upstream prevention in schools is better **information sharing and digital interventions**; Causality - the reason that young people are more susceptible to MH problems are the physiological changes and transitions (not the wider determinants and relational patterns that they have been subject to from birth); **Early intervention for psychosis only**; What is not said – it is about reducing racism, poverty, etc… Mental health not linked obesity or alcoholic misuse		Offer more support to bereaved families to prevent suicide in them (but not how this will be successfully achieved); Having waiting time standards will mean that waiting times reduce; **Research** (not mental health specific) **should focus on genomics, prediction** of diagnostic patterns, data, providing information for people to **make informed choices**; **Digital advancements** to shine a light on health inequalities (but not what to do about them); Need access to people's data for progress in population health; Condones NHS involvement in developing guidelines for healthy housing and built environments (only in appendix) Doesn't say how expansion for all of these services to

							meet needs for individual therapies will match the growth of funding; Doesn't talk about community psychology in CAMHS which can reduce root of inequalities, MH and offending; Work on wider social problems is in the appendix only
Nov 2018	Prevention is better than cure: Our vision to help you live well for longer	DoHSC vision for prevention. At the same time as Matt Hancock's speech. Introduces the green paper Advancing our Health. About mental and physical health		Prevention will stop people **living in poor health**; It will secure health and social **services for the future**; It will **boost the economy**; Help meet the '**Aging Society Grand Challenge** Mission'; Old service models are outdated; There is a **long term return** on investment; Reduces pressures on the NHS; People with serious mental health problems die 20 years earlier (talking about	Prevention is keeping people **well and out of hospital**; Prevention is looking at the **root causes** of ill health; Is population level; **Individuals and families are responsible** for keeping well, as well as **wider determinants**; Prevention examples – **vaccination programs, banning smoking** (used to suggest this is what is encouraged by this document, but these broad overarching strategies always fails to be	Says spending, not just focus, is needed for prevention (unclear where is this provided); Backtrack to huge amount of **individual responsibility** that had reduced since the FYFV; **Market analogies** – health is an asset; Lots of reference to health of the economy	**Increasing primary and community care**; Greater investment in prevention; Health and social care system can – pick up problems earlier, provide support to stop getting worse, treat whole person not symptoms, put people in control of their health; Campaigns like **Time to Change** raise **awareness and reduce stigma**; Need to focus on **healthier lifestyles**; Individuals and families need to be active, give,

				serious MH, but then exercise and sleep are the answer);	recommended for mental health, not willing to change overarching national economic and social policy); UK is at the **cutting edge** of prevention, global leaders; Prevention is people staying healthy, happy and independent as long as possible; **Health is an asset** to be protected Inequalities are not inevitable (although limited strategies for addressing them); It is our personal responsibility to eat, drink and sleep enough, and take action to improve our mental health. But also **early experiences environment**, services; Need to tackle root causes, need to use data and technology (overstated); "This means **giving people the knowledge, skills and** confidence to take full		keep learning, connect and take notice (neoliberal and paternalistic); NHS to use its large economic and social presence through local spending and employment decisions (doesn't expand on what or how); **NHS should improve** the health and **wellbeing of its staff** (not how); Focus on women and **perinatal;** Using te**chnology** and people's **personal data,** predictive; Parents to help children's language development at home; Evidence based '**reducing parental conflict programme'** (on closer inspection is individualising and responsiblising) Do 'what we can' to stop advertising and social media impacting children's mental health;

					control of their lives and their health and social care, and making healthy choices as easy as possible.” (like with most of them) mental and physical health prevention being discussed in the same breath; Some diseases **cannot be prevented** – like **MH problems arising from traumatic childhood** events; Social and economic environments are more important than health services. So we need to work on healthier lifestyles (direct contradiction); Lifestyles factors that cause mental health problems are **lack of sleep**, over use of **screen time**, and cyber bullying on **social media** (very far off the evidence base) Environmental causes include **overcrowded homes**, safe access to **green space**, not being in work,		MH clinicians offering advice and support in schools; Online and inhouse **school counselling**; ‘Get set to go’ program **encouraging physical activity** in those with MH problems; **Social prescribing for loneliness**; Describes the kind of work that is mentally healthy in the actions section, but no indication of any actions suggested towards this, employers own choice/initiatives; **Evidence based** treatment for children’s mental health disorders; Mental health **outreach to those at risk**;

					workless households (suggested it is the literal not working that leads to the children's disadvantage, not other variables leading to both), loneliess (not poverty, discrimination, unsafe neighbourhoods, etc. Only focusing on limited aspects without rationale for doing so); A **problem is our population aging and diversifying**; Living well starts with individuals and families; It is the NHS and social care's fault they've **talked about prevention and not actioned it** (nothing to do with policy, complexity or funding); Local Government and NHS need to take more responsibility; Advertising and social media impact children's MH; The causes of the causes must be addressed;		

					Help people manage their own conditions;		
Aug 2017	Prevention Concord at for better mental health: Prevention on planning for local areas	Public Health England planning resource for the Prevention Concordat, a recommendation from the FYFV and Advancing our health. A provision of resources and a statement of intent for wider sectors, local authorities and	Government departments, local authorities, commissioners, health and wellbeing boards, service providers, public, private and voluntary sector organisations	Mental health is a growing public concern; Prevention is to achieve a **fairer and more equal society**; Tackling wider determinants of mental ill health is cost effective, its about the effective use of limited resources; Necessary in order **to transform the health system**; Mental health problems are prevalent and so is stigma; Better mental health helps people **deal with stress**, **be more productive,** have **better physical health**, better relationships; So people can make use of their abilities, cope and **contribute productively** to the community	Should be given equal attention to treatment; Looking at **the wider causes of MH** and how they should be tackled – reducing **inequality, wider social determinants**, wellbeing in communities; Prevention is **about those who are vulnerable to conditions**, showing signs (like prevention) or who are already experiencing them (secondary and tertiary); **Whole population approaches** are for strengthening individuals (e.g. mental health literacy), communities and healthy places (e.g. housing) and wider determinants (e.g. mentally healthy policy), reducing structural barriers to health (e.g. poverty, discrimination, education) (seems to suggest that the	**More focus on the 'how'**, and that is leaning heavily on a physical health metaphor/science/evidence base/**positivist/linear cause and effect** More move towards the notion of primary prevention, but still **conflated with secondary and tertiary**. And **without funding;** Focus on productivity and contributing to society	**Evidence based interventions** include 'make every contact count'; Additional funding isn't provided, this can be done **within existing resources;** Local areas need to plan for **their specific community**, undertake a huge assessment, bring partners together, broker and pool resources, review existing strategies, develop overarching plan, intervene in ways that can be linked, mutually reinforcing, so outcomes can be measured overall, long term view, secure cross party support, have a single leader, decide locally which outcomes to measure (all with no funding, local areas are responsible if they fail).

		organisations to commit to prevention			wider determinants need to wait for policy); Prevention Concordat materials to be used for prevention, but also improving treatment; Prevention is a priority for PHE; It requires cross-sector action; It requires **evidenced based and NICE guidance**; It is the use of upstream interventions; Must **be tailored to local needs**; Prevention of onset, development and escalation of mental health problems; Strategic aims must be developed and **outcomes measurable** (or else it isn't worth doing. Not going to be simple, will hold up the process, will only result in some actions, not others); Use of **data is important** to achieve prevention;		Actions suggested are about how to go about the process, focusing on local assessment and deciding outcomes - not what to actually do. We know what risk factors are, they just mentioned them, why does that need to be the use of resources? Procrastination, promissory note; Primary prevention actions: Staff in health, education, social care to **identify those at risk** of mental health inequality, **Educating** others about MH to reduce stigma/discrimination (evidence based), Encourage people to have increased contact with people with MH problems, Programs to improve **mental health literacy** inc with 'advice workers' e.g. those advising on finances, Protect **green spaces,**

					Analyse and understand key risk and protective factors locally; Target prevention towards those; Public health is an art and a science. It is to preventing mental ill health through the **choices of individuals, organisations** and **communities;** MH not just about disorders, but a spectrum that includes wellbeing. Promotion of good health; **Primary (upstream**, target **most of the population**, so why the focus on each local area, information and them implementing), secondary and tertiary, mental health promotion part of primary; **Claims the resource focuses on primary prevention** and yet throughout the guidance is for all three; **Giving every child the best start** in life. Also work with adults and older adults;		Use NICE to encourage whole school approach to MH, Integrate **housing and welfare services into specialist mental health services** (so not primary, because they have MH problems already)

					Needs focus **on adversity and trauma**, which impact our biology and physical health; It is noted that what makes it difficult is **nation and local policy interests**, national and local **funding** and levels of inequality (if not addressing these, how is it primary/population level? Responsiblising local communities, less responsibility towards government); Each local area will have a different set of priorities (what, no commonalities at all, no national plans that could help?) Should draw on **human rights** based approach;		
Feb 2016	Five Year Forward View for Mental Health	Report from the independen t Mental Health		Preventative approaches are needed for the **people and families**, but also to reduce **costs** for the NHS and **economic burden**;	There is consensus and desire to shift towards prevention; **Experts by experience** said one of the things they	More focus on process of MH problems developing;	**Cross governmental** approach; **Quicker/more access** to CYP mental health services;

		Taskforce to NHS England, recommendations about parity of esteem, wider action on social determinants, and focus on inequalities		MH policy has gradually improved and drawn more attention to mental illness, but paradoxically not resulted in improved outcomes, due to increase in demand; The cost of MH is so great, more should be invested into services for it (in the same way as for physical health treatment, medical analogy assumed to be applicable)	**wanted was prevention.** Everyone agrees it is for the best; Most focus on prevention is secondary preventing physical health in those with MH problems. **Access** to quality MH care **isn't service users' only priority**, also **want focus on wider determinants** – place to live, work, good relationships in community; Inequalities need tackline at a local and national level to prevent MH problems – racial, poverty, unemployment, discrimination; In terms of cause of MH problems – it can happen to **anyone at any time**, random (contradiction); Most MH problems are established by 25; there is high risk in low income families, sets off a trajectory, what is needed is quicker and more access to mental health services for	Somewhat less about individual responsibility and blaming; **More focus on wider determinants** even though didn't always make it to the recommendations, some **acknowledgement that they didn't know** what these would look like; Acknowledge need more research into causes	Access to p**erinatal** services; Smoking s**creening** and health education for those with MH problems; Screening will reduce the health inequalities gap, but it isn't currently working so we need to double down (not take a wider look at why it is not working); More mental health provision (in the form of traditional services/CBT?) for those with long term conditions; Better access to **specialist occupational health** for MH problems; A lot of old people are depressed, worse if in care homes, need better diagnosis and access to services (rather than unpicking what is depressing them about their life); **Fund secondary care,** not only focus on primary care;

					children (not prevention of the poverty, etc); Prevention would be **intervening with mothers** with MH problems, to prevent children having emotional/social/cognitive impacts, via access to specialist community MH provision (not thinking about why they might be depressed and anxious more broadly, and offering more financial support, or potential to leave DV relationships, societal disadvantage towards women, societal expectations around motherhood, e.g. Link with poverty not made); The early death of those with MH problems is easily preventable/preventable illnesses due to smoking (not the deeply bodily embedded differences in those with severe mental health problems from		Increase the same psychological therapy provision but to more adults; ACES - Care leavers, looked after, disabled, victims of abuse – needs more expert advice about their needs, should have different budgets for accessing treatment and more **parenting programs (secondary,** inidividualising, not reducing the trauma happening in the first place); MH services should **support people to find and stay in work**; Should be local authority Mental Health Prevention Plans to focus on public mental health and promotion, we still **need more information** about **local populations** before we know what they will look like; Prevention should include The Department of Health,

					infancy that might result in more smoking and illness); Or, those with long term illness develop mental health problems (always linear cause and effect, affects the solutions given which are too simplified. Not a complex, dynamic interplay with wider context from birth); Employment and housing are important for good mental health, but also to recovery once you have a MH problem; **Marginalised groups** and those who have been **traumatised** are identified as having more MH problems (but the two aren't linked, and why these groups have more MH problems not explored, beyond poor housing for BAME groups. No mention of discrimination, racism and reducing ACES needing to be addressed at a wider level and the role the NHS		the Department of Communities and Local Government, NHS England, HM Treasury; Should be **specialist housing** for those with mental health problems, case to use NHS land for this (not good housing for all to prevent mental health problems); **Reduce stigma** though supporting grassroots organisations to raise awareness about MH (could be like community psychology, but they probably mean more along the lines of Talking Matters); **Mental health research needed** (but doesn't mention focus on prevention) Need partnership involvement in commissioning, need to **reduce variability in spend**;

					could take in its area of that); Suicide is increasing, we should stop it by increasing safety precautions in inpatients and noticing it in GP appointments (not looking at why people are choosing to end their lives); The **problem with services** is there is **not enough**, too much v**ariation**, limiting access to psychological/NICE treatments; The **racial inequalities are the differential access** to care that result in suicides or poor outcomes (not racism itself being detrimental to MH); **Recognition that screening** of high risk people with MH problems for health problems is **secondary prevention**; There is low take up of information about physical health, and little evidence that checks lead to uptake		Need **co-production** so services can be appropriate (but not encouraging radically different services); Recommends a prevention concordat;

					of evidence based interventions – but monitoring **should continu**e, incentives for GPs, with **extra effort** made to stop people smoking (why if it isn't working?); People's mental health is promoted by being equal citizens; The same individual help, but earlier, is what people want; Prevention is the only way that lasting change can be achieved, but it is **not the remit of the NHS alone**; Good parenting is needed (no mention of what effects good parenting, individualised). As well as good schools, work, etc; Prevention is: early identification, early intervention for children and quick access, evidence based (ie CBT); Employment assumed to be preventative, maybe good		

					reason they don't work, maybe not a priority; Data and digital revolution necessary for prevention; Those with lived experience focused on ACES, wider determinants, MH promotion in schools and workplaces, environment, support to mothers, loneliness (as well as self-management, stopping existing problems escalating, physical/mental health); People also wanted **more research into the causes of mental health** so that prevention could be better targeted, acknowledged that prevention is a big research gap and that causes of MH and promoting good MH should be prioritised;		
2014	NHS Five Year Forward View	NHS England strategy and	NHS stakeholders including	We need to focus on prevention to **reduce burden on the NHS**;	**Individuals are responsible** for causing the challenges for the NHS;		'**Hard-hitting** national action'

		planning document. A policy framework for the coming five years. NHS wide rather than specific to mental health	commissioners, managers and GPs. Local authorities, voluntary sector providers	Because preventable illness is widespread and health inequalities deep rooted; Dramatic statements about the future of **NHS sustainability**, the **health of millions of children**, and the **economic prosperity** of Britain all **depending on prevention and public health**; Prevention will help towards 2% net **efficiency/demand savings**; Increasing demand from long term conditions; Not focusing on prevention would mean stalling life expectancies, widening health inequalities, and reduced ability to fund new treatments	Promoting wellbeing and preventing ill health is about **choices**. It is these choices that mean preventable illness is widespread; The **NHS is not solely responsible** for prevention, also local communities, local authorities, employers, and the next government; Warnings have not been headed; NHS 'on the hook'; Hard hitting national action; Work on prevention outlined as self-evident, what the public 'clearly want'. Strong words instil fear about the **consequences if don't** meet these challenges; The NHS is responsible for managing well in some areas, but where it doesn't, the challenges are 'common to all industrialised countries'';		More public health related powers to **local government** and mayors; Three levels of integration and patient self-management is what is needed; Shift in**vestment** from acute to **primary and community care**; Give GP CCGs more control of wider budget; Fund **Multispecialty Community Providers**; Funding to meet this will come from efficiency and 'continuation of current budget protection'. Also **increased use of volunteers** (not increase in funding); The alternative to the suggested ways forward are to 'muddle through for the next few years'; **There is consensus** about what the changes to the NHS need to be; Can't achieve change without investing in

					Prevention is linked to supported self-care and patients becoming more involved, **informed** and having more choice; ‘if the nation fails to get serious about prevention…’ Some illnesses are ‘wholly avoidable’ and crowd out potentially more deserving areas like new treatments; Health inequalities are about variation in quality of care given; Poor health related behaviours are influenced by, and reinforce, health inequalities; Not just lifestyle, but also **deprivation and social and economic** factors in preventable illness; **Local authority has the responsibility** for public health, the NHS role is secondary prevention; Evidence based interventions are key to this;		current and future workforce; Focus on alcohol, fast food, tobacco, and other factors influencing mental and physical health; Incentives healthier behaviour; The programme for preventative services by NHS England will be **coming in the future**; Targeted support to help people with mental health problems find and **keep employment**; Do more to help people manage their own health – **courses, information**; Support carers (doesn’t say how); Use local NHS funding to link with voluntary sector who are better placed to tackle wider determinants; Be a non-discriminatory employer, **reduce mental health stigm**a through time to talk, more diversity of workforce;

					Preventative actions are 'slow burn, high impact'; Accessing hard to reach groups re. their health behaviours is a problem; The problem with mental distress is its economic impact; The problem is they are **not getting enough individual treatment** for disorders. Not enough of the NHS budget goes on mental health treatment even though it is the highest burden of disease; The active prevention and public health agenda is about **new models of primary and out-of hospital care**. And greater support for patients, carers and **community** organisations;		Primary and Acute Care Systems – new styles of primary care where there are a lot of health inequalities, e.g. hospitals opening their own GP surgeries; Fund **crisis services** and **liaison psychiatry** to **prevent A&E admissions**; Equal response to physical health, press on with **IAPT**; Less waiting times, more new beds, better case management, early intervention with **psychological therapy**, **expand access**, extra staff;

7.4. WORKED EXAMPLE OF CDA PROCESS

The screenshot below features the first page and a half of AoH, and the CDA process that was undertaken. Following the reading and re-reading of the text, colour-coded highlighting was used to code themes and features in the data, for example different conceptualisations of health, mental health or prevention, values, subjectivities, and so on. Comment boxed were used to record ideas and reflections regarding the text. This was used to draw out discursive themes and structure the analysis under cohesive headings and subheadings.

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Executive summary

1. Opportunities

The 2020s will be the decade of proactive, predictive, and personalised prevention. This means:

- targeted support
- tailored lifestyle advice
- personalised care
- greater protection against future threats

New technologies such as genomics and artificial intelligence will help us create a new prevention model that means the NHS will be there for people even before they are born. For example, if a child had inherited a rare disease we might be able to diagnose and start treatment while they are still in the womb, so they are born healthy.

Using data held by the NHS, and generated by smart devices worn by individuals, we will be able to usher in a new wave of intelligent public health where everyone has access to their health information and many more health interventions are personalised.

In the 2020s, people will not be passive recipients of care. They will be co-creators of their own health. The challenge is to equip them with the skills, knowledge and confidence they need to help themselves.

We are:

– **Embedding genomics in routine healthcare** and making the UK the home of the genomic revolution

– **Reviewing the NHS Health Check** and setting out a bold future vision for NHS screening

– **Launching phase 1 of a Predictive Prevention** work programme from Public Health England

2. Challenges

Over the decades, traditional public health interventions have led to significant improvements in the nation's health.

Thanks to our concerted efforts on smoking, we now have one of the lowest smoking rates in Europe with fewer than 1 in 6 adults smoking. Yet, for the 14% of adults who still smoke, it's the main risk to health. Smokers are disproportionately located in areas of high deprivation. In Blackpool, 1 in 4 pregnant women smoke. In Westminster, it's 1 in 50.

Obesity is a major health challenge that we've been less successful in tackling. And clean air will continue to be challenging for the next decade. On mental health, we've improved access to services. In the 2020s, we need to work towards 'parity of esteem' not just for how conditions are treated, but also for how they are prevented. On dementia, we know 'what's good for your heart is also good for your head'. A timely diagnosis also enables people with dementia to access the adv ... elp them to live well with the condition, and ... e.

darts
Prevention - parity of esteem with physical health, the same process

The new personalised prevention model offers the opportunity to build on the success of traditional public health interventions and rise to these new challenges.

The NHS is also doing more on prevention. The Long Term Plan contained a whole chapter on prevention, and set out a package of new measures, including:

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