

Mental health teaching in the training of public health
professionals: A thematic analysis of interviews with key
stakeholders

A thesis submitted in partial fulfilment of the requirements of the
University of East London for the Professional Doctorate in Clinical
Psychology

Hannah Frenken

May 2021

ACKNOWLEDGEMENTS

I am so grateful to all the people who gave their time to participate in this study, many of whom were in the midst of dealing with the COVID-19 pandemic as part of the public health workforce at the time.

I would also like to say a huge thank you to David Harper for his supervision of this project, and in general for his influence on my own training journey.

Finally enormous thanks to Dan, Kieran, Roger, Hildy and John.

ABSTRACT

Background: Public health approaches to mental health, or ‘public mental health’, is an area of increasing interest in public health strategy in the UK (NHS England, 2016b), alongside growing recognition of the need for preventative mental health approaches (Public Health England, 2017a). The infrastructure around this however is limited. Developing skills and knowledge in the senior public health workforce has been cited as a key priority, but there is little clarity as to how this will be achieved. Training and teaching offer opportunities to develop the conceptual basis of public mental health and promote theoretically-rigorous practices.

Aims: This study aimed to explore the coverage and content of mental health teaching available across the public health speciality training pathway, as well as barriers and facilitators to accessing mental health teaching content.

Method: Interviews were conducted with 14 participants who had a professional connection to a Master of Public Health course, or placement-based component of regional speciality training programmes. A critical realist methodology was taken, and thematic analysis was used to analyse transcripts.

Results: Four main themes were identified: ‘lacking a coherent conceptualisation of mental health’; ‘the relationship between concepts, workforce and service structures’; ‘conceptual frameworks informing the curriculum’; and ‘structural causes of an unsystematic and heterogeneous approach’.

Conclusions: There was a widespread lack of opportunity to access mental health teaching across the Masters courses. Placement-based learning primarily took place in clinical settings rather than preventative contexts. De-prioritisation of teaching was shaped by conceptualisations of mental health and an overarching medical paradigm, as well as structural factors which marginalised public mental health. The implications include a need to review the current ad hoc approach to training, as well as a need for development of theories and concepts in the public mental health discipline. The findings resonate with current interest in population and preventative approaches in clinical psychology and indicate opportunities for collaboration with mutual disciplinary benefit.

CONTENTS

ACKNOWLEDGEMENTS	ii
ABSTRACT	iii
LIST OF TABLES AND FIGURES	viii
LIST OF ABBREVIATIONS	ix
1. INTRODUCTION	1
1.1. Chapter Overview	1
1.1.1. Approach to Literature Search	2
1.2. Public Health and Public Mental Health	3
1.2.1. What is Public Health?	3
1.2.2. Health Promotion and Prevention as Key Public Health Activities	4
1.2.3. Key Bodies in UK Public Health	5
1.2.4. Overview of the Public Health Workforce	7
1.3. What is Public Mental Health?	8
1.3.1. Population Approaches to Mental Health	8
1.3.2. Social Inequalities, Mental Health and Access to Treatment	9
1.3.3. Public Mental Health Policy and Strategic Context	10
1.4. Key Ideas, Concepts and Debates in Public Mental Health	12
1.4.1. Definitions and Models of Mental Health in Public Mental Health	12
1.4.2. Prevalence of a Mental Health and Wellbeing Dichotomy	13
1.4.3. Relationship of Conceptualisations of Mental Health to the Medical Model	14
1.5. Causal Frameworks Theorizing the Determinants of Mental Health	15
1.5.1. The Prevalence of the Ecological Model in Theorizing Causes	16
1.5.2. Limitations of the Ecological Model and Implications for Policy and Strategy	17
1.6. Critical Issues in Public Mental Health	19
1.6.1. Austerity, Cuts to Funding and Allocation of Resources	19
1.6.2. Unresolved Conceptual Issues	20

1.6.3. Policy Emphasis on Public Mental Health Without the Workforce Infrastructure	22
1.6.4. Summary	22
1.7. Training and the Public Mental Health Agenda	23
1.7.1. Opportunities of the Specialty Training Programme	24
1.7.2. Implications and Relevance for Clinical Psychology	25
1.8. Aims and Research Questions	26
2. METHOD	28
2.1. Methodology	28
2.1.1 Philosophical Framework	28
2.1.2. Research Design	29
2.2. Participants	30
2.2.1. Inclusion Criteria	30
2.2.2. Recruitment	30
2.2.3. Sample	31
2.3. Procedure	31
2.3.1. Developing the Interview Schedule	31
2.3.2. Data Collection	32
2.4. Analysis	33
2.4.1. Stages of Critical Realist Thematic Analysis	34
2.5. Research Quality	36
2.5.1. Contribution	36
2.5.2. Credibility	36
2.5.3. Rigour	37
2.5.4. Reflexivity	37
2.6. Ethical Considerations	39
2.6.1. Ethical Approval	39
2.6.2. Informed Consent	39

2.6.3. Confidentiality and Anonymity	40
2.6.4. Data Protection	40
3. RESULTS	41
3.1. Master of Public Health Across the UK: Content Overview	41
3.2. Content Overview of Sampled MPH Courses	42
3.2.1. Core and Optional Modules	42
3.2.2. Coverage of Mental Health and Wellbeing	43
3.3. Thematic Analysis	43
3.3.1. Theme 1: Lacking a Coherent Conceptualisation of Mental Health	45
3.3.2. Theme 2: The Relationship between Concepts, Workforce and Service Structures	48
3.3.3. Theme 3: Conceptual Frameworks informing the Curriculum	55
3.3.4. Theme 4: Structural Causes of an Unsystematic and Heterogeneous Approach	62
4. DISCUSSION	71
4.1. Research Questions, Findings and Previous Literature	71
4.1.1. To What Extent is Mental Health Covered in the Specialist Public Health Training Programme?	71
4.1.2. What Theoretical and Conceptual Frameworks are Drawn Upon in Teaching and Training?	75
4.1.3. What are the Barriers and Facilitators to Including Public Mental Health in the Training?	78
4.1.4. What are the Practical Implications of the Current Coverage in Teaching and Training?	82
4.2. Implications	84
4.2.1. Implications for the Teaching and Training of Public Health Specialists in Public Mental and Practice	84
4.2.2. Implications for Clinical Psychology's Contribution to Public Mental Health and Prevention	85

4.2.3. Areas for Further Research	87
4.3. Critical Review	88
4.3.1. Research Quality	88
4.3.2. Reflexivity	90
4.4. Conclusion	92
5. REFERENCES	94
6. APPENDICES	110
APPENDIX A: Study advertisement	110
APPENDIX B: Interview schedules	111
APPENDIX C: Letter of ethical approval	113
APPENDIX D: Participant information sheet	116
APPENDIX E: Consent form	118
APPENDIX F: Debrief form	120
APPENDIX G: Coded transcript segments	122
APPENDIX H: Extract of coding table	125
APPENDIX I: Development of thematic framework	128
APPENDIX J: Extract of reflexive journal	132
APPENDIX K: Change of title approval form	133

LIST OF TABLES AND FIGURES

Table 1 Overview of Core and Optional Mental Health Teaching across 43 MPH Courses	42
Table 2 Global Themes and Sub-themes of Thematic Analysis	44
Figure 1 The Dual Continuum Model (Keyes and Lopez, 2002)	13
Figure 2 The Main Determinants of Health (Dahlgren & Whitehead, 1991).	16
Figure 3 Ecosocial Theory and Embodying Inequality (Krieger, 2011).	18

LIST OF ABBREVIATIONS

BPS	British Psychological Society
CAMHS	Child and Adolescent Mental Health Services
CPD	Continuing Professional Development
CR	Critical Realism
FC	Faculty Curriculum
MaPH	Participant identifier: Master of Public Health
MPH	Master of Public Health
NHS	National Health Service
PH	Public Health
PHE	Public Health England
PMH	Public Mental Health
STP	Speciality Training Programme
TA	Thematic Analysis
UK	United Kingdom
WHO	World Health Organisation

1. INTRODUCTION

1.1. Chapter Overview

In 2016, Professor John Ashton, then president of the Faculty of Public Health, heralded the “dawn of a new era in mental health”: the era of population mental health (Faculty of Public Health, 2016). In fact, the potential rewards and moral imperative of a public health approach to mental health have been described and advocated for some time (Albee, 1999). What is perhaps new is the emergence of public mental health as a topic of considerable interest in policy at national and international level, and the emergence of public mental health as a discipline of theory, research and practice.

In order to establish itself however, the field requires a workforce of senior public health professionals who are able to promote and implement the work of public mental health. This is increasingly recognised as a priority and has been the focus of strategy and guidance in the United Kingdom since 2015 (Public Health England, 2015). Despite commitments to promote this agenda, including curriculum and training reviews, exactly how the specialist workforce will develop expertise in the area has not been operationalised. There are opportunities along the current training route for public health specialists, which normally includes a one-year Master’s in Public Health (MPH), followed by four years in placement-based training. Currently however, due in part to the variation across MPH courses and opportunities across regions for placement training, very little is understood about the coverage of mental health training available to specialist trainees.

The role of theoretical frameworks and methodological paradigms cannot be overstated in this task; developing a public mental health workforce with the competencies required of lead practitioners requires a grounding in solid theoretical rationale, to ensure the delivery of interventions in line with the interests of the general population and the most disadvantaged groups in society. The nascency of the field as a theoretical discipline in its own right raises dilemmas for the sense-making of

‘mental health’. These issues are discussed, including the utilisation in public health of the work of psychiatry and psychology, and considers how the causes of mental health problems are made sense of within epidemiology and public health. The chapter goes on to describe how current practice in PMH reflects an extension of unresolved theoretical questions, and the implications of practice for the promotion of certain ideas about mental health among the public health workforce as well as the general public. The rationale for the current research is then underscored, where the workforce development agenda and current approaches to skilling-up a public mental health workforce is presented.

To locate this research within the context of public health, the chapter begins with an overview of key tenets of public health, followed by the rationale for a public mental health approach.

1.1.1. Approach to Literature Search

The research question concerns the policy and strategy of public health and statutory bodies, as well as theoretical literature relating to epidemiology and disciplines of mental health such as psychology and psychiatry. The starting point of the literature search was a series of documents issued by Public Health England (PHE) stating the need for mental health expertise in the senior workforce (PHE 2015; 2018; 2020). To search for further related documentation, the snowball method was used, where references and citations in policy and strategy documentation were used to identify relevant literature. This method offered a valuable way to understand the network of policy and strategy across statutory domains and indicated empirical evidence that had been instrumental in the construction and rationale of the documents.

Policy and strategy documentation, or ‘grey’ and ‘white’ literature, is primarily located on institution or organisational websites rather than research databases. Greenhalgh and Peacock (2005) advise against protocol driven search strategies in the review of complex, heterogenous evidence, particularly those undertaken for policymaking questions. Informal approaches including snowball methods are recommended as a powerful means of identifying sources from a range of locations.

Given the current lack of research addressing this area, the diverse kinds of literature of importance to the question, and the inclusion of theoretical, policy and empirical literature, a narrative review was decided upon to provide further clarification and insight, and present an overview of key issues relevant to the area (Greenhalgh et al., 2018).

1.2. Public Health and Public Mental Health

This section orientates the chapter by outlining what public health is, how it has been applied to mental health, and the current policy and strategic context.

1.2.1. What is Public Health?

Public health has been defined as the “art and science of preventing disease, prolonging life and promoting health through the organised efforts of society” (WHO, 1998, p. 3). Conceptualisations of public health have changed significantly over the years, fluctuating with the organisation of communities and society, the perceived role of the ruling classes in taking care of the wellbeing of citizens, and the extent to which responsibilities for health have been attributed to citizens themselves (Carr et al., 2007).

Core functions of a public health system are to assess the health of a population, identify problems, make sense of the causes of the problems and devise strategies to improve them. An ongoing debate regards the extent to which public health orients itself to medicine and the treatment of ill health, or takes a broader focus on the underlying social causes of health and their distribution in populations (Leeder, 2007). Contemporary Western public health literature and policy aligns itself with the latter, “assuring the [societal] conditions in which people can be healthy” (Institute of Medicine, 1988, p.40), through coordinated efforts aimed at preventing disease and promoting health. In contrast to medical approaches to disease intervention, from a public health perspective, the patient is the community.

Public health is traditionally a medical discipline. Epidemiology, the study of population health, is the cornerstone of public health methodology, concerned with understanding the nature and distribution of health issues among a population. Epidemiology draws on biomedical science, particularly for communicable diseases, as well as statistics to support assessment of risk and efficacy of interventions, and environmental health science. Much of public health in the 19th and 20th centuries focused on the control of infectious diseases. Increasingly, public health is turning towards social and behavioural sciences, as non-communicable diseases like obesity and heart disease account for the largest proportion of mortality rates worldwide (PHE, 2014).

1.2.2. Health Promotion and Prevention as Key Public Health Activities

Health promotion and prevention are widely held to be separate but complementary endeavours in public health. Conceptually, they are distinguished in terms of their relative focus on disease. Prevention of ill health is concerned with understanding the factors that contribute to disease development in order to take preventative action. On the other hand, the aims of health promotion tend to focus on the promotion of “optimum wellness” of populations (Carr, 2007, p.100).

In theory, health promotion activities emphasise the conditions of people’s lives, work, and other structures underlying health problems. Health promotion is relatively new in the official discourse of public health. In 1986, the World Health Organisation defined health promotion as the “process of enabling people to increase control over and improve their health [...] emphasising social and personal resources as well as physical capabilities” (WHO, 1986). Carvalho (1996) cites this acknowledgement of the need to integrate environmental, political, social and behavioural aspects as a milestone in medicine-based public health.

It has been argued that health promotion activities prevent diseases, and that the difference between promotion and prevention is mostly conceptual (Tengland, 2010). Others view this conceptual departure as critical, as it raises a number of theoretical challenges, but also opportunities to take a broader perspective and work on

integrating different disciplinary frameworks and begin addressing the limits of epidemiology in understanding health in its broadest sense (Czresnia, 1999).

In turn, prevention has traditionally been concerned with disease classification or diagnosis, and aetiological pathways which can be interrupted to prevent the occurrence or progression of illness. Prevention strategies have been categorised according to primary, secondary and tertiary prevention (Gordon, 1987).

Primary prevention refers to strategies which prevent the health event or disease itself. Primary preventative strategies are usually directed against upstream risk factors, such as policies banning smoking in public places, and need to be implemented at specific periods before the onset of the disease. Secondary prevention focuses on intervening early where a population may already be exhibiting signs of a health issue, such as social prescribing of gym memberships for patients at risk of diabetes. Tertiary prevention involves working with individuals who have developed a health condition towards recovery and reduction in the impacts of illness on other areas of life.

1.2.3. Key Bodies in UK Public Health

1.2.3.1. Public Health England, local authorities and public health departments

Following the Health and Social Care Act 2012, local authorities (LA) have greater responsibility for improving the health of their local populations. Each local authority is required to employ a Director of Public Health, who leads the LA on its public health strategy (Heath, 2014). This is supported by a wider public health department in each LA, comprised of a specialist workforce of consultants and a wider workforce of practitioners. Statutory responsibilities of public health departments include the weighing and measuring of children, health check assessments, sexual health services and services aimed at reducing drug and alcohol misuse. Public health departments are also required to conduct research into health improvement, provide advice to the public, and offer facilities to prevent and treat illness such as smoking cessation clinics (Heath, 2014).

Directors of Public Health have been positioned as “key change agents” (Department of Health, 2012b, p.7), responsible for supporting local political leadership on public health, and challenging local partners including the NHS to progress public health practice. Directors are statutory members of Health and Wellbeing Boards, comprised of representatives from the LA, NHS and Clinical Commissioning Groups (CCG) to devise Joint Strategic Needs Assessments as a basis for public health initiatives in the locality.

Public Health England (PHE) was formed through the Act, acting as the designated National Focal Point for the UK on public health matters. PHE employed 5,000 staff, comprised of scientists, researchers, public health specialists and practitioners. Its role was to support the work of public health departments through providing specialist services and advice, providing data and evidence on public health outcomes. PHE also had a strategic role in advising local and national government, the NHS, industry and the general public to promote public health aims (Department of Health, 2019).

As of April 2021, Public Health England (PHE) was disbanded and reconfigured into a new UK Health Security Agency (UKHSA) and Office for Health Promotion, prompted by lessons learned from the COVID-19 pandemic (Department of Health, 2020).

1.2.3.2. The Faculty of Public Health

The Faculty of Public Health is the standard setting body for public health specialists in the UK, setting standards for training, examination, and specialist practice. It also advocates for public health nationally and internationally, and disseminates knowledge and guidance around public health, publishing the Journal of Public Health and Public Health Today. The Faculty provides a programme of CPD for its members and facilitates Special Interest Groups where members may develop areas of interest that may not be covered in their training. The Faculty’s primary objectives are to promote the advancement of knowledge in the field of public health, to develop and maintain the highest standards of professional competence, and to act as an authoritative body for consultation and advocacy in matters concerning public health (Faculty of Public Health, 2014).

The Faculty is affiliated with the Academy of Medical Royal Colleges. It was originally a medical Faculty, the Faculty of Community Medicine, but became the Faculty of Public Health in 1972, and now has a multidisciplinary membership.

1.2.4. Overview of the Public Health Workforce

1.2.4.1. Core workforce: public health specialists and practitioners

Public health specialists are senior leaders in the public health workforce, and typically take up roles in consultant posts or as Directors of Public Health. There are different routes into these roles, though most specialists go through the speciality training programme, which consists of a one-year Master of Public Health (MPH) followed by four years on placement training in public health teams. A survey in 2019 found that on average 84 people per year enter the speciality career pathway, with 60 of these undertaking the speciality training programme (STP) as opposed to the alternative portfolio route (Kidney, 2019). On completing the programme, trainees register with either the General Medical Council or UK Public Health Register (UKPHR) regulatory professional bodies, according to whether they have prior medical training. Around half of trainees register with each, indicating that half of the trainee cohort tends to have a medical background.

Public health practitioners (PHP) make up a larger proportion of the core workforce, with around 10,000 in post compared to 1,450 specialists (Centre for Workforce Development, 2014). In contrast to specialist professionals who may be considered to have a more strategic role, PHPs are the front-line workers who deliver the services to individuals and communities, manage workforces and support commissioning processes. They may also be located in research settings. There are no set requirements or defined training routes for PHPs, but they can voluntarily register with the UKPHR.

1.2.4.2. Wider workforce

The wider public health workforce comprises any individual who through their paid or unpaid work has opportunities to impact the health and wellbeing of the public, but is

not employed in a specialist or practitioner role (PHE, 2019), for example those working in emergency services or housing. The size of this workforce is estimated at 15-20 million people.

1.3. What is Public Mental Health?

A widely cited definition of the remit of a public mental health approach originates from the WHO's Mental Health Action Plan 2013-2020 (WHO, 2013) and comprises three key areas of work:

- 1) mental health promotion, primarily concerned with addressing the determinants of positive mental health or wellbeing
- 2) mental illness prevention, concerned with addressing the determinants of mental illness or disorder
- 3) treatment and rehabilitation of people with mental illness, concerned with quality of life and ameliorating further impacts associated with chronic or severe conditions.

The rationale for a public mental health approach has emerged from the debates about the efficacy of treatment and the best way to meet increasing demand as the prevalence of mental health problems increases (Andrews & Henderson, 2004).

1.3.1. Population Approaches to Mental Health

Public mental health is concerned with population-level prevalence and inequalities in mental health problems. The population approach to mental health is a closely related concept to public mental health, and focuses on fostering conditions that reduce health inequalities and poor mental health. This could include social and economic policy interventions, public health interventions and health care interventions (Purtilo et al., 2020). Population approaches are a response to the growing recognition that clinical services alone do not maximise population health, due to limited capacity of services and variable efficacy of treatment options (Jorm et al., 2017).

Clinical psychologists have also been advocates of population approaches to mental health. As put by George Albee: “no mass disorder has ever been eliminated by treating one person at a time” (Albee, 1999, p.133). Therapeutic services will only reach a small proportion of society (Humphreys, 1996), and are reactive responses to problems rather than preventative. This is both a pragmatic issue as well as conceptual and ethical one (Harper, 2016). Given the evidence of the role of wider context and inequality in mental health difficulties, individual therapy has been criticised for promoting the idea of individual pathology or weakness, and the idea that distress arising from our relationship with external structures over which we have little control can be ameliorated by wilful intrapsychic change (Smail, 2005).

1.3.2. Social Inequalities, Mental Health and Access to Treatment

The impact of social inequalities and adversity on mental health has been well-established (Elliott, 2016; Marmot, 2010; Friedli, 2009). The “social gradient” in mental health refers to the incremental decrease in mental health with decreases in socioeconomic status, evident in children as young as three years of age (WHO, 2014). The social gradient relates to economics, as well as cultural, relational and environmental factors (Mental Health Foundation, 2020). For example, socioeconomic adversity is a key determinant of exposure to a range of other adverse determinants of mental health problems, such as poor housing, state and interpersonal violence, childhood abuse, as well as reduced agency, trust and feelings of safety (Rogers & Pilgrim, 2003).

Social and demographic factors are also well-known to determine treatment access, and the nature of treatment accessed. For example, higher treatment rates for common mental health problems have been associated with being female, White British, economically inactive and in poor general health. Low household income has been linked to requesting but not receiving mental health treatment (McManus et al., 2016). Minoritized ethnic groups are among those least likely to access treatment for mental health problems. Treatment rates for Black people in England are particularly low, and those who do access services are more likely to report negative experiences and poorer outcomes (Synergi Collaborative Centre, 2018).

This further highlights the rationale for population level approaches to mental health which focus on preventative interventions other than individualised treatment approaches. This has potential for universal benefit, including for those who are systematically disadvantaged by the healthcare system. Increasing service capacities without a nuanced understanding of inequalities in mental health and service access risks widening the gap further, as root causes remain unaddressed, and populations remain excluded from support.

1.3.3. Public Mental Health Policy and Strategic Context

The past two decades have seen a growing emphasis on applying public health approaches to mental health issues in health policies and strategy. The World Health Organisation (WHO) Mental Health Declaration for Europe (2005) and European Commission Green Paper on Mental Health (2005) raised the profile of a population approach to mental health with a focus on prevention. The United Nations Sustainable Development Goals (Costanza et al., 2016) also prioritised mental health as a core area for development and committed to treatment and prevention of non-communicable diseases including mental disorder and promotion of mental wellbeing.

The WHO's Mental Health Action Plan 2013-2020 laid out a 'global roadmap' for mental health emphasising promotion of mental health and prevention of mental illness (WHO, 2013). This informed a range of developments in guidelines and policy in the UK, responding to a growing acknowledgment of the limited effectiveness of treatment and the economic case to do better (Friedli & Parsonage, 2007).

1.3.3.1. The lack of primary prevention in policy

Public mental health gained increasing visibility in the UK's NHS and public health policy following the publication of landmark mental health strategy documents: No Health without Mental Health (Department of Health, 2011) and the NHS Five Year Forward View (NHS England, 2014). Despite advocacy for preventative approaches across strategy (Department of Health, 2012; 2014b; NHS England, 2015b) primary prevention has rarely been addressed. Proposed interventions have generally focused

on tertiary or secondary prevention, such as improving the quality and availability of services, and early intervention (Department of Health, 2014b).

Other recommended interventions have focused on building resilience and self-esteem in children and young people, described as preventative in terms of ostensibly reducing their risk of developing mental health problems in future, despite poor evidence for sustained effects of resilience-enhancing mental health promotion programmes in schools (Fenwick-Smith et al., 2018). Subsequent strategies have focused on early intervention services, liaison psychiatry across acute trusts and reducing waiting times for primary care services (NHS England, 2014b). Others have focused early intervention and early access to services particularly for children and increasing rates of employment in adults with mental health problems (NHS England, 2016). Access to services and increasing treatment capacity have attracted the most attention (NHS England, 2016b). This is despite extensive research commissioned by the government into the most effective, evidence-based strategies for reducing health inequalities which focus on policy-level action (Marmot et al., 2011).

While this theme is pervasive in PHE's strategy (PHE, 2019), a Prevention Concordat consensus statement marked a shift in emphasis towards upstream determinants in preventative efforts; the statement signatories included 39 county councils and 68 statutory, professional, and voluntary sector organisations (PHE, 2017a; 2017b).

1.3.3.2. The lack of primary prevention in implementation

A review commissioned by PHE examined the evidence for health prevention and promotion approaches, providing a useful overview of current approaches to public mental health (Goldie et al., 2016). The review highlighted similar trends, including a focus on secondary or tertiary prevention, targeting either individuals, their immediate relationships or their interaction with services rather than action on wider determinants aligned with a population and primary prevention approach. Analysis of local planning arrangements for prevention of mental health problems in 35 local authority areas in England found highly variable coverage (Kings Fund & PHE, 2017). Reflecting priorities identified in the policy context, vastly more attention was given to availability and quality of services than primary prevention: 100% of surveyed councils addressed

early years, family, schools and perinatal mental health in their planning documents, while just 13% identified debt or poverty as an issue related to the local work on public mental health.

In summary, currently there is a disconnect between the rhetoric around public mental health and prevention, and the recommendations and actions which focus disproportionately on secondary and tertiary prevention. Action on population mental health focuses on provision and access to services which aim to support the wellbeing of individuals through low-intensity interventions, such as resilience-building in schools or stress management in workplaces, and less on upstream determinants. This raises questions as to how mental health is understood within public health, particularly how causes of mental health problems are conceptualised and clarification of some key debates relevant to this issue.

1.4. Key Ideas, Concepts and Debates in Public Mental Health

The way mental health is defined is of central importance to the way it is responded to, and under whose jurisdiction it falls. It determines the lens through which mental health phenomena are viewed, and the understandings available in making sense of causes and formulating prevention. This section outlines some of the dominant terms and concepts in the discourse of public mental health, the frameworks used in understanding causal processes, and critical debates shaping how the public health responds to mental health issues at population level.

1.4.1. Definitions and Models of Mental Health in Public Mental Health

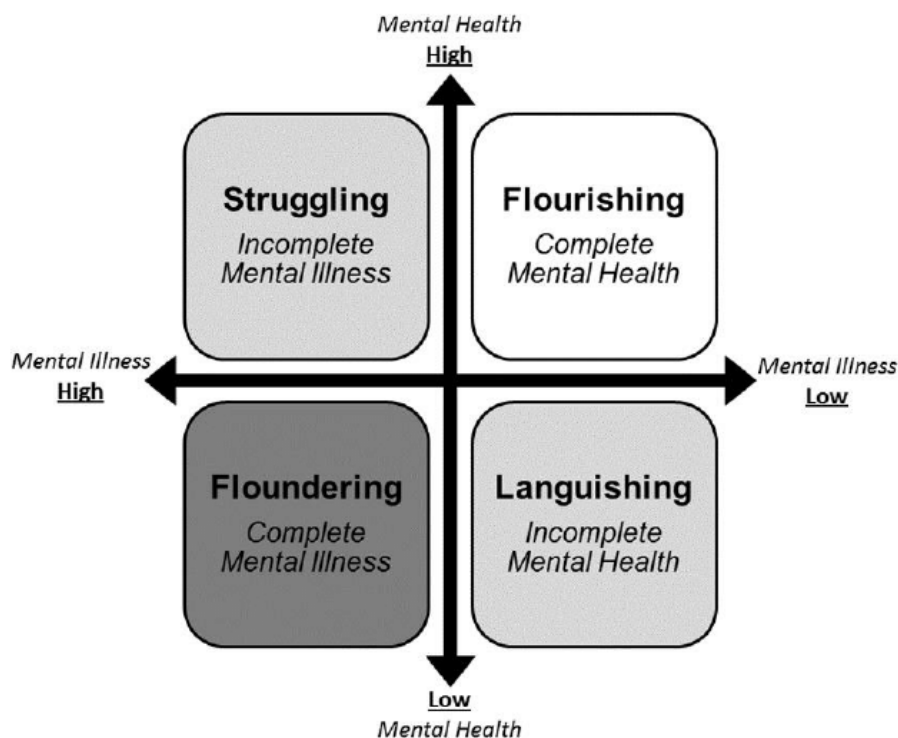
According to the Faculty of Public Health (2016), '*mental health*' encompasses "mental health problems, conditions, illnesses and disorders through to mental wellbeing and positive mental health". '*Mental health problems*' refers to both 'mental disorder' and mental health problems below diagnostic threshold. '*Mental wellbeing*' is used to refer to a state of feeling good (happiness, life satisfaction) and functioning well (self-acceptance, personal growth, positive relations with others, autonomy). It is considered a component of total wellbeing, in addition to physical and social wellbeing.

1.4.2. Prevalence of a Mental Health and Wellbeing Dichotomy

The WHO (2006) definition of health, which states that mental health is not just the absence of disease but a state of complete wellbeing, has permeated the way that mental health is defined in public health. Conceptualising mental health (or 'illness') and wellbeing as dissociable has had a profound impact on the way mental health is understood in public mental health. The dual continuum model, illustrated in Figure 1, is widely drawn upon in public health literature (Keyes & Lopez, 2002).

Figure 1

The Dual Continuum Model (Keyes and Lopez, 2002)



The impact of this conceptualisation of mental health on public mental health policy and practice is particularly salient in the demarcation between 'prevention' work and 'health promotion' work. Mental health prevention tends to be understood as the prevention of mental 'illness'. Wellbeing on the other hand is often located under health promotion activities.

The construct of 'wellbeing' has been critiqued. The Chief Medical Director discouraged its inclusion in mental health strategy due to concerns about it being inadequately defined, poorly measured, and used widely in grey literature not subject to peer review (Davies, 2013). Indeed, the way concepts of wellbeing and mental health and illness are invoked across public mental health literature is at times inconsistent and confusing. In the opening pages of the Faculty strategy (2016), they acknowledge the difficulties with the ontological distinction between psychiatric disorder and mental wellbeing in the dual continuum model, and favour instead a single continuum model, referencing epidemiological research finding measures of mental health being normally-distributed within populations. Yet, they go on to define mental health problems as inclusive of psychiatric disorder, but "avoid the term mental illness as a catch all label because of its connotations with the bio-medical model" (2016, p.10). When discussing the causes of mental health problems in the population, the strategy highlights the need for current ways of thinking to encompass social context and the role of inequality, but in particular the interplay between social context and the genome, indicating an implicit biological foundationalism.

1.4.3. Relationship of Conceptualisations of Mental Health to the Medical Model

The idea that mental health problems are equivalent to medical diseases is known as the 'medical model' of mental health. Taking a medical lens to mental health impacts more than the way mental health is conceptualised. As outlined by Middleton and Moncrieff (2018), the medical model entails a number of wider assumptions, such as the idea that psychiatric practice is uncontroversial and straightforward. It also impacts practices, including the jurisdiction of psychiatry as a medical speciality addressing mental 'illness' and the applications of positivist methodologies in coming to know about mental health problems, their causes and solutions. The medical model has been criticised for promoting the existence of diagnostic categories with poor evidence of validity or reliability (British Psychological Society, 2013), and for the sometimes harmful practices rationalised by the model, such as its functions of social control, and misuse of psychopharmaceuticals.

The popularity of the dual continuum model and concept of mental wellbeing may relate to the way it resolves, at least superficially, some theoretical complexities. For example, it accounts for the existence of distressed people who don't fit diagnostic criteria without requiring interrogation of the validity or reliability of diagnostic categories. 'Wellbeing' is predicated upon its distinction from diagnosable mental illness, diagnostic language is used uncritically, and the dual continuum model assumes no meaningful difference between forms of mental health problems.

Retaining the validity of mental illness and diagnostic categories enables wellbeing to be positioned as a departure from medicalisation while maintaining the individual as a site of analysis in population mental health. Wellbeing is generally described in terms of intrapsychic constructs borrowed from positive psychology, such as self-efficacy (Schwarzer & Renner, 2000) and locus of control (Wallston & Wallston, 1978). It also implies (at least) two types of distressed population: the mentally ill and the mentally healthy who experience poor wellbeing. Public health bodies can thus ostensibly de-medicalise their literature and practice by focusing on wellbeing, because mental illness is cast as a health issue. Arguably these hypotheses are borne out in the implementation of public mental health initiatives (section 1.3.3.).

1.5. Causal Frameworks Theorizing the Determinants of Mental Health

While it is widely agreed and well-evidenced that mental health is profoundly shaped by the impacts of social inequalities (Friedli, 2009; Marmot et al., 2011), the mechanisms by which context determines mental health is less clearly articulated in public mental health literature. Causal frameworks which formulate the mechanisms leading to mental health problems in a population are crucial in devising interventions. There are many frameworks used in public health to conceptualise these mechanisms, and broadly these can be categorised into ecological frameworks, which consider layers of determinants in either a cross-sectional or life-course approach, and ecosocial frameworks which emphasise structural inequality, and the cumulative and synergistic interplay between various influences on health.

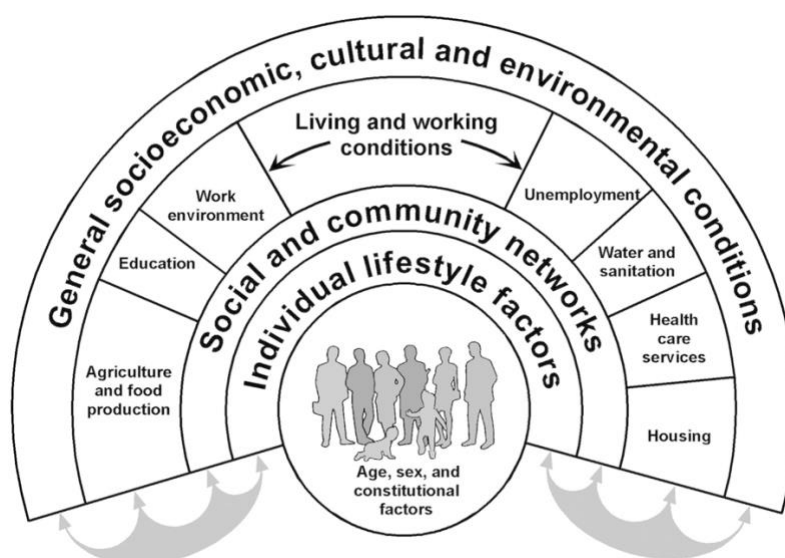
1.5.1. The Prevalence of the Ecological Model in Theorizing Causes

In epidemiology, a cause can be “anything that makes a difference” (Susser, 1991). The methodology used in researching determinants is of central importance to the way determinants are understood and eventually framed in policy. A common technique is to use regression analyses, which model the relative contribution of ‘independent variables’ on ‘outcomes’, often focusing on isolating causes. This approach models determinants in linear relationships.

In line with this linear causal paradigm, the determinants of mental health are often theoretically conceptualised according to variations of the ecological model, which conceptualises determinants in a layered way from “macro” level or distal determinants like globalisation or climate change, through to “micro” level, or proximal, determinants, such as individual factors, interpersonal relationships and familial factors. A frequently-cited model of health determinants is illustrated below in Figure 2.

Figure 2

The Main Determinants of Health (Dahlgren & Whitehead, 1991).



From this perspective, wider determinants of mental health shape people's cumulative exposure across the life-course to proximal (behavioural, psychosocial, biological) exposures and lead to health outcomes; a version of the diathesis-stress framework, where the risk of disease depends on exposure to adverse circumstances and the biological or other susceptibility (diatheses) of the individual.

This way of conceptualising the adjacency of factors has implications for conceptualising their relative causal potency (Krieger, 2008) as it is assumed that: (1) proximal factors are those which operate directly on or in the body; (2) all other exposures are relegated to the realm of distal; (3) causal potency is linked to proximity; (4) distal causes exert their influence through proximal factors. This kind of framework has been criticised for eschewing discussions of power and injustice in favour of causal pragmatism, where proximal determinants offer ostensibly greater opportunity for intervention than distal determinants requiring social change (Krieger, 1994).

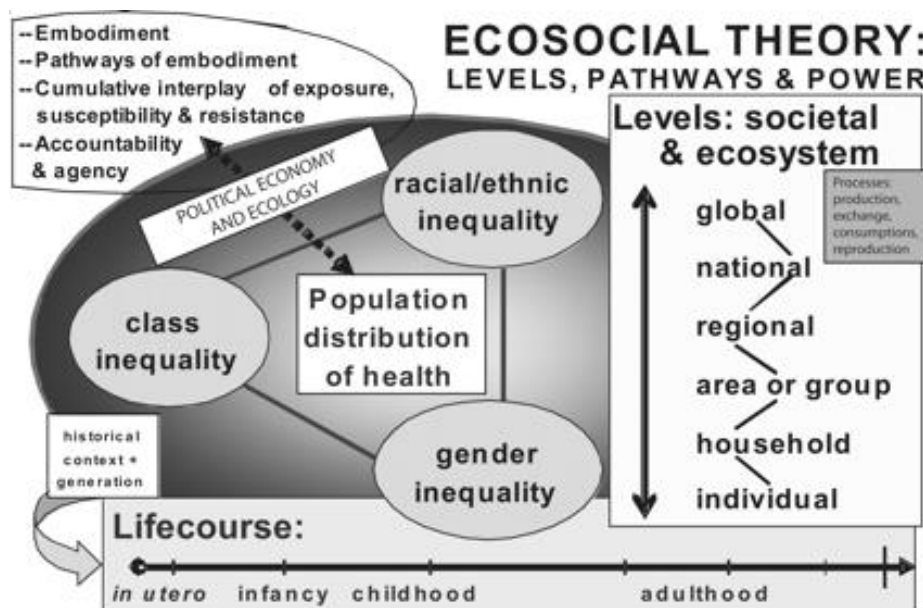
This is apparent in the Faculty of Public Health's (2016) proposal as to how Dahlgren and Whitehead's (1991) model be extended to adequately accommodate 'key' determinants in public mental health, to include: the role of family relationships in formative years of brain development; gene-environment interactions; and constructs related to wellbeing like 'health beliefs' and self-efficacy'.

1.5.2. Limitations of the Ecological Model and Implications for Policy and Strategy

Evidence suggests that determinants exert their effects in non-linear, cumulative and synergistic ways, and that mental health is not just an outcome, but can be a determinant and mediator of effects of determinants (Friedli, 2009). Galea et al. (2010) advocate a shift in research methods towards multi-level analysis that can account for non-linear effects and dynamic feedback between determinants. Ecosocial theories offer an alternative view on the distribution of health inequalities and determinants of health, which aim to make issues of class, race/ ethnicity, gender and political economies and ideologies explicit (Figure 3, Krieger 2011; Krieger et al. 2012).

Figure 3

Ecosocial Theory and Embodying Inequality (Krieger, 2011).



This perspective holds that understanding the determinants of health at a population level differs from understanding how disease occurs at an individual level. Firstly, distributions of disease are embodied expressions of distributions of power, trust and opportunity afforded unequally across societies. Secondly, inequality must be understood in terms of the relationship between privileged and disadvantaged groups in society (Krieger, 2008).

The theoretical model or framework used impacts the way mental health can be defined. Under linear or diathesis-stress models, health and wellbeing are constructed as determinants, mediators or outcomes. The ecological framework positions mental health and wellbeing as proximal 'risk' variables or assets, and the individual becomes a site for analysis, which lends itself more to a "high-risk" approach rather than a population approach to mental health (Rose, 2001).

An ecosocial framework on the other hand accommodates the complex interplay between factors across levels, and understands outcomes at the individual level to reflect the embodiment of context. This has implications for the relative focus on individual and wider factors. Ecological frameworks and diathesis-stress models

rationalise the prevailing approach to public mental health at present, namely the emphasis on decontextualised and individualised approaches like mental health literacy, and wellbeing promotion initiatives like the 5 Ways to Wellbeing (Goldie et al., 2016). An ecosocial framework, with an explicit consideration of social justice, power and systems of oppression might object to this course of action for reasons including: the promotion of hegemonic psychiatric forms of knowledge and medicalisation of distress; alignment with neoliberal ideologies connected to individual blame and responsibility; and the impact of these effects on critical consciousness about the contextual sources of distress.

1.6. Critical Issues in Public Mental Health

As outlined above, a significant issue for public mental health is the lack of action at primary prevention level, and the contradictions in theory, policy and implementation.

1.6.1. Austerity, Cuts to Funding and Allocation of Resources

Mental health prevention and promotion activities accounted for less than 0.03% of NHS spending on mental health, equivalent to £3 million in 2015 (All Party Parliamentary Group, 2015). They accounted for 1.36% of local authority spending in 2014 (Mind, 2014), equivalent to around £40 million. To put this into perspective, the spend on preventative interventions around sexual health that year was £671 million (Department for Communities and Local Government, 2014). In 2016 £1 billion was pledged for mental health prevention activities by 2020/21, accompanied by recommendations focusing on secondary and tertiary prevention activities (NHS England, 2015).

Public health leaders are arguably in a double bind, where the government simultaneously increase expectations and responsibilities of public health services while cutting budgets. Leaders have put pressure on the government to provide longer term guaranteed funding to support large scale meaningful changes; a major public inquiry recommended ringfenced budgets for at least 10 years, which the government rejected (Iacobucci, 2018). A survey of public health departments found that 89% had

public health funds reallocated to other LA services and 72% believed that their budgets were not sufficient to fulfil demand (Faculty of Public Health, 2018).

1.6.2. Unresolved Conceptual Issues

The gaps between the evidence base, policy and implementation around public mental health suggest that more work is required to develop the theoretical underpinnings of the discipline. Stockols et al. (2013) have suggested that in order for public mental health to establish itself as a discipline, there needs to be better integration of different disciplinary perspectives and the development of conceptually coherent frameworks to support a robust approach. Smith and Wilkins (2018) have pointed out a challenge for conceptually robust approaches is the workforce divide between research and practice, which can lead to a disconnect between those who focus on explaining and understanding, and those who aim to make changes. This is particularly relevant if those responsible for devising strategy and policy are reviewing the evidence without an appreciation of the critical theoretical issues at hand.

Kaplan (2004) cites an over-emphasis in public health on methods over theory, and that shifting the balance towards elaborating theory will help to address questions that may never be solved with better data or analytic techniques. Being more precise when describing terms and constructs could improve consistency and understanding across the discipline and in turn encourage theoretical development (Gauffin & Dunlavy, 2019). Making paradigms explicit in research is also a question of theoretical integrity, and helps communicate the assumptions made in the course of making sense of complex phenomena. This is especially important given the study of inequalities of different groups, with some authors considering it essential that theoretical work on systems of oppression and their effects is engaged with (Jones, 2000; Krieger, 2016).

1.6.2.1. Lack of engagement with psychological theory and debates

The conceptualisations of psychological processes in public mental health literature largely focus on ideas from behavioural change theories, focusing largely on individual factors such as knowledge, skills, beliefs, motivation, and to a lesser extent environmental context and resources (Michie et al., 2005). The implicit assumption is

often therefore that if individuals have the information to make better health choices, or have the resilience to withstand adversity, then the mental health and wellbeing of the population will improve. This reasoning is dissonant with the evidence strongly indicating the causal role of context in shaping mental health problems, and population-based understandings of and approaches to mental health

Clinical psychology has significantly contributed to conceptualising individualised or intrapsychic processes (Humphreys, 1996) but also has important contributions to make which cast doubt on the validity of these assumptions and offer alternative understandings commensurable with population mental health approaches. For example, Smail (2005) highlighted that the idea of intervening at the individual level was conceptually, and therefore ethically, dubious, if it is accepted that social factors primarily cause mental health problems. Individualised ideas of mental health and intra-psychic change promote the notion that people are able to change their contextually bound experiences of distress through changing some aspect of their thoughts or beliefs.

There are well-established debates within mental health disciplines around the validity of psychiatric constructs and the ideological nature of psychiatric theory and practice (Pilgrim & Rogers, 2005). However these are not referenced in the theoretical work of public mental health, and the framing of 'wellbeing' versus 'mental health/ illness' indicates a perfunctory acknowledgement of limitations of the medical model that have not percolated the depths of public mental health theory and concepts.

1.6.2.2. Implications of conceptual issues for upstream change

There is still a lack of consensus in public health as to what is meant by 'mental health' and what the causal mechanisms are that underpin mental health problems. Policy-making tends to be dominated by paradigms or 'monopolies of understanding', because stakeholders involved in the process tend to simplify the issue; partly because the complexity and breadth of evidence relevant policy is unwieldy, but also because it allows well-established ways of thinking, values and ideology to go unquestioned (Baumgartner et al., 2009). One hypothesis about the success of the wellbeing agenda might be that its alignment with status quo ideas about mental health

and wider ideologies allows for less political friction than a social justice approach focusing on primary prevention. Alternative messages for policy-makers would likely improve their chances if based on a robust and coherent theoretical understanding.

1.6.3. Policy Emphasis on Public Mental Health Without the Workforce Infrastructure

There is currently no formal arrangement for the delivery of training to support the development of a public mental health specialist workforce. A review by PHE found that current provision of mental health promotion and prevention training was mostly targeted towards the wider workforce (PHE, 2016). The review also found that trainings were primarily packages focused on wellbeing, mental health literacy and suicide prevention, which indicates the contextualised understandings of mental health may not be widespread in training. Training was found to be commissioned locally, and there was no standardised approach to developing skills and knowledge in public mental health.

How the specialist workforce is to be developed is less clear. The workforce development call to action (PHE, 2018) saw the Faculty of Public Health commit to a review of its speciality curriculum. As of 2021, following a light-touch review of the curriculum, mental health features only in terms of practitioner self-care. Other commitments were made in line with workforce development recommendations made in the No Health Without Mental Health implementation plan (Department of Health, 2012a). This included the development of training of the specialist workforce by the Faculty in collaboration with the Royal College of Psychiatrists, and increased CPD opportunities. Overall, it is unclear how public health specialists currently garner the understanding needed to implement transformative prevention approaches with a solid theoretical and conceptual grounding.

1.6.4. Summary

Public mental health is an area of increasing interest at policy level, though at levels of theory and practice there remain a number of challenges. There is a lack of engagement in the literature with key debates and psychological theory, and the

impression that assumptions about the causes and amelioration of mental health go unexamined. Theoretical coherence is important for policy change, as well as ensuring conceptually and ethically rigorous approaches, and is viewed as an important area for development to promote public mental health. The specialist public health professionals are seen as ‘key change agents’ in public health, but there is little clarity as to how they are supported through their training to fulfil this role.

1.7. Training and the Public Mental Health Agenda

A major criticism of the current approach to public mental health has been that the workforce responsible for implementing it does not have the necessary training or expertise; this has been cited as a reason for the variable translation of the evidence base into appropriate and effective interventions (Campion, 2019), as well as the struggle for parity of esteem and lack of advocacy for public mental health at senior levels (PHE, 2015).

PHE’s public mental health workforce development framework (2015) raised the profile of this issue, leading to a call to action endorsed by the Faculty of Public Health among others (PHE, 2018). A key ambition of the framework was the development of a specialist workforce which has the expertise to lead mental health as a public health priority. The core principles outlined in the framework include that the workforce should “know the nature and dimensions of mental health and mental illness” and “the determinants at structural, community and individual levels” among other things.

One of the pledges of the Prevention Concordat (2020) was that conditions would be created for leadership on public mental health. This included senior leaders and partners having a shared understanding of public mental health, in order to promote a shared vision. What has been less clearly stated is how this is to be achieved, although increasing attention is turning towards the training and competency development of public health professionals in mental health. Training of public health specialists, who have particularly powerful roles given their involvement with the design and delivery of public mental health initiatives, may offer particular opportunities in moving the field forward.

1.7.1. Opportunities of the Specialty Training Programme

A total of 14 specialty training programmes (STP) are run across the UK in demarcated regions or 'deaneries', and are overseen by a Postgraduate Dean, a Head of School and/ or a Training Programme Director. The STP is the most common route into specialist public health careers, such as consultant and Director of Public Health positions. Training normally lasts for five years and comprises at least four years of service work plus a period of academic training, normally through a Master of Public Health (MPH) course. The training covers 10 key areas of public health practice within domains of health improvement, health protection and public health or health and social care, plus professionalism competencies. The curriculum focuses on broad competency domains rather than disease or domain-specific competencies, and is designed by the Faculty of Public Health so that those without a medical background can access training. Currently around half of graduates have a medical background on entry (Kidney, 2019).

The Master of Public Health (MPH) is a key phase of academic training of public health specialists. MPH content varies considerably from one course to the next, however courses aimed at people taking the speciality training tend to be aligned to the Faculty curriculum (Faculty of Public Health, 2015). While there are many postgraduate courses available in the UK to study public health, including Master of Sciences, the MPH is the required qualification for the academic component of the STP. In addition, the MPH is completed by postgraduates who are not undertaking the STP; STP learners are a minority of the cohort

That a core part of the speciality training takes place in an academic setting offers opportunities for the development and implementation of public mental health. MPH students come from a range of disciplinary backgrounds, and at postgraduate level may play an active role in theory development. Gauffin and Dunlavy (2019) suggest that the challenge for public health of integrating multidisciplinary theories and approaches may be best addressed in the postgraduate setting, where students with

a range of disciplinary backgrounds could contribute to the integration and development of knowledge.

Currently very little is known about the way mental health is addressed in the MPH teaching. A desktop survey of MPH courses across the UK found that only 20% included public mental health in their curricula (PHE, 2016). Aside from what can be gleaned from institution websites, there is no documentation around the content of the teaching, or what kinds of understandings are promoted in the teaching.

After completing the MPH, all trainees undertake experiential placement-based learning closely supervised by an educational supervisor. Placements in a health protection setting is mandatory, in addition to at least two other training locations. Again, very little is known about the extent to which mental health-related placements are undertaken by trainees. Given the level of implementation of public mental health approaches however, it is likely that training experiences on placement would be limited to settings focusing on secondary prevention, such as early intervention clinical settings, or tertiary prevention settings in NHS mental health treatment areas.

1.7.2. Implications and Relevance for Clinical Psychology

Public mental health is directly relevant to the work of clinical psychologists, and the agenda is gaining visibility. The British Psychological Society (BPS) Manifesto (2019a) made a cross-sector commitment to addressing the determinants of health inequalities and ensuring that public health interventions are designed and delivered by those with appropriate psychological knowledge, skills and training. The BPS have recently addressed the competency of the psychological workforce, advocating that clinical psychologists are trained to understand the impact of social inequalities, and that an ethos of critical community psychology should inform the curriculum of training courses (BPS, 2019b). In this way, clinical psychology is undergoing its own journey of disciplinary development and finding means to expand understanding and build capabilities that scaffold preventative, population approaches to mental health. An important related discussion is on-going, regarding the potential opportunities of

clinical psychologists and public health specialists working together more closely, and the benefits of sharing expertise (Harper, 2017).

Clinical psychology as a discipline has great deal to offer public mental health, far beyond the current application of psychological theory. Furthermore, clinical psychology provides theoretical and methodological means to make sense of and identify gaps in the training of public health specialty trainees, where the goal in mind is a specialist workforce that “know the nature and dimensions of mental health and mental illness” (PHE, 2015). In particular, it has a well-established critical theoretical literature to support reflection of current practices in public mental health, particularly of the limitations of the medical model (see BPS, 2013 for a brief overview). It also has developed theoretical frameworks which could help develop the public mental health theoretical base, towards more elaborated and sophisticated understandings of the causes of mental health problems, and in turn what preventative solutions might look like (see for example, the Power Threat Meaning Framework: Johnstone & Boyle, 2018). The issues presented in this chapter indicate areas where theoretical perspectives in clinical psychology might support the development of conceptual and theoretical issues in public mental health. Analysis of the training of speciality trainees could elucidate in more detail where clinical psychology may be able to contribute.

1.8. Aims and Research Questions

The current implementation of public mental health approaches reflects a number of issues. This includes the limited elaboration and robustness of conceptual frameworks, a lack of ownership and openness about the theoretical assumptions and ideologies shaping the literature, and a disconnect between the evidence and what is ultimately recommended in policy and strategy. At each of these stages, for public mental health to be implemented effectively, there requires a senior workforce in place with the skills and knowledge to address these concerns and shift the discipline towards practicing from a place of theoretical and ethical integrity. Cultivating a solid understanding of public mental health in senior professionals may also strengthen the cause and redress the neglect of mental health prevention, given their prominent role in commissioning and planning, and relative opportunities for advocacy at policy level.

The senior workforce are identified as key changemakers in this quest across strategy and policy documents, in the context of a wider agenda to develop the workforce. However, there has been a lack of concrete action to achieve these aims.

The specialty training programme is a promising site for delivering the vision of the workforce development agenda, however very little is known about the coverage of mental health across these programmes. This research aims to begin elucidating this. This is an important question, and timely. The workforce development agenda is current, yet there has been no further action to progress its aims. The only information available currently is that a minority of the courses reference mental health in their module guides. In terms of the actual content that is covered, this is largely unknown.

Given the relative lack of interest in public mental health, from the lack elaboration of its theories to its relative under-investment, an important question concerns the way in which key stakeholders in the training of public health specialists view the issue; how do they themselves understand public mental health? What is their understanding of the lay of the land in teaching and training around public mental health, and what implications are there for practice? Finally, the wider issues impacting curriculum development will be explored; what do stakeholders see as facilitating or preventing the inclusion of public mental health in the course of speciality training? This research will explore this issue in discussion with key stakeholders, who are identified as those with particular expertise and professional relationships with the STP.

To summarise, the following research questions are proposed:

1. To what extent is mental health covered in the specialist public health training programme?
2. What theoretical and conceptual frameworks are drawn upon in teaching and training?
3. What are the barriers and facilitators to including public mental health in the training?
4. What are the practical implications of the current coverage in teaching and training?

2. METHOD

2.1. Methodology

2.1.1 Philosophical Framework

Philosophical and theoretical assumptions are made in the process of research, which shape the research questions, determine the applicability of methods, and limit the conclusions of the analysis. Clarifying these assumptions is important to the integrity of the methodology and the interpretation of the end results (Ponterotto, 2005).

This research takes the position of “critical realism” (Bhaskar, 1998). Ontologically, critical realism holds that there is an independent and enduring reality. In this research for example, there is an ambition to gain an insight into causal processes underlying the education of public health trainees around mental health, and that there exists a material reality where this education impacts public health practice.

Epistemologically, and in contrast to naïve realism, critical realism acknowledges that this reality can only be accessed or measured imperfectly, and is interpreted subjectively according to the attitudes, beliefs and other biases held by participants and researchers (Banister et al., 1994). For example, this research assumes that the answers interviewees provide will reveal their understanding of different concepts, but that these understandings are influenced by structural and contextual factors perhaps unknown or unarticulated by the participant. Likewise, the interpretation of the data is through the subjective lens of the researcher: an interpretive epistemology (Archer, 1995).

This paradigm was chosen as the methodology to address the research, because it accommodates ontological differences and epistemological challenges raised by different questions posed. One of the areas of questioning focuses on what training and education is available in the field around mental health for a specific group of

trainees. It might be that a sample of people familiar with training programmes have a shared understanding, or ontology, of what training and education is and what it looks like in their field. However the question of how mental health is conceptualised in public health teaching may invoke more varied underlying assumptions, conceptualisations or ideologies. It asks: “piece together different explanations or observations you have encountered on this issue to create a narrative”. The assumption made by this methodology is that participant’s responses will be shaped by contextual and structural influences, such as prevailing narratives in public health, the political climate, or other, and that there is room to make interpretations about this as part of the analysis. Attempts to address these complexities are considered in methods of analysis and epistemic reflexivity (section 2.6.4.).

2.1.2. Research Design

A number of factors informed the decision to use a qualitative design to address the research questions. A position of critical realism indicated the kind of data and analyses that could be applied to the research question. Fletcher’s (2017) guidelines for the application of qualitative methods to critical realist research prioritise in-depth interpretive data, such as interviews, as a means to identify themes for further analysis.

This research aimed to explore the views of its participants on a number of issues, and to make theoretical inferences about underlying mechanisms and structures which may have influenced these (Willig, 2013). A qualitative design employing interviews enables flexible and detailed exploration of participants’ understandings. Given the lack of prior research in this area, the ability to explore issues in discussion with participants was an important feature of a qualitative design and informed the decision to use interviews as a means of data collection.

2.2. Participants

2.2.1. Inclusion Criteria

The inclusion criteria were decided based on the training arrangements for public health specialists, which involves a one-year Master of Public Health (MPH) course, and 4 further years of placement-based training. Two groups of participants were eligible, according to the following criteria:

Public health professionals:

- with extensive expertise in the area of public mental health *and* working in a public mental health capacity in the UK
- who held a senior role related to the training of trainee public health registrars post MPH

Academic staff from MPH courses:

- working in a teaching role on an MPH course in the UK

Postgraduate courses were excluded from the recruitment phase (see below) if:

- the qualification did not result in an MPH, (for example, those leading to MSc or MPhil)
- the qualification had a specialist focus (for example, MPH with Nutrition)

2.2.2. Recruitment

Public health professionals located in regional training programmes were recruited through internet searches to gather contact details of eligible participants. The study was also advertised on social media (see Appendix A), targeting professionals with an interest in the area and eligibility for participation.

Recruitment of academic staff from MPH courses began with a desktop search and cross-check of online databases (www.prospects.ac.uk, www.mastersportal.com, www.findamasters.com) to create a catalogue of all MPH courses in the UK. This led to the identification of 43 MPH courses. Course web pages for each university were

then individually searched for available contact details of course staff or administrators. Email contacts were catalogued, and eligible participants were contacted in alphabetical order of the institution offering the MPH, until a sufficient number of participants had been recruited.

2.2.3. Sample

Fourteen participants were purposively recruited to take part in the research. Six participants were academics working on MPH courses, five of these had also current or previous experience working as public health professionals with an understanding of regional training activities. Six participants were public health professionals involved with regional training programmes. Two participants were public health professionals with extensive public mental health experience who had knowledge of the landscape of training around public mental health available to public health trainees. The participants are identified in the transcripts as follows:

- MaPH: participants with a teaching role on an MPH course ($n=6$)
- PH - participants connected to regional training programmes ($n=6$)
- PMH - participants with particular expertise in public mental health ($n=2$)

Guest et al., (2006) suggest that where the aim is to understand perceptions or beliefs held by a group that share expertise related to the subject area, 12 interviews of 45 minutes should be sufficient to reach data saturation. This research comprised 14 interviews of 1 hour each.

2.3. Procedure

2.3.1. Developing the Interview Schedule

A semi-structured interview (Appendix B) was designed to gather a breadth of data covering four main areas. These areas of questioning were directly linked to the research questions regarding the coverage and content of mental health training, as well as giving space for discussion about the wider influences determining the way training is covered and approached. They were also linked to the author's reading of

the grey and white literature, that certain theoretical or conceptual ideas were promoted and others, important for a population approach to mental health, were de-emphasised. In supervision discussions it was agreed that this research should not only explore the coverage of teaching, but the conceptualisation of mental health within teaching, through the taught content and nature of placement opportunities.

As follows, the four main areas covered in the interview schedule were:

- what training on mental health is available to public health trainees, if any?
- how is mental health understood in public health training and practice?
- what are the barriers or facilitators for trainees in accessing public mental health teaching/ training?
- what impact do participants think these issues have on public mental health practice?

Narrowing down the key areas of interest was important, given the intention to keep interview length to one hour. Given how little is currently documented about this area, the scope was intentionally broad to allow tangents that may not be anticipated by existing literature.

The decision to use semi-structured interviews was to allow participants to speak freely and at length about the issues at hand, and because the research questions focused on participant understanding and meaning (Willig, 2013). The interview was semi-structured in that all interviews had a fixed timeframe of 1 hour, had fixed roles as to who was the interviewer and interviewee, and had an interview agenda which was referred to across all interviews. This was combined with more informal aspects, including open-ended questions, unscheduled prompt questions and time allocated to allow themes raised by participants to be explored further.

2.3.2. Data Collection

2.3.2.1. Interviews

Interviews were arranged by email and were conducted and recorded using Microsoft Teams. Due to confidentiality agreements, participants were asked to have

their cameras turned off during the recording. I enabled my camera so that participants could see the researcher and to help develop rapport. All interviews were opened with an introduction of who I was and a recap of information about the project.

Microsoft Teams allows live captioning of interviews. Captions were uploaded onto Microsoft Word, where each interview was re-played alongside reading, correcting caption errors, formatting and anonymising the transcription.

2.3.2.2. MPH module information

To provide an overview of the coverage of mental health teaching across the 43 MPH courses catalogued in the recruitment phase, each course website was searched and available module information was recorded. The amount of detail available for each course varied; only six course websites gave access to the course specification. However, all websites featured an outline of core and optional modules. Modules were considered to be relevant to public mental health if they featured “mental health” or “wellbeing” in their description. A record was made as to whether this content featured in core modules, optional modules, and whether it was the focus of the module or mentioned as part of a wider topic area.

2.4. Analysis

The interview data were analysed using Thematic Analysis (TA; Braun & Clarke, 2006). TA involves the “search for themes that emerge as being important to the description of the phenomenon [under investigation]” (Fereday & Muir-Cochrane, 2006, p.82). It can be applied to the examination of semantic or surface-level themes, as well as latent or underlying themes in the form of ideologies, assumptions and conceptualisations that shape the semantic content (Willig, 2013). It aligns with different philosophical frameworks and can be conducted from a CR position.

Analysis from a critical realist position focuses on explanation and causal analysis rather than merely thick empirical description of a given context, which can otherwise

be the output of TA. In this way, TA from CR position looks beyond observable themes to make inferences about underlying processes, influences or mechanisms. CR analysis proceeds from a theoretical direction but is open to adjusting and revising this in response to the data, as part of the recursive process of TA. The aim is to find the best explanation “without commitment to the content of specific theories and [recognition of] the conditional nature of all its results” (Bhaskar, 1979, p.6).

2.4.1. Stages of Critical Realist Thematic Analysis

This section describes the process of analysing the interview transcripts. While it is presented in a step-wise linear way, the process was recursive and stages were revisited back and forth, until a thematic framework was established.

2.4.1.1. Defining the data set

One intention of this research was to gather perspectives across a group of participants in order to make claims about themes occurring across a sample. As such the data set was conceptualised as the entire “corpus” of interviews.

2.4.1.2. Becoming familiar with the data

Before listening back to interviews, the automated captions recorded on Microsoft Teams was read through and initial formatting edits were made. All interviews were then listened to while the audio captions were edited for errors and formatted into transcripts. Transcribing is recognised as a key phase in interpretation of the data (Bird, 2005) and initial observations about relevant issues arising in the interviews were noted down during this process. All interviews were transcribed before coding began.

2.4.1.3. Generating initial codes

Finalised transcripts were uploaded onto NVivo for coding. Transcript files were named according to whether the interview belonged to a participant from the MaPH sample or the PH/ PHM sample, so that prevalence in codes between the groups could be monitored. Initial codes were produced by identifying features that were relevant to the research questions. Coding was approached deductively, without an

a priori coding frame (Boyatzis, 1998). As coding proceeded through the fourteen interviews, a large number of codes were initially generated. A second coding cycle reduced the number of codes by refining, re-organising codes and grouping into provisional themes.

2.4.1.4. Searching for and reviewing themes

Themes were identified according to prevalence or “demi-regularities” in codes across the data set, searching for tendencies or broken patterns in the data (Danermark et al., 2002). A theme was also designated if it captured something important relating to the research question, but was not necessarily prevalent across interviews. The initial search for themes was guided by the four main areas covered in the interview schedule, producing themes that described the data rather than engaged with conceptual features. At this stage, themes and extracts were shared with my supervisor, who shared their ideas about underlying trends in the data, which supported a re-organisation in the next phase.

2.4.1.5. Defining and naming themes

Abduction is a process of inference that “raises the level of theoretical engagement beyond thick description of the empirical entities, with an acknowledgement that the chosen theory is fallible” and is part of a CR analysis (Fletcher, 2017, p. 188). When themes were reviewed according to their fit with the overall data, they were redescribed drawing on knowledge from the literature and key debates in the field. This enabled me to look beyond what was said by participants and engage with some of these theoretical ideas as themes were configured and named. Themes were defined in a way that made clear links to the research question, while giving a sense of the scope of issues arising in the data.

Another important step in a CR analysis is retroduction. The goal of retroduction is to identify the necessary contexts for a causal mechanism to take effect, and result in the data observed at the empirical level. This involves making interpretations beyond what has been said and relating it to an underlying causal structure. Sometimes this includes deviating from participant’s own descriptions to provide elaborated interpretations of reality (Parr, 2013). Retroduction is the “central mode of inference”

in CR (Lawson, 1998, p. 156), and maps onto Braun and Clarke's (2006) description of interpretation in TA, where analytic claims are grounded in the latent meanings, assumptions and conditions giving rise to themes.

2.4.1.6. Presenting findings

Compelling extracts were selected to illustrate themes alongside a coherent, analytic narrative account of the data.

2.5. Research Quality

There are a range of perspectives as to how best to appraise the quality of qualitative research. Spencer and Ritchie (2011) outline a framework for appraising the quality of qualitative research, using three quality principles: the contribution of the research; the credibility of the research; and the rigour with which it is conducted. These principles are outlined below, and will be used to appraise the quality of this research in the discussion.

2.5.1. Contribution

This refers to the extent to which this research contributes to the wider understanding about the research area. This relates to the clarity of the discussion on how findings bring new or alternative insights, the way that findings related to pre-existing knowledge or theories, and of the limitations of the evidence presented. Assessment of the research contribution also refers to the applicability of the findings beyond the context of the study. This requires sufficient detail about the research context, particularly the methods and sample group. The research contribution also concerns the extent to which it has value to the participants, and consideration of the potential impact of the research on participants.

2.5.2. Credibility

Credibility concerns the extent to which the evidence supports the claims of the findings. This includes increasing transparency as to how the raw data fit higher

order categories or themes, for example through the inclusion of direct quotes to support claims. Discussion of the research process should be clear and reflexive, providing a detailed audit trail enabling readers to assess the credibility and plausibility of claims made about the findings. Presenting findings in terms of how they relate to existing knowledge is another means to evaluate plausibility. Credibility can also be assessed by reviewing attempts to validate the process of analysis, for example through asking another appraiser to audit the analysis process or comment on the preliminary findings to support refinement of conclusions.

2.5.3. Rigour

Rigour concerns the documentation of the research process, the demonstration of reflexivity, and the defence of the overall strategy. The rationale and appropriateness of the chosen design should be clear, particularly regarding how they apply to the study objectives. Likewise, the limitations of the methods used and the implications of this for the findings must be taken into consideration. Rigour also may be evaluated through the description of the analysis process, documentation of data codes and explanation as to how themes are arrived at. A clearly constructed narrative thematic account illustrated using raw data is another indicator of rigour in thematic research.

Sensitivity to ethical issues raised by the research is crucial, and management of ethical challenges should be clearly described. This includes ensuring confidentiality, privacy, informed consent, potential harm, and the implications of power dynamics between the researcher and participants. Reflexivity in the research process can be demonstrated through the inclusion of a research diary, which logs the analytical journey as well as the impact of the process on the researcher.

2.5.4. Reflexivity

Reflexivity is the ongoing consideration of how researcher subjectivity influences the research (Yardley, 2008). Personal reflexivity is often described in terms of researcher disclaimers about their personal characteristics, aspects of social identity

and values or assumptions about a research topic, in order to situate the research from their subjective position. Sweet (2020) criticised the tendency for performative and rudimentary engagement with reflexivity in social sciences which often ends at the point of disclosing “I am X, and this may have influenced my findings”. A more rigorous engagement with reflexivity might be the integration of personal and epistemological reflexivity.

2.5.4.1. Personal reflexivity

I have a “view from somewhere” (Haraway, 1988, p.590). I am a white, middle-class heterosexual woman who was born and raised in the United Kingdom in an age of neoliberalism and austerity. For my lifetime I have been surrounded by particular cultural narratives about mental health. My position as a doctoral student provides a ‘legitimate’ context for me to produce research. Some aspects of my identity become more salient when interviewing participants, and in turn affect the unfolding of interviews. These disclosures do not allow me to proceed unproblematically (Sweet, 2020).

Some authors have suggested methods for engaging with reflexivity, including “bracketing” and reflexive journals, where researchers commit to ongoing reflection and documentation of their rationales, decisions, emotional responses and interpretations in the research process (Fischer, 2009). While bracketing aspires to the identification and setting aside of researcher assumptions or biases, I did not set out to create an objective report – impossible from a CR position. Rather I used a journal to try and bring more awareness to subjectivity in the research process, particularly the experience of interviewing and the process of TA, to deconstruct the validity and credibility of the findings through the discussion.

2.5.4.2. Epistemological reflexivity

Epistemological reflexivity is oriented to the process of coming to know, and how this interacts with aspects of our social location both in terms of personal identity, assumptions and values, as well as the broader practices of the field and considerations about stakes in the work and power (Maton, 2003).

A dilemma in the design of this research was the question of how to access participants ideas and conceptualisations of mental health without reifying a concept in the process. In the process of interviewing participants, it was necessary to use certain language or concepts in order to explore their thoughts on the topic, while holding in mind that the meaning of these terms for me and the participant may be very different. A related challenge was interpreting the conceptualisations of mental health underpinning the descriptions given by participants without assuming we were 'on the same page' when using words like 'resilience', 'medical model', 'wider determinants' etc.

Given my own professional and academic background, knowledge of particular theoretical frameworks will undoubtedly have shaped the questions I asked, my framing of questions and my reading of the data. The potential impact of this will be considered in the discussion.

2.6. Ethical Considerations

2.6.1. Ethical Approval

Ethical Approval was obtained through the University of East London Ethics Committee, subject to minor amendments (see Appendix C).

2.6.2. Informed Consent

Participants were sent a Participant Information Sheet (Appendix D) by email, when invited to participate in the research. This included information about why they had been invited, what their participation would involve, confidentiality, withdrawal procedures and contact information of the researcher and supervisor. Consent forms were emailed to participants before the interview (Appendix E), and verbal consent was gained again at the beginning of each interview.

Participants were given up to three weeks after their interview to request their information be withdrawn from the study. This was agreed beforehand in the consent

form and sited in the debrief form (Appendix F). Questions were invited at the end of each interview, where participants had an opportunity to ask about the research and anticipated uses of the findings.

2.6.3. Confidentiality and Anonymity

Confidentiality was ensured by storing anonymised transcripts, audio files and contact information separately. Where the participant had identified themselves or others in the interview, either by name or workplace, this was altered or removed during transcription.

2.6.4. Data Protection

Transcripts and consent forms were saved in an encrypted folder on the researcher's computer. All files were backed up on an encrypted external hard drive and onto the secure server of the University of East London. Audio files were stored separately on the university's secure server and deleted after transcription. Data was accessible only to the researcher, supervisor and examiner.

3. RESULTS

This chapter presents the results of the analysis. As the sample of participants represent only a fraction of MPH courses and wider training programmes across the UK, the chapter begins with an overview of the coverage of mental health across MPH courses in the UK to help locate the thematic analysis in the wider training context. An overview is then presented of the taught content of MPH courses linked to interviewees to contextualise the thematic analysis and provide a sense of the coverage of mental health teaching in the sample representing five courses. This is followed by the thematic analysis of interview data.

3.1. Master of Public Health Across the UK: Content Overview

Table 1 presents the findings from the desktop search of 43 MPH courses across the UK. The search found that none of the MPH courses had a core module focusing on mental health, although seven core modules across six courses mentioned mental health as part of another module focus. Four optional modules across four MPH courses took a focus on mental health. Two of these were explicitly oriented towards psychiatric or medical understandings of mental 'illness'. One focused on workplace wellbeing. Only one module appeared to offer comprehensive coverage of key aspects of PMH, including definitions and concepts, the role of context and social determinants, and interventions to promote mental health and wellbeing.

Table 1*Overview of Core and Optional Mental Health Teaching across 43 MPH Courses*

	Frequency	Module Titles
Core modules focusing on mental health	0	n/a
Core modules referencing mental health as part of another core topic	7 modules across 6 courses (16%)	Globalisation and Public Health Epidemiology and Statistics (x 2) Issues in Public Health Introduction to Public Health Key Issues in Global Public Health Behaviour Change
Optional modules focusing on mental health	4 modules across 4 courses (9%)	Mental Health and Illness Assessment Workplace Wellbeing Introduction to Global Mental Health Public Mental Health and Wellbeing

3.2. Content Overview of Sampled MPH Courses

3.2.1. Core and Optional Modules

Five MPH courses were represented in the interviews. Each course was comprised of four to five core modules, plus a dissertation module. There were similarities across the courses in terms of the core module areas. All five provided at least one core module on epidemiological statistics and research methods, four out of five courses provided more than one core module relating to this area, comprising 25% to 80% of core modules. Four out of five courses also featured a core module relating to foundations or fundamentals of public health, covering public health theory, concepts and application to practice. Two out of five courses had a core module dedicated to the social and environmental determinants of health.

A notable difference between the courses was the availability and breadth of optional modules. The courses offered between zero to ten optional modules, covering a

diverse range of topics with little overlap. Commonalities in the optional modules between courses related to research methods and analysis (two out of five) and global health (two out of five).

3.2.2. Coverage of Mental Health and Wellbeing

Institutional website descriptions of the core modules across the five MPH courses featured “mental health” once, in the context of an example of current and emerging topics in health improvement. The same course offered specific teaching on public mental health and wellbeing as an optional module. Four out of five courses did not mention “mental health” anywhere in their course description.

Interviewees gave overviews of the coverage of mental health topics in the MPH courses, highlighting possible gaps in knowledge depending on their role. Where mental health was not explicitly covered in specific teaching, it was said to be covered as part of other teaching in an ad hoc way. This was via teaching on epidemiology or foundations in public health, wider determinants, research methods and health impact assessments. Where mental health was explicitly covered in teaching, topics covered were said to include wider determinants, the neuroscience of childhood and adverse childhood experiences, mental and physical health, public mental health intervention settings, health impact assessments and self-care.

3.3. Thematic Analysis

Interviews were analysed thematically, according to the steps described in Section 2.5. Themes were organised into a hierarchy of sub-themes and global themes, and are outlined in Table 2.

Table 2*Global Themes and Sub-themes of Thematic Analysis*

Global Themes	Sub-Themes
Lacking a coherent conceptualisation of mental health	<p>Implicit dualism in teaching content:</p> <p>Differentiating between ‘mental health’ and ‘wellbeing’</p> <p>Implicit dualism in public mental health placements</p>
The relationship between concepts, workforce, and service structures	<p>Public mental health falls in the gap</p> <p>The challenges of primary prevention and action on social determinants</p> <p>Public mental health is marginalised and excluded</p>
Conceptual frameworks informing the curriculum	<p>‘Health’ seen as subsuming ‘mental health’</p> <p>‘Integrated’ versus ‘segregated’ approaches to coverage of mental health</p> <p>An emphasis on bio-social explanatory causal models</p> <p>A lack of depth and sophistication in the coverage of debates</p>
Structural causes of an unsystematic and heterogeneous approach	<p>Curriculum and dissertation topic dependent on interests and availability of staff</p> <p>Placements dependent on the interests of trainees and supervisors</p> <p>Conceptualisations of ‘outcomes’ shape approach</p> <p>Visibility and leadership from mental health professions</p> <p>Impact of the political climate on public health</p>

3.3.1. Theme 1: Lacking a Coherent Conceptualisation of Mental Health

A consistent theme across interviews was the way in which mental health was defined. Participants described 'mental health' in terms of 'mental health and wellbeing', conceptualising mental health and wellbeing as distinct concepts. This was evident both in the interviews with MaPH participants and in the PH/ PMH participants.

3.3.1.1. Implicit dualism in teaching content: Differentiating between 'mental health' and 'wellbeing'

All six MaPH interviewees differentiated between 'mental health' (which was seen as synonymous with psychiatric categories of disorder and with treatment services) and 'wellbeing'. This was presented as a standard approach in public health and was how mental health was conceptualised in teaching.

MaPH2: we've talked about mental wellbeing as being different from mental illness, so you can have a severe and enduring mental health problem but still have good mental wellbeing at least some of the time, so they are not same thing. So we do talk about them as being different [...] I think most people in public health would recognize them as being different

Wellbeing was viewed as a less pathologizing concept than mental health which was associated with a binary model of health and disease. However, participants highlighted difficulty in making the separation in practice.

MaPH5: when we talk about health and wellbeing [in public health], I think not many people actually really split [it] out well, being they see health and wellbeing as a single entity that is just, you know, slightly vague. I think when you're talking about wellbeing [...] about promoting wellbeing [...] there's also times where you're looking at [a] much more disease centric model where you're thinking about, for example, trying to prevent suicide, actually detecting

things like you know self-harm and all the rest of it [...] I think it is actually quite a heterogeneous basket of different things.

The challenge of applying this differentiation in practice indicates a conceptual confusion and overlap between 'health' and 'wellbeing'. Wellbeing was seen as a non-medical concept and was associated with health promotion. Prevention of mental health problems (e.g. prevention of suicide) was associated with a medical model. This distinction was a common one throughout the interviews but the overlap between these two concepts in theory and practice was often recognised, as MaPH5 notes "it is actually a heterogenous basket of different things".

3.3.1.2. Implicit dualism in public mental health placements

Four of the eight participants in PH or PMH roles described the way that placements might be conceptualised as a 'public mental health' placement according to 'mental health' and 'wellbeing' dualism. Accordingly, placement opportunities were often located in clinical service or 'health' settings, or oriented towards a 'wellbeing' agenda.

The lack of a shared understanding of 'what public health does' emerged in other interviews. Participants discussed the dilemma of what would be identified as a mental health placement, due to a lack of understanding between public health and local authorities. A particular issue seemed to be that possible sites of intervention for primary prevention work might not be recognised by others as relevant to 'mental health'.

PH1: It would either, be, you know, can you go and work with CAMHS or with um, it would be that clinical, not necessarily that population, mental health. I don't think they [...] would have a placement in housing looking at the impact of poor housing. You know insecure housing too expensive and all that. I don't think those dots have been joined and even though public health have been in the local authority for... five years plus no- longer? I still don't think there's a huge understanding from the local authority of what public health does and from public health, what the local authority does

This participant had been asked about the range of placement opportunities that could conceivably be available to trainees wanting to develop skills in public mental health, and housing was mentioned in the interview question as a prompt to explore non-treatment service settings. The participant expresses the dualism between clinical services and settings related to upstream determinants, giving the example of Child and Adolescent Mental Health Services (CAMHS). A lack of integration between public health and the local authority is also highlighted here as a contributing factor to the dualistic way of conceptualising mental health as a matter for health services.

Participant PH3 described mental health-related placements as those ranging from service settings such as perinatal mental health through to wellbeing work, which focused on resilience. However placements focusing on primary prevention were not listed.

PH3: registrars have undertaken mental health projects within local authorities [...] there's been a couple on mental health needs assessment, one working on suicide prevention, a couple of registrars actually linked in with Public Health England... one is with [external organisation] on the strategic approach to health and wellbeing, which has got a large focus on mental health and resilience. That registrar's also undertaken some work on perinatal mental health with one of our academic units.

Another participant commented on how the integration that was hoped for between local authorities and public health had not happened. They linked this to an enduring uncertainty about whether work on social or environmental determinants would be identified as the work of public mental health.

PH5: the whole point of moving public health into local authorities was to ensure that practitioners and in this case trainees have the opportunity to engage with you know whether it's housing, whether it's communities, whether it's green space, whether it's some of the things that the local authority do around you know, commissioning treatment, they should be well placed to

have a coherent and overall view of public mental health and how some of the projects could and should promote positive mental health and wellbeing [...]my point is would somebody recognize you know if it's around green space or access to you know the built or urban environment, would they recognize that as a key driver to improving mental health?

In summary, placements were generally concerned with secondary prevention, located in clinical service settings or focusing on a particular issue such as suicide or self-harm, or 'wellbeing' activities such as resilience building. There was a lack of clarity as to what a PMH placement might look like that was concerned with primary prevention of mental health problems. Ideas about upstream placement settings invoked pre-existing projects and 'wellbeing' seemed to be viewed as one of a number of potential positive outcomes rather than as a central focus

3.3.2. Theme 2: The Relationship between Concepts, Workforce and Service Structures

An overarching theme was how the differentiation between 'mental health' and 'wellbeing' related to the organisation of the workforce and service structures. Organisational and professional remit appeared to both shape and be shaped by these ideas, with implications for ownership of prevention and promotion in population mental health. Discussions of professional remit also touched on issues of power and the boundary between health and the political sphere. The understanding of 'mental health' and 'wellbeing' in the wider workforce also connected with issues of professional status and parity of esteem, with implications for the training of incoming public health specialists.

3.3.2.1. Public mental health falls in the gap

Seven out of eight PH/ PMH participants described how the dualism of 'mental health' and 'wellbeing' permeated perceptions of public mental health's role, and the understanding of professional remit. Participants felt that 'mental health' was often understood as an NHS issue, to be left to psychiatry and outside of the remit of local

authorities or public health. 'Wellbeing' on the other hand was a term recognised to be within the remit of local authorities and public health.

PH6: when I was Director of Public Health in a local authority context we would always talk about wellbeing 'cause it's a word that they understood as their responsibility [...] as soon as you put the word "health" in they said "ah well that's the NHS's problem"

Participant PH6 indicates how conceptualisations of mental health determine the way it is responded to, and under whose jurisdiction it falls.

As public mental health bridged the domains of mental health services and public health it could fail to be adequately addressed by either:

PMH1: you either do pure public health or you do pure psychiatry and unfortunately public mental health falls in the gap and I think this is something that's been really there for a long time and I think you know it's always someone else's job [...] that public mental health population approach to mental health I think is absolutely critical and missing in both public health and mental health treatment.

'Mental health' was thus viewed as lying within the domain of treatment and therefore the responsibility of psychiatry and mental health services. Prevention and promotion are considered less the domain of 'mental health' than 'wellbeing'. As a result, population approaches to 'mental health' were "always someone else's job".

The gap between the two domains was also exemplified by service structures, the lack of a defined workforce and the lack of roles which attracted professional esteem. One participant, whose role was primarily in mental health improvement as a public health practitioner, described the confusion of colleagues who wished to know her professional clinical title and her view that a standardized qualification for professionals working in 'wellbeing' would "lend kudos" (PH1). This could be linked to the debate around parity of esteem, whereby situating the work of 'wellbeing' outside of the 'mental health' medical model diminishes its status and value.

PH1: I think it's just that whole population mental health agenda really. Because it's not really well understood. As soon as you talk about public mental health [colleagues] think mental illness [...] People think like as I said previously that I... Am I qualified as a clinician or a psychologist? I think there is a need for that. Just a bit of a standardization really.

The differentiation between 'mental health' and 'wellbeing' dualism was also exemplified by a perceived focus on a traditional treatment-based service model:

PMH2: we invest in a lot of individual approaches that are professional-led, that are suited to our organizational structures. And the need to sort of turn that around really. And think of it from a community perspective. And what needs do the community have and how can it be more Community-centred

Here conceptualisations were seen to reflect existing structures and professions whereas an alternative community-based approach might require a transformation of traditional structures.

3.3.2.2. The challenges of primary prevention and action on social determinants

A theme across both MaPH and PH/ PMH interviews was the challenge of taking action on wider determinants, both regarding the means of effecting change and the factors that should be targeted. Four out of six participants from MaPH courses discussed this as a key aspect of the teaching.

MaPH2: a lot of what we would be trying to work with students on would be how do you engage with the determinants? What can you do to you know... How can you understand them, and then make a difference to them?

However, as this participant noted, the location of public health within the local authority opened up the potential for upstream intervention though this potential was tempered by the need for interventions to be guided by pragmatic considerations (e.g. which officials are "going to make the energy").

MaPH1: not many people in the academic world have sat about in a district health authority or a local authority trying to change public health so they have a rather... airy fairy view of how you do this stuff ... But you are actually looking to shift a system. And if you're working in a local authority and you've got one of the counsellors dead keen on doing something in the local schools, it doesn't matter how much you want to work on food banks - you go and work on schools because you've got somebody there who's going to make the energy

In addition to pragmatic issues, participants also distinguished between the remit of public health and government, with wider determinants being seen as within the economic or political sphere.

MaPH3: it's always a tension [...] the scope of public health [...] early on the question I pose to [students] is what should the scope of public health be? So the whole trajectory through the 20th century has been in some ways broadening out the scope of public health and asking questions of more and more kind of, social and political questions I guess, economic questions

However, six of the eight PH/ PMH participants reported that addressing determinants was difficult. For example, academic models might be unrealistic and a more pragmatic approach to change might be required.

PH3: people are looking at the things that they can actually make changes to or help with because actually like you say, if you're looking at the causes of causes well, then you're stepping into politics. Now we've got a Tory government. So that yeah, um, you know, and you know, if you look at the benefit system in this country, you know. So these are the things that we can actually alter.

This recognition that many social determinants could only be addressed at the level of national government policies created a dilemma in that, whilst they might be seen

as having a responsibility for addressing social determinants, they might lack the power to do so.

One response to this dilemma was to focus on smaller scale practical interventions, which reflected a discrepancy between theory and practice:

PH6: you'll find in people in public health will, certainly on a theoretical level will be more on the kind of wider determinants side, but you know, on a practical level of what they do in their day job may well focus a bit more on specific things that can be done.

However one potential effect of this might be that such interventions might be unsystematic and ad hoc, an issue which will be addressed in other themes.

3.3.2.3. Public mental health is marginalised and excluded

The view the public mental health fell in the gap between NHS services and public health was exemplified by a perceived lack of status of public mental health. This sub-theme connected various issues raised across the interviews concerning the de-emphasis and marginalisation of public mental health in a range of ways.

Among the PH/ PMH participants this was a prevalent theme, arising in 6 out of 8 interviews.

PMH1: we're really looking at 1/3 of UK disease burden due to mental disorder. And yet it's 2% of public health spend, and I think that then links to education and training [...] I think mental [health] is really, I think, disproportionately excluded [in training] given the opportunities it offers to public health and this may in fact relate to possibly broader issues of discrimination, stigma, or just lack of understanding about what those opportunities are.

The participant PMH1 above expresses how priority-setting at the level of funding allocations shapes attitudes and priorities downstream, believing mental health to be

“disproportionately excluded” in training. They also hypothesise that the reason for this may be a lack of understanding about the opportunities public mental health approaches can bring.

With regards to public mental health roles, the same participant highlighted their impression of how specialty roles in public mental health were valued.

PMH1: my [NHS Trust] don't see public mental health as a part of their work, so they will not fund any of my time. So I have to work [full time in another role] and do my public mental health work in my own time [...] that's the value they put on it.

This extract demonstrates a case in point of the organisational confusion regarding ‘health’, ‘wellbeing’ and public health remit: the NHS sees itself as concerned with psychiatry and treatment and sees public mental health as ‘someone else’s job’, yet ‘someone else’ does not step in to hold that remit and provide funding.

The marginalisation or de-valuing of public mental health work was also indicated through the demand for public mental health placements by trainees.

PH5: I've been a consultant for some time and an education supervisor in the NHS and local authorities supervising trainees... from a medical and non-medical background. Nobody has come up and said, you know I would like to do a placement in a mental health trust [...] They wanna do other placements: Field Epidemiology, Health Protection, Colindale, you know specific interests in various, you know, infectious diseases and all the rest of it.

This extract demonstrates that public mental health is marginalised even within the discipline of public health, with medically-oriented fields attracting most attention from trainees.

The following extracts highlighted the lack of professional status and esteem held towards those working in public mental health. Participant PH5 noted the lack of visible leaders in academia.

PH5: I couldn't point to the profile of somebody in a public mental health specialist: "professor in..." You know, I don't see anybody in public health who has that profile. You've got [name] [...] quite prominent in the field. I see lots of people who are, you know, working in the area. Yeah, but do they have that level of profile, I don't know

Linking with the 'health' and 'wellbeing' dualism observed in earlier themes, one participant described the relatively lower status of public health speciality roles compared with medics, indicating the sacrifices needing to be made by those choosing to enter the field.

PMH2: there's certainly a loss of status and pay for people who've been in medical training and so then go into public health, but they're people that have seen the light and want to do prevention rather than only treatments

Two out of six MaPH interviews touched on this theme, which helped illustrate the pervasiveness of this disparity in public mental health. The participant MaPH1 expressed the issue of public mental health's status in academia.

MaPH1: And then I moved to [University]. There was an absolutely no way I was going to get a chair in [University] working on that sort of stuff. Absolutely no way [...] And the students on the course don't take [teaching on PMH] because it's "what's that got to do with public health?"

It is possible, therefore, that the perceived lack of professional status might lead to a vicious cycle – teaching and placements might not be offered because they did not align with trainee interests, and trainees would continue to miss opportunities to develop knowledge of public mental health.

3.3.3. Theme 3: Conceptual Frameworks informing the Curriculum

This theme concerns the conceptual frameworks that underpinned the definitions and models used by participants when making sense of ‘mental health’ in teaching. Three sub-themes related to this. Firstly, mental health was seen to be subsumed by health, with implications for understanding the determinants of mental health. Linked to this was the sub-theme of approaches to teaching, and the debate around ‘integrated’ versus ‘segregated’ teaching, reflecting the general subsuming of mental health into health. The final sub-theme concerns the explanatory causal models arising in the interviews, namely the understanding and application of a bio-social framework.

3.3.3.1. ‘Health’ seen as subsuming ‘mental health’

This sub-theme concerned the lack of differentiation between overall or physical health and mental health. Key aspects of this were the notion that determinants of mental and physical health were the same or did not need to be meaningfully distinguished, as part of making sense of mental health and wellbeing. This sub-theme was more prevalent in the MaPH sample, referenced in four of six interviews.

MaPH2: in my [course title], that is about overall wellbeing which includes mental wellbeing, it's is not just about, I mean hopefully by then the students have got the sort of got the message that it's not just about a medically defined definition of health, it is much broader than that [...] I've always felt that mental health, we shouldn't really separate it too much from physical health because the determinants are the same and public health is largely about the determinants.

This extract highlighted the idea that the determinants of mental and physical health are the same, and therefore theorising about ‘mental health’ and wider determinants was either not necessary or was part of other content discussing wider determinants, perhaps in the context of physical health.

Two out of eight of the PH/ PMH participants also alluded to this issue. One participant noted that the understanding of wider determinants was confused by the 'health' and 'wellbeing' dualism.

PH5: I think often the literature is a little bit muddled. I think we probably think about mental wellbeing much more when we're thinking about determinants than about mental illness and [...] when we think about mental illness, it's much more about so, what kind of what kind of treatment, care, and support do people with particularly severe and enduring mental health problems need?

There seemed to be a lack of clarity as to the role of wider determinants in 'mental illness' and 'wellbeing', which links to the way in which prevention and promotion are understood in practice and the associated division of labour. Mental health or "illness" seemed to be outside of the scope of prevention or promotion.

3.3.3.2. 'Integrated' versus 'segregated' approaches to coverage of mental health

Related to the previous sub-theme, a recurring dilemma in the interviews was whether or not teaching and training should provide specific content differentiated as public mental health, or whether it should be integrated among other topics. This sub-theme was identified in three of eight PH/ PMH interviews.

PMH2: that, whole you know segregated versus integrated approach, which is always there when we talk about mental health, that old "This is part of everything we do anyway, so we don't need to single out specific mental health and competencies, skills needed" [...] it tends to be mental health tagged onto health. You know, health described that is mental and physical health without really getting into the detail.

This participant emphasized the prevalence of this way of approaching public mental health teaching, and related this to the kind of skills and competencies trainees were thought to require for the work. The implication being that public mental health is

something incidental to other aspects of public health theory and practice, enshrined in competency frameworks.

PH6: there's always this thing about having you know, cross cutting issues are at risk of being lost, but they're also at risk of being lost if you have one learning outcome that people then tick. I've done my public mental health outcome I don't need to do it again. You want to see this is across... you know you'll be picking it up at all sorts of points in your training, but the danger is then people might not even notice that they've done it, or that they are doing or might not have that sort of focus.

The context of this comment was the debate around foundational content for a time-limited course covering a large area of possible topics. The participant explained that many other issues are often subsumed in a similar way to public mental health teaching, such as issues around public health ethics, climate change or artificial intelligence. This was partly a pragmatic approach to covering wide-ranging topics in a limited time, and there was an acknowledgement of the pros and cons of this approach. It also connected again to the conceptualisation of 'mental health' and 'wellbeing' as a "cross cutting issue". The concerns about delivering teaching in a siloed or 'tick box' way echoed comments from other participants.

Three out of six MaPH participants discussed this.

MaPH4: In some ways I think embedding what we would call public mental health issues into, across the modules in some ways might actually save it from becoming too medicalised. Because then if you have a discrete module on public mental health you're almost saying it's something out-with [...] the danger that it becomes a little bit siloed

'Siloed' teaching was a concern because of the potential of over-emphasising a distinction between mental health and physical health. A key concern appeared to be that segregating teaching would lead to it being presented in a more "medicalised" way.

MaPH2: I think mental wellbeing is part of health and it would I feel uncomfortable with kind of pigeon-holing it apart and saying it's not, you know something that you think of separately to general wellbeing or general health

Integrated approaches to teaching were discussed more favourably than “siloed” or “pigeon-holing” teaching, and this was linked to the way mental health and physical health were conceptualised.

3.3.3.3. An emphasis on bio-social explanatory causal models

While all MaPH participants said that ‘mental health’ or ‘wellbeing’ would be touched upon in some way during teaching, usually as an example of another core topic area, most participants did not have a clear sense of what models or frameworks were used in teaching to make sense of these concepts. Two out of six interviews with MPH participants referenced a biopsychosocial model, however the psychological aspects of this were not clearly articulated. One participant described the importance of early childhood relationships for the development of resilience associated with neurophysiological development and allostatic load.

Instead, a bio-social model appeared to be the implicit framework used in teaching where issues of public mental health were covered. Four out of six MaPH participants raised this.

MaPH6: The thing that should knit it altogether is the biopsychosocial approach to everything. And you know when, when we're considering the determinants of health that the full range of determinants are considered and you know the medical model only goes so far.

“Biopsychosocial” was referenced in a vague, catch-all manner, constructed as something distinct from the medical model. It was not clear whether this was understood as a non-medicalised model, or an extension of the medical model that also encompassed non-medical aspects like social context. This related to conceptual confusion in the definitions of ‘health’ and ‘wellbeing’ whereby ‘mental health/ illness’ was a binary medical concept, and ‘wellbeing’ sat outside of medicine

in the realms of social context and psychological wellbeing. Participants did not differentiate whether this framework applied to both 'mental health' and 'wellbeing'.

Reference to the biopsychosocial model also lacked clarity as to the psychological components of the model. Generic 'determinants' presumably referred to social determinants. The following extract provided an example of how psychological factors or processes were not explicitly considered, and the adoption of an implicit bio-social framework.

MaPH2: Um, I think it would be a mixed bag or sort of... A mixture of sort of biochemical and social determinants. I think it would be a brave person who tried to argue that it was only one or the other. Yeah, I think that would be wrong. I suspect people kind of leaning towards one or the other depending on their background and their sort of life experience I guess.

Again, psychological processes were unarticulated. The participant highlighted how a bio-social framework was not formally agreed upon and used implicitly, and emphasis on the 'bio' or 'social' varied according to the "background" of the person making sense of the issue.

Three out of six of the PH/ PMH participants touched on a bio-social model. The lack of theorizing about mental health under this framework was pointed out in the following extract.

PMH2: lots of work on health behaviours without understanding the causal pathway between the two and not, actually mental health explains how wider determinants impact on health behaviours [...] you know, the impact of poverty on stress and how stress impacts on our health behaviours and directly on our on our physical health and allostatic load etc. That is, I don't think it's understood or applied in practice

This extract highlighted that health behaviours and social determinants may be considered in the way mental health is thought about in teaching. Mental health was considered to be a mediator between wider determinants and physical health,

through physiological stress processes like “allostatic load”. Again, there was no articulation of psychological processes involved in causal framework of the determinants of mental health.

In summary, participants invoked a bio-social model that varied between participants, rather than a clearly defined and shared framework. Process models like diathesis-stress were invoked implicitly, usually to try to explain the psychological aspects of the model, although psychological processes only referred to stress and focused on the physiological aspects of stress responses. There was a lack of clarity as to the extent to which the framework was rooted in the medical model or how it applied to ostensibly distinct constructs of ‘health’ and ‘wellbeing’.

3.3.3.4. A lack of depth and sophistication in the coverage of debates

Earlier sub-themes identified conceptual confusion in public mental health and inconsistently and superficially understood conceptual frameworks. This sub-theme focuses instead on the overarching lack of depth and elaboration of public mental health theory and concepts present in the MPH teaching. While this relates to other themes, this particular issue was prevalent across interviews, and can be understood as a structural factor creating the conditions for conceptual confusion, lack of interrogation of theoretical frameworks and obscured assumptions about public mental health.

Five out of six interviews described a lack of in-depth coverage of public mental health. This directly linked to the courses that provided only integrated teaching rather than designated public mental health teaching.

MaPH2: No, they [mental wellbeing and mental illness] are considered as completely different things. So mental illness is a sort of medically defined, mostly condition, whereas mental well, so I have to say we don't talk about... I haven't really talked about this in the MPH. Yeah, I don't. I don't think this is something we really cover very much in the MPH.

Definitions of 'mental health' and 'wellbeing' were not covered in some courses at all. The extract below arose in the context of questioning around the causal frameworks used in teaching to make sense of mental health, and how this linked to conceptualisations of what 'mental health' means.

MaPH2: I have to say this level of debate we don't have in the MPH at all, in relation to mental health it's um... Yeah, I don't think students... would be exposed to any of this until they were working in a health board or an authority and were dealing with some of the issues that come up there. And unless they choose to do something- you know they might do a dissertation on something along these lines... for the bulk, students wouldn't get into this level of discussion about it [...] You know, it's probably the level of depth that you're trying to get from me doesn't really exist.

This extract alludes to an assumption made across the board that trainees would access key debates in mental health on placements. Importantly, access to this was determined largely by trainee preference, indicating that these debates were not considered foundational.

Two extracts below described the course's focus when thinking about mental health. The two contrast in terms of focusing either on disease-centric models or mental health promotion and wellbeing, but both describe a lack of depth in coverage.

MaPH5: I taught on one other MPH [...] I think that where you do have mental health, it's the psychiatry, diagnosed conditions, type stuff and the Epidemiology of schizophrenia. It's not about population mental health

MaPH6: we talk about our mental health promotion strategies, our suicide prevention strategies and then talk about you know what factors contribute to people either developing mental health problems or how they can keep themselves well. It's not covered in great depth. I mean, it's touched upon in various places, but it's not covered in a lot of depth

Six out of eight PH/ PMH participants also noted the lack of depth in teaching around public mental health on MPH courses.

PH5: And actually as having reviewed some of the MPHs as well, that's part of my role, I haven't seen specific modules on public mental health nor how mental health would inform public health practice.

PH1 contrasted the dominant ways of thinking about mental health in public health with other settings, like education, where there is a broader understanding.

PH1: if we work with educational colleagues, they have a totally different language. So they will talk about social, emotional, mental health and that will come from the paperwork [...] from the Department of Education and so their understanding is broader than ours, and then you've got your clinical NHS staff which talk about mental health, which actually what they're really talking about is mental illness. So I think there's a lack of a consistent understanding really of what that word means, and then again obviously you've got the population who think mental health is about mental illness and not necessarily about you know how you feel, how you think, how you behave day to day.

Again this point linked to the challenges of lacking a shared language or conceptual framework about mental health, and the disciplinary differences in making sense of the issue. The “clinical NHS” perspective focused on mental “illness”, or a medical model, and this was viewed as pervasive across the general public.

3.3.4. Theme 4: Structural Causes of an Unsystematic and Heterogeneous Approach

This theme draws together structural issues discussed in the interviews, which shape an ad hoc, unsystematic and pragmatic approach to public mental health teaching and training. This includes the arrangements of the training curriculum and contingency of the interests and availability of staff and supervisors, impacting MPH teaching and placement training opportunities. This also included the wider culture

and approach to public health, including outcome-driven cultures, which disincentivised public mental health approaches. Lack of psychological thought leadership in shaping theoretically coherent understandings of public mental health was also a sub-theme. Finally, the wider political context was considered, as a major structural factor contributing to the current unsystematic and heterogeneous approach.

3.3.4.1. Curriculum and dissertation topic dependent on the interests and availability of staff

Participants highlighted the intentional permissiveness of the curriculum, focusing on high-level competencies, viewing public mental health as a specific health issue that should be woven into teaching along with other health topics at the discretion of the MPH.

An important structural issue shaping the MPH curriculum relates to the Faculty diplomate exam syllabus. This was relevant to both the MPH curriculum and the ongoing placement training.

MaPH6: we try to align it with the Faculty of Public Health syllabus for the diplomate exam. So while mental health will be referred to in there it's only a tiny part of a huge curriculum, you know so. I guess we recognize the importance of it, but you know, we have so much else we have to cover

PH5: The Faculty of Public Health exams aren't aligned to it, so therefore nothing is going to change. We're not gonna teach our registrars if it's not in the curriculum, they're busy enough

Five out of six MaPH participants described the various practical challenges of curriculum development. One key issue was the expertise available in the department as a limiting factor on designing and delivering teaching.

MaPH3: We used to have a session on mental health but then that member of staff left. So we didn't have the expertise so shifted slightly.

The following extract also describes the importance of expertise outside of the department.

MaPH4: You're always looking at things you can add in, things you can improve, and partly it's down to the interests and expertise of the people who, not just in the core team that deliver programs, but also the people who you know around.

Another participant highlighted the role of departmental staff in nurturing interests in trainees, the implication being that trainees are less likely to pursue a public mental health specialism given the relative lack of public mental health coverage and academic staff with the specialism.

MaPH2: In theory students could look at any [dissertation topic] they're interested in, but in practice often they'll still be, you know, will be enthused by something that's covered in one of the courses that they've taken, or by somebody that they've met, one of the academics that they've met.

This extract also echoes other interviews, where dissertation topics were viewed as a means to cover gaps in the curriculum. Again, this was down to the interests of the trainee. Another participant also highlighted that dissertation topic supervisors would tend to be matched with trainees according to methodologies rather than subject area, requiring trainees with an interest in public mental health to self-direct their learning.

3.3.4.2. Placements dependent on the interests of trainees and supervisors

Despite the assumption that trainees would garner public mental health expertise through placements after the MPH, there was no systematic approach to allocation of public mental health placements. Three of six MaPH participants commented on this, given their understanding of the placement training aspect and connections with specialist training programmes in their region.

MaPH2: if you were to say to your educational supervisor, “I’m interested in mental health” and I was trying to find somebody to suggest that you had a [placement] attachment, I would be looking for a consultant who had a named interest in mental health, probably, which is most likely to be in an NHS board

MaPH6 made the same point acknowledging that “no trainees are ever going to get the same experience”.

The need to be pragmatic about meeting competency requirements and finding placements with supervision impacted the consistency of training experiences in public mental health.

This issue was picked up in six out of eight PH/ PMH interviews.

PH6: So it depends on... the availability of projects to do mental health and in that sense you know people will vary in the amount of public mental health they do, because if they work in a setting, so for example, we've had a public health consultant in the Mental Health Trust for a good 20 years. So there's always been a placement in the Mental Health Trust [...] other people might have been working on, say, smoking cessation in Mental Health Trusts or you know or commissioning of mental health services so there's a whole range of opportunities but. Um, but, you know, but equally it would be possible to go through training without necessarily doing much mental health.

Again this extract linked to the issue of what is considered a public mental health placement: a heterogeneous selection generally oriented around treatment services. This ad hoc approach was likely to be a pragmatic solution to a lack of upstream settings explicitly identified as related to public mental health, and the relative availability of placements in NHS settings likely to take a more clinical or psychiatric orientation towards mental health.

Another participant commented that, as with the content of teaching, the content of placement experience and the competencies developed within them reflected the interests and backgrounds of supervisors.

PH5: I suppose the third element is people like myself and their supervisors their educational supervisors, their placement supervisors, and how we are able, perhaps trained, perhaps competent, capable or able to have an influence on the way that they consider public mental health. I think, in terms of the overall training package

3.3.4.3. Conceptualisations of 'outcomes' shape approach

This sub-theme related to how public mental health approaches are limited by dominant ideas about how it should be measured, both in the evidence base, and in practice-based evidence such as monitoring service performance.

Three of the MaPH participants highlighted the issue in relation to the epidemiological evidence base. The extract below raised the importance of how outcomes were conceptualised and measured, which impacted the understanding of the importance of mental health issues for population health. It was important whether outcomes were measured in terms of a reduction of mental illness or 'disease', or improvement in quality of life.

MaPH1: So once you get onto "QALYs", quality adjusted life years, [mental health] gets a bit more important. So then it starts ranking with heart disease and cancer.

Dominant outcomes and Key Performance Indicators in Public Health created challenges for quantifying the impact of interventions.

MaPH5: the challenge is how on earth do you measure any of these- social prescribing I think is a good example of this [...] you know, we're driven in a performance culture to measure stuff, but you just can't measure some of it.

This linked to other comments from participants who described a pragmatic approach to focusing interventions on proximal determinants or compartmentalised

issues, such as a smoking cessation intervention, and highlights how the requirements of commissioners shape the kinds of work available.

Two out of eight PH/ PMH participants spoke about dominant concepts of morbidity and mortality, and the relative focus on mortality over morbidity.

PH6: I think it's a problem in public health sometimes because we tend to focus on causes of premature mortality rather than morbidity [...] Yeah, what's reducing people's quality of life, you know, what are the causes of morbidity [...] you know often when people are looking at data they focus on mortality and that tends to reduce a focus on mental health. Um, they end up with just looking at suicide rates as a sort of... almost a proxy for mental health issues, and so I think that's a bigger picture issue that actually we underestimate mental health because we focus on mortality rather morbidity

The focus on mortality overshadowed the important impact of mental health issues, and led to “proxy” measures of mental health being used in research, such as suicide rather than quality of life.

3.3.4.4. Visibility and leadership from mental health professions

The lack of elaborated psychological understandings evidenced in public mental health teaching was linked to a lack of visibility of psychology, both in terms of theoretical perspectives, and advocacy and leadership.

One participant from the MaPH sample commented on the differences in how public mental health is conceptualised from a psychological perspective compared to a medical perspective, which was the participant's background before specialising in public health.

MaPH5: I genuinely think you guys have no idea just how little we understand. It's just such a different way of thinking

The comment arose in discussion about how psychological theory is communicated by psychologists, and that it can be received by non-psychologists as abstract, hard to apply and hard to understand. There was a sense that psychologists were not active in disseminating psychological theory in the field of public health in a way that was accessible or could be utilised.

Three of the eight PH/PMH participants touched on this, citing a need for support to both provide alternative conceptual frameworks and be available to explain these. The “mental health” profession was seen as not being represented in influential or high-profile posts, in the same way as other professions, and it was implied that psychological theory and ways of working were not disseminated:

PH6: we sometimes need a focus or someone to kind of explain things and give you kind of frameworks for people to work on because it feels a bit different in terms of physical health. I don't know whether the government has a chief psychology officer. I mean the thing is there's a lot of mental health disciplines and, you know, maybe some leadership from them in terms of [...] visibility to the other professions [...] mental health professions don't seem to be visible in that sense

3.3.4.5. Impact of the political climate on public health

As noted in the introduction chapter, public health services have been devastated by funding cuts, in parallel with cuts to vital community services and organisations whose work directly and indirectly supported public health aims. Participants frequently referred to these funding constraints as a key structural problem.

Five out of eight PH/ PMH participants discussed this issue.

PMH1: “You're welcome to do public mental health, but we're not paying for it. You can only do it if you get secondment to other organizations” so you know sort of the problem is public health has lost all its funding.

PH6: there is a tendency politically to look for an intervention. A neater intervention. You know, in terms of you know, increasing access to psychological therapies that the... you know health intervention is often politically the more popular choice than saying that some of our national policies are a problem here and we need to deal with the deeper issues than just putting more psychologists into the care system.

This extract from PH6 linked to the previous sub-theme (section 3.3.2.2.), regarding the challenge of action on social determinants requiring policy-level change, which led to a focus on treatment services as a pragmatic solution.

PH1: The whole Every Mind Matters campaign came from a... the Conservative Government. I think they included it in the manifesto or something where they said they would train, I don't know, something ridiculous like a million people in mental health first aid [...] it's just really frustrating that you kinda go: "really? Is that what we're looking at?"

These extracts describe the influence of political agendas on population mental health practices, leading to unsystematic interventions aligning with fashions and prevailing narratives, for example around resilience, self-care and 'illness' or treatment.

Three out of six MaPH participants mentioned this as central to the difficulties in delivering a population approach to mental health. The following extract highlights the way public health has been disproportionately targeted by the cuts, and how this has solidified the division of labour and perceptions about professional remit.

MaPH3: we have, of course, the last 10 years been working under austerity, which... public health has been an easy target. And we've seen huge decreases to public health funding, which again I imagine would have made it harder to shift responsibilities or to amend responsibilities.

Another participant highlighted a disconnect between the interview's focus on knowledge and skill development, with the realities of resource and capacity after a

decade of austerity. The sense being that the workforce was equipped with the necessary skills and knowledge but unable to deliver due to funding.

MaPH4: they do not have the resources and the capacity to address issues that were already getting out of hand in different parts of the country in different regions, but now are frightening to be honest [...] I'm always a little bit dubious when it comes to [...] looking at professionals improving their skills, their knowledge, all that kind of thing. And then if you look at communities now, it seems you know increasingly becomes about increasing their resilience but all of that is often a response to poor resources [...] from my perspective, yeah, chronic lack of resourcing and support for teams for public health teams is real is... the underlying cause really.

This extract also makes the link between the political climate and the 'wellbeing' agenda, implying that when wider context is deteriorating, attention shifts to helping people cope with it. This may connect with earlier comments about the division of labour and public health's remit; the more politicised and overwhelming the determinant, the less it is seen as the remit of public health and the greater the pull towards small-scale, affordable intervention packages.

4. DISCUSSION

The aim of this study was to explore the coverage and content of mental health teaching available to trainees on the public health STP. In addition to gaining an insight into how widespread mental health teaching is, the study also aimed to understand more about the conceptual frameworks and theoretical aspects of the teaching, both in terms of the taught content in MPH courses and in terms of the settings of placement-based learning. Given the lack of research in this area, the study aimed to elucidate some of the wider issues contributing to training, both in terms of barriers and facilitators.

Four themes were identified in the analysis of fourteen interviews: 'lacking a coherent conceptualisation of mental health'; 'the relationship between concepts, workforce and service structures'; 'conceptual frameworks informing the curriculum'; and 'structural causes of an unsystematic and heterogeneous approach'. This chapter discusses these findings in relation to the research questions and literature. The strengths and limitations of the study are then discussed, and the potential implications of the research are considered in relation to both public health and clinical psychology.

4.1. Research Questions, Findings and Previous Literature

This section discusses how the findings of the study speak to the research questions and literature. Each research question is addressed in turn.

4.1.1. To What Extent is Mental Health Covered in the Specialist Public Health Training Programme?

4.1.1.1. Coverage in the MPH

Out of 43 MPH courses identified across the UK, only four offered a module focusing on mental health, and only one of these modules focused specifically on public mental health. These modules were all optional. Seven core modules were found across six courses that included mental health in the module description. This finding is

consistent with previous research finding a low coverage of public mental health in the module outlines in MPH courses (PHE, 2016).

In line with coverage across the UK, the sample of participants linked to MPH courses in this study described very limited coverage. Four out of the five MPH courses represented in the sample did not mention mental health anywhere in their online module outlines. While one participant represented an MPH with a public mental health oriented optional module, the majority of participants described mental health teaching as being woven through other core or optional topics, such as research methods, or public health principles. This integrated approach was implemented in an ad hoc way. Mental health may have been discussed as an example of another public health topic, such as conducting health needs assessments, rather than as a distinct area of inquiry. Mental health would also be more likely to be covered if the departmental staff had particular expertise and interest in the area, which left it liable to marginalisation, particularly in light of the relatively low profile of public mental health, which is discussed further below.

There was a clear sense across interviews that teaching on mental health was not covered in depth, with some participants reporting that even definitions of mental health might not be discussed in the teaching. Participants struggled to identify key models, theories or frameworks that would be used in the teaching of mental health issues. The lack of depth of coverage was linked by participants to the challenge of devising a curriculum for a time-limited course, the implication being that other areas were deemed a higher priority. The factors contributing to the prioritisation of different topic areas was linked to the Faculty Curriculum (2015) and other wider issues, discussed further in following sections.

Another reason for ad hoc and superficial coverage was linked to the debate around integrated or segregated teaching on mental health. Participants raised concerns that stand-alone teaching could become a tick-box exercise, implying that this would not be a solution to superficial coverage and that integrated teaching was conceptually more meaningful. They highlighted concerns about the conceptual coherence of segregated teaching: integrated teaching was justified by the conceptualisation that mental health was subsumed by health, sharing the same determinants, and therefore

should be considered alongside other issues concurrently rather than through specific teaching. This echoes the discourse in high-profile strategy (for example Department of Health, 2011), but indicates that key issues fundamental to theoretically-grounded public mental health approaches may not be widely appreciated. For example, the important debates about the differences between mental and physical health and the issues with understanding mental health through the lens of the medical paradigm (Middleton & Moncrieff, 2018).

The lack of dedicated teaching meant that many trainees would need to self-direct their learning around public health. Dissertation topics were viewed as a means to cover these gaps, with trainees able to choose their area of interest, however there was a lack of clarity as to how trainees would access key theoretical works and debates in the course of their academic component of the STP.

4.1.1.2. Coverage in placements

Opportunities for specialty trainees to develop skills and knowledge in public mental health were also limited. Unlike the MPH coverage, which appeared to be amenable to the interests and priorities of academic departments, the placement training relied upon the existing settings and work streams ongoing in the region. Trainees wishing to gain experience in public mental health would most likely have been allocated to clinical mental health settings within the NHS, or discrete projects with a mental health aspect, such as alcohol harm reduction services. Fewer participants described mental health promotion work as part of the placement training of trainees, which may reflect the predominant role of public health practitioners in promotion work rather than specialists.

The lack of access to placements offering experiential learning in preventative approaches to mental health reflects the general lack of primary prevention work taking place around mental health (Goldie et al., 2016) and indicates the kinds of skills and experience public health specialists have the opportunity to develop. In general, public health speciality trainees wanting to undertake a public mental health-oriented placement would be practicing in settings dominated by psychiatric paradigms with a focus on treatment rather than primary prevention.

Placement settings were also determined by the availability of a suitable educational supervisor. This issue connects to wider systemic factors in the landscape of public mental health, particularly the lack of preventative public mental health work being implemented and the paucity of specialists in the area. This links to issues that are discussed in more detail below, particularly the marginalisation of public mental health in funding allocation, the status of public mental health work within the discipline and relative to medicine, and the lack of conceptual depth and elaboration that help to perpetuate these issues.

4.1.1.3. Summary

Coverage of mental health teaching and training opportunities was very limited for speciality trainees. The sampled MPH courses rarely provided any focused teaching on mental health, and favoured an approach that wove mental health into other topic areas, or relied on trainees to self-direct their learning. This promoted an ad hoc approach to mental health teaching and facilitates marginalisation of teaching. Placement experiences were similarly limited, and were viewed exclusively in terms of settings doing 'mental health' work, which amounted to clinical mental health settings, with participants unsure what a primary preventative placement would look like. Some participants recognised that there was a lack of appreciation across public health and local authorities, that many areas of local authority work lent themselves to primary prevention mental health work. This highlighted missed opportunities related to how mental health and prevention are conceptualised and the pervasiveness of psychiatric understandings as a barrier to learning opportunities in the STP.

This approach to teaching and training raises questions as to how trainees are enabled to access some of the key critical debates relevant to public mental health, and to develop understandings outside of the psychiatric paradigm. This has implications for the extent to which trainees leave training with the knowledge to challenge and transform the current focus on treatment, and promote preventative approaches. It also indicates how the status and value of public mental health is communicated implicitly, through the lack of teaching or the cursory coverage of topics secondary to other core topics.

4.1.2. What Theoretical and Conceptual Frameworks are Drawn Upon in Teaching and Training?

There was a general lack of clarity and consistency across interviews regarding the theoretical and conceptual frameworks drawn upon in teaching, particularly in the explicit curriculum of MPH courses. This related to conceptualisations or definitions of mental health, the frameworks used to understand the causes of mental health problems in the population, and the meaning of the medical model of mental health in public health.

4.1.2.1. Conceptualisations of mental health

A global theme in the analysis was the 'lack of a coherent conceptualisation of mental health'. Confusion and lack of a shared understanding around the language of mental health was mentioned in both sample groups, and echoed sentiments in the literature. Many participants distinguished between concepts of 'mental health' and 'wellbeing', implicitly or explicitly drawing on the dual continuum model of mental health and wellbeing (Keyes & Lopez, 2002). 'Mental health' was also used as a euphemism for 'mental illness', while 'wellbeing' was considered a less pathologizing or medicalised term.

Several participants commented that these concepts were not well-delineated and overlapped in theory and practice. This touches on criticisms of the 'wellbeing' construct (Davies, 2013) and indicates unresolved conceptual issues in the way public health defines mental health. Yet the dualism seemed to significantly shape the approach to mental health teaching and placement training and promote gaps in teaching. In the MPH, some courses focused their limited teaching on either wellbeing or mental health, the latter taking more explicitly medicalised psychiatric perspectives.

The significance of the dualism for placement learning was linked to the parsing out of wellbeing as a health promotion activity, and mental health or illness as a health service activity, leaving the prevention of mental health problems to "fall in the gap". This is consistent with implementation and strategy documentation which shows a

preference for interventions focused on individualised wellbeing initiatives and increasing access to services (Goldie et al., 2016; Kings Fund & PHE, 2017). The primary prevention work is marginal, hence the lack of placement opportunities in this area.

A sub-theme relating to the conceptualisation of mental health in teaching was that 'health was seen to subsume mental health', whereby participants described a preference for integrated teaching due to mental health being conceived as integral to overall health. The conceptualisation of mental health as part of overall health is a widely held notion in the white and grey literature, however this appeared to lead to assumptions that mental health did not entail unique theoretical considerations worthy of dedicated teaching. This also implicates an assumption that a physical health 'lens' can be taken to the understanding of mental health in teaching, and disregards well-documented critiques of the application of positivist medical paradigms to phenomena such as human experience (Middleton & Moncrieff, 2018).

4.1.2.2. Causal explanatory frameworks of mental health problems at population level

There was a notable lack of depth and elaboration around causal frameworks of mental health problems in the explicit curriculum across MPH courses. The sub-theme regarding the conceptualisation of mental health as integral or subsumed by overall health arguably played out here, as the interviews indicated a lack of rationale for in-depth, dedicated mental health teaching. As one participant put it: "the determinants are the same" for physical and mental health. Another participant mentioned the discrepant focus on health behaviours in the work, but that the causal pathways were still poorly understood.

The biopsychosocial model was referenced by name, though when participants described what was meant by this, only biological and social factors or processes were described, in general terms such as "biochemical" determinants and "stress". Stress was invoked as an intermediary between context and biology in line with a diathesis-stress model and it was unclear whether stress was conceptualised as the psychological component of the causal framework. However it tended to be described in terms of its impact on health behaviours and allostatic load, rather than other

psychological processes such as shame, erosion of trust, or the psychic impact of disempowerment and threat (Johnstone & Boyle, 2018). This is in line with literature, which makes claims to a biopsychosocial approach but often lacks depth in articulating psychological aspects and rarely references psychological theory (PHE, 2017c). The invocation of the diathesis-stress model and unelaborated psychological mechanisms reflects the dominant thinking in the public mental health literature. Critical debates around mental health were absent in both the literature and across most of the teaching. Participants noted that there was a lack of accessible psychological thought leadership in public health, and that this would support integrated conceptualisations.

4.1.2.3. The medical model and the psychiatric paradigm

Several participants alluded to the desirability of moving away from a medicalised understanding of mental health problems. This was raised in the context of definitions of mental health and wellbeing, the preference for integrated rather than 'siloed' teaching, and the merits of a biopsychosocial, or bio-social, approach. The rationale for this was thinly described, but related to the perceived validity of a conceptual distinction between mental health and wellbeing, and the limits of a medical model for explanation.

In fact, the tenets of the medical model as it is generally understood in critical psychiatry and psychology were largely missing in the discussions. There was no reference to debates about the validity of psychiatric diagnoses, mental 'illness' and the various consequences of psychiatric conceptualisations (Middleton & Moncrieff, 2018), the desirability of therapy as a treatment approach for mental health problems, and the obfuscation of the role of context, power and inequality (Smail, 2005). It seemed that the 'medical model' was understood to mean simply the conceptualisation of a biologically-based mental disorder, rather than an entire paradigm shaping definitions, methodologies, evidence base and practice approaches, some of which may contradict the aims of public health approaches to mental health. Further research might investigate in more detail the meaning of a medical model to educators in public health, as this has important implications for public mental health. Particularly, if there is a limited appreciation for the well-evidenced critiques of psychiatry and the medical paradigm, this may hinder

development of an integrated multidisciplinary approach which incorporates non-medical disciplines with important contributions to make to public mental health. It may prevent a focus on systems of oppression and inequality, and perpetuate a treatment-focused approach to population mental health.

4.1.2.4. Summary

In summary, while social determinants of mental health were highlighted in teaching, the findings indicate a biological foundationalism in the conceptual frameworks prevalent in teaching and placement training. The academic component of training was said by participants to take a biopsychosocial perspective, though psychological aspects were considered in a reductive way, focusing on the physiological or behavioural sequelae of stress rather than, for example, meaning. Placement work tended to take place in clinical mental health settings or in discrete projects underpinned by medicalised and individualised understandings of mental health. There appears to be a lack of coverage of key debates, and a lack of explicit reflection on the assumptions of concepts, models, and theories. However, there was enthusiasm for non-medicalised ways of understanding mental health, and a recognition of the value in exploring conceptual issues in more depth. In terms of the MPH, suggestions were made that this was hampered by a lack of accessible psychological thought leadership in the discipline, and challenge of in-depth teaching in a time-limited course.

4.1.3. What are the Barriers and Facilitators to Including Public Mental Health in the Training?

This section describes the higher-level factors highlighted in the interviews as helping or hindering the availability of training for public health specialty trainees.

4.1.3.1. The role of the curriculum in ensuring that training meets the needs of a public mental health workforce

Participants across the board highlighted the importance of the Faculty Curriculum (FC) in shaping teaching content on the MPH, and the kinds of competencies trainees would need to gain through placement-based learning. While MPH courses were not

required to align themselves to the FC, this was a choice some courses made to make themselves attractive places for trainees to take their masters. It was acknowledged that the FC set intentionally broad and high-level competencies, and that domain specific competencies were avoided; mental health was not featured in the FC, but neither was cardiovascular disease for example. The notion of mental health as subsumed by overall health, and the assumption that mental health can be taught analogously to physical health, permeates the curriculum.

This raises questions as to what is expected of public health specialists, and how they are expected to meet those expectations. The current discussion around workforce development for public mental health aspires to build a specialist workforce that can develop a shared understanding of mental health within the public health system, have the expertise to lead mental health as a priority, and translate evidence into recommendations for policy, commissioning and strategy (PHE, 2015).

A barrier to progressing public mental health identified in the literature was the researcher-practitioner divide (Smith & Wilkins, 2018), which was linked to the poor translation of evidence into policy and ineffective implementation of interventions at the level of primary prevention: either one works in academia and produces the knowledge, or one works in public health departments and implements change. Participants identified the FC as appropriate in its scope and level of specificity because the training was about developing the skills to “do the job”. However, it is conceivable that the lack of requirement to engage with critical and multidisciplinary perspectives on mental health reifies the practitioner-researcher divide and limits the capacity of specialists to achieve the goals of developing a shared understanding of mental health and translating evidence into action.

4.1.3.2. How the political context shapes learning opportunities for trainees

A structural issue which determined the availability of placements oriented towards primary prevention work was the wider political context which determined the current approach to practice, particularly in terms of funding arrangements and the need for political support in implementing interventions.

In line with data on resource allocation (Mind, 2014) participants described the lack of funding invested in public health, particularly public mental health. This was seen to reflect how public mental health was under-valued in terms of the vast potential of work in this area for other areas of population health. The lack of primary prevention work in public mental health was also linked to the general under-resourcing of mental health services in treatment settings, with public health seemingly recruited to plug the gaps in provision, rather than focus on prevention.

Another key influence on current approaches to public mental health was the need for political support for implementation. Participants highlighted that prevention initiatives looking at policy-level change tended to be viewed less favourably by politicians than packages of work targeting individuals, such as mental health first aid or wellbeing promotion initiatives.

Exploring the reasons for a lack of upstream buy-in to preventative approaches is beyond the scope of this study, though hypotheses were proposed by participants. This included the government's desire to be seen to be 'tackling' mental health. Packages like mental health first aid, which featured in the 2017 Conservative manifesto, may be more readily understood by the general public as a mental health intervention than more upstream interventions, given the extent to which social context is obscured from public discourse around mental health. Another suggestion was that a lack of understanding of the evidence base led to poorly justified implementation.

4.1.3.3. Lack of status of public mental health as a barrier to training

There was a clear theme in the interviews about the relative lack of status of public mental health in comparison to medicine, and to physical health domains of public health. This was evident in the disproportionately low allocation of funding, the lack of demand for public mental health trainee placements, and the disproportionately limited opportunities for career progression as an academic or practitioner of public mental health.

The lack of high-profile specialists in the field was acknowledged as a barrier to attracting trainees into the area, and also linked to the availability of educational

supervisors with particular public mental health expertise for placement training. This was connected to systemic attitudes towards public mental health in universities, where senior academic roles were seen to be less likely to be awarded to those with public mental health specialisms than other areas of public health.

MPH course content was largely determined by the expertise and interests of departmental staff. In this way, the sense that public mental health was not a valued or prestigious career choice was a barrier to both MPH and placement learning opportunities and a major contributor to the ad hoc approach to mental health coverage.

4.1.3.4. Resisting dis-incentivisation, looking for opportunities

One of the most striking facilitators of including public mental health in training was the ways in which participants worked to overcome the various structural and contextual barriers mentioned above. One example of this is that, despite the systematic devaluing of working or specialising in the area, relative to other fields of public health, some participants had dedicated themselves to the discipline. Those who had a particular interest in the area had advocated for and delivered public mental health teaching, sometimes in the face of significant dis-incentivisation.

Many participants valued public mental health as an area offering great opportunities to wider public health agendas, and considered it something important that could warrant greater coverage in teaching. Participants were open about possibilities to develop learning opportunities, particularly in the MPH, despite grappling with limited resources and time. Participants were humble about their expertise, and several shared the view that greater collaboration with other disciplines and mental health professionals would progress public mental health theory and practice.

4.1.3.5. Summary

Several barriers to including public mental health in the training were identified. These were related to pragmatic issues of the time-limited MPH, and the high-level competency approach in the FC which permitted flexibility in coverage. A structural barrier was the wider institutional culture which marginalised mental health. This

ranged from the level of government funding which shaped placement opportunities by limiting the number of settings doing work in public mental health, to the lack of professional status of public mental health, and subsequently the lack of specialists in the field available to advocate for training or offer supervision. These factors likely combine to influence how attractive the field of public mental health is to prospective trainees and thereby how likely it is that they initiate their own learning in the area or choose a dissertation on the topic to cover gaps in taught content. Nevertheless, despite these challenges many participants believed this to be an important area of work, with potential for development through sharing interdisciplinary expertise.

4.1.4. What are the Practical Implications of the Current Coverage in Teaching and Training?

This question was concerned with participants' views on the impact of a lack of teaching and training opportunities on the public mental health discipline.

4.1.4.1. Differences of opinion as to the significance of the issue

Participants varied in the degree to which they viewed the lack of coverage to be a problem. Indeed, most participants trusted that trainees would gain the experience needed to be effective in public mental health throughout the course of training, in spite of the lack of systematic approach to ensuring access to training. This may link to how participants considered dedicated mental health teaching to be unnecessary, due to the view that mental health was subsumed by health, and therefore an ad hoc approach to teaching was of no great consequence to the practice of public mental health; trainees would pick up the skills in other domains of work. This again indicates the lack of a robust conceptual understanding of what public mental health is, and an overarching medical framework which views mental health through the same 'lens' as physical health.

Other participants were unclear about the implications of the lack of teaching, acknowledging that it was something they had not previously considered. However a smaller number of participants identified the neglect of the area in teaching to have significant consequences for the discipline. A key implication was raised in relation to

the application of evidence to developing public mental health approaches. The lack of training was seen to be key in maintaining inadequately justified interventions and the systemic lack of robust knowledge of the evidence base and its limitations.

4.1.4.2. Public mental health falls in the gap

Despite ambivalence about the implications cited above, the lack of training was seen in different ways to reflect a neglect of mental health which was endemic in public health. The lack of training did not just apply to trainees: there is no requirement of any mental health training across the breadth of the public health workforce, including those with specific responsibilities in the area. Supervisors were likely to have entered the profession through the STP, and those working in public mental health were likely to be working in settings other than primary prevention, under a medical model. Yet, supervisors and placement-based learning experiences were assumed or expected to provide training omitted in the MPH. PHPs who do the majority of front-line and mental health promotion work enter the profession as lay-workers and gain seniority through experience. One participant highlighted how the lack of training for PHPs impacted the status of their work, as the community recognises each other's status through professional qualification.

Relatedly, the lack of teaching and training opportunities was linked to workforce divides which maintained a neglect of public mental health. Participants noted the tendency for mental health prevention to be allocated to the work of clinical services as secondary or tertiary prevention, and wellbeing promotion to the PHP remit. This relates directly to the way mental health and wellbeing are conceptualised, and the failure to develop an integrated framework of public mental health which formulates mental health prevention outside of the medical model. This was noted both within public health and among LA colleagues. However, given that public health specialists are tasked with the promotion of public mental health approaches including meaningful primary prevention, it falls to them to communicate and advocate for alternatives. In addition to the gap in practice, the gap in knowledge production and utilisation between researchers and practitioners was implied. Smith and Wilkins (2018) recognised this tendency in public health, rooted in the dual focus on research and practice, and the associated ideas about whose focus is explaining and understanding, and whose

focus is implementing change. Further research might explore this issue in more detail, as it may speak to the level of depth and sophistication of theoretical knowledge public health specialists are considered to require to be effective in practice.

4.1.4.1. Summary

Participants differed in their views as to how important public mental health training was for trainees, and several took the view that a lack of training was more or less inconsequential for the practice of public mental health. This illustrates the importance of unexamined conceptual frameworks, such as 'mental health is just a part of health', for the way in which training is approached and how priorities might be allocated to other topics. Some however viewed the lack of training as fundamental to the current lack of status of public mental health, the continued conceptual issues preventing meaningful population approaches, and the way responsibility for public mental health was attributed to parts of the workforce.

4.2. Implications

The findings are considered below in terms of the implications for the training and practice of public mental health, and the implications for clinical psychology as a partner in the public mental health agenda. Areas for further research are then discussed.

4.2.1. Implications for the Teaching and Training of Public Health Specialists in Public Mental and Practice

The findings suggest that the efforts from PHE to develop public mental health competencies in the senior workforce, through the workforce development framework (PHE, 2015), call to action (PHE, 2018) and prevention concordat (PHE 2017a; 2017b) have not led to concrete, systematic or strategic approaches to training in the STP. There is a lack of infrastructure in place to scaffold public mental health training, linked to the de-emphasis on public mental health, which fosters an ad hoc approach to training. This includes a lack of emphasis in the FC on public mental health, a lack of

expertise in the field, and a lack of investment in primary prevention work which limits the learning experiences available through placements.

A key implication of the findings is that opportunities to develop the discipline of public mental health are being missed; not only is training a pertinent setting to shift understandings and equip future professionals with the skills and knowledge to lead on meaningful public mental health, but it is also an opportunity to develop and strengthen the theoretical basis of public mental health which has widely been acknowledged as confused and partial. Furthermore, developing the conceptual substance of public mental health is likely foundational to the development of the discipline in gaining parity with and independence from psychiatry and medicine, as has been the case for clinical psychology (Sarason, 1981).

Training has the potential to disrupt the prevailing ambiguity and inefficacy rife in public mental health and progress the discipline in theory and practice. However the approach that is taken in delivering teaching is important. MPH courses may consider what is implied about the value of public mental health through optional and cursory mental health teaching, and how this also promotes marginalisation of public mental health. MPH courses may also consider how adequately the content of any mental health teaching supports trainees to make sense of mental health and the causes of mental health, with a critical understanding of the limitations of current dominant paradigms. This is likely to require an intentional commitment to support busy academic departments and bring in a range of perspectives, perhaps through collaboration with colleagues from other disciplines.

4.2.2. Implications for Clinical Psychology's Contribution to Public Mental Health and Prevention

The findings indicate that there are important theoretical contributions that can be made by clinical psychology towards a more coherent and robust theoretical basis of public mental health. Importantly, the work of community psychology and critical psychological perspectives emphasise population approaches to mental health, prevention rather than treatment, and the role of social context. This work also

provides a conceptual alternative to the psychiatric paradigm: the Power Threat Meaning Framework (Johnstone & Boyle, 2018) for example provides a comprehensive and detailed synthesis of the evidence around social determinants of mental health, while elucidating the limitations of medical interpretations of mental health and other key critical debates. That these theoretical ideas are missing from training indicates a missed opportunity to address current gaps and ambiguities.

However, the findings also suggest challenges for clinical psychology in joining with the MPH. The perception of clinical psychology within public health is a particular area for further exploration. The findings implied that clinical psychological theory was viewed as abstract and therefore of little practice use in the public health arena. The findings also raise the question of the status of clinical psychology as a non-medical discipline, and the value of clinical psychology's contribution if viewed only as a discipline with expertise in individual treatment. This speaks to the labour divide identified in public mental health, and the positioning of psychiatry.

The avenues that clinical psychologists can pursue to influence public health training is also unclear. Clinical psychologists undergo at least six years of higher education in order to qualify, and so the five years of further training in the STP may be prohibitive to clinical psychologists entering the senior public mental health workforce. However, there are other avenues for influence and collaboration. Participants saw a need for psychological thought leadership within public health. Clinical psychologists may increase the visibility of psychological theory by publishing relevant research in journals likely to be read by public health specialists. They may collaborate with the FPH PMH Special Interest Group, perhaps producing a similar document to the BPS Division of Health Psychology's publication 'Why Directors of Public Health need to know a Health Psychologist' (BPS, 2015). Indeed, clinical psychology training programmes could collaborate with local public health departments, where trainees could not only share, but learn more about public health theory and practice in a mutually-beneficial exchange between disciplines.

Further exploration of the possibilities for collaboration would complement the ongoing discussion within clinical psychology about what can be done within the

discipline to promote preventative and population-based ways of working (Harper, 2016).

4.2.3. Areas for Further Research

This research was a preliminary exploration of an area that, to the author's knowledge, had not previously been studied. The findings have raised a number of questions for further research which would support the understanding of the issue.

Firstly, the initial design of this study included a survey component for students on MPH courses, but was revised due to practical issues in the course of conducting research during the COVID-19 pandemic. Further research could help elaborate these findings by hearing from public health trainees about their views on public mental health as a career choice, their understandings of mental health and prevention work, and what kind of teaching they would like to access on public mental health. This could bring more depth to the current findings and help clarify the value of teaching, both in terms of trainee desire for teaching and in terms of, for example, the extent to which they hold medicalised or partial understandings.

Further research could also help elaborate on the perspectives of public health professionals, such as those interviewed in the present study, as to their views on the value of clinical psychology in theory and practice, how they perceive opportunities for collaboration within education and the STP, and their views on the utility of bodies of theory that they may heretofore have not encountered, such as the PTMF (Johnstone & Boyle, 2018).

This research identified prevalent dualisms in both the understanding of mental health and wellbeing, and the division of labour attributed to mental health and wellbeing. Given the lack of theoretical depth in the MPH and previous research indicating a researcher-practitioner divide in public health (Smith & Wilkins, 2018), further research could aim to better understand whether the MPH is considered primarily a vocational training, and how this impacts the relationship trainees have with the production of knowledge and development of theory in the academic setting.

4.3. Critical Review

This section critically evaluates the study, using the framework outlined by Spencer and Ritchie (2011). Research quality is evaluated according to three quality principles: contribution; credibility; and rigour of the research.

4.3.1. Research Quality

4.3.1.1. Contribution of the research

This relates to whether the study contributes to the wider understanding about the research area, in light of existing theory and knowledge, applicability beyond the study, and its limitations. To the author's knowledge, this has been the first study to explore the mental health teaching of UK public health specialists. The study aimed to advance understanding not only about the coverage of teaching, but also the conceptual and theoretical content of teaching. The study also aimed to explore the barriers and facilitators of teaching, to add value to the possible practical implications of the research findings. The rationale for the research was considered in light of existing literature related to the topic in Section 1. The findings are detailed in Section 3, and discussed in relation to the research question and existing literature in Section 4. The practical and theoretical implications of the results have been presented in Section 4.2.

The value of the research for its participants was shared anecdotally during or after interviews. Some participants from the MPH group reflected that the discussion had been valuable as it prompted them to think in more detail about the way mental health teaching was approached on their course. One participant however highlighted that they felt unsure about the validity of the interview's focus on knowledge and skill development, because they viewed the issue to be primarily a resource and capacity issue. This highlights how the research may be received by some in the public health field, and highlighted the importance of acknowledging structural barriers in the discussion of the findings, which was presented in Section 4.1.3. This raised other

considerations for reflexivity in terms of participants' experience of the interview process, covered in Section 4.3.2. below.

The contribution of the research is determined by the strengths and limitations of the research design and methods used. A strength of this study was the applicability of the sample group to the wider workforce of educators in roles on MPH courses and regional training programmes; in particular, the sample reflected the wider group in that few had a background in public mental health. The use of semi-structured interviews enabled detailed discussion with flexibility to explore issues raised by participants according to what felt most relevant to them. This was useful given the exploratory nature of the research and necessary given the lack of prior research to guide a more structured interview.

However, this came at the expense of a more standardised approach, which could have ensured that all interviews covered the same areas, to gather the most possible perspectives on each area. Fortunately, themes were broadly shared across interviews and so this is unlikely to have impacted data saturation (Guest et al., 2006). Another limitation of the interview approach was that it was necessarily restricted to fewer participants than, for example, a survey design or series of focus groups might have done.

4.3.1.2. Credibility of the research

Research credibility relates to the plausibility of the findings in light of the evidence and existing literature. Care has been taken to provide a clear audit trail of ideas, rationale, literature and methodology throughout this report. Transparency as to how the raw data fitted the higher-order themes was increased through the inclusion of coded transcript segments to show the origins of the themes (Appendix G) alongside an example coding table (Appendix H) and iterations of the thematic framework (Appendix I). To support a transparent and reflexive account, consideration of how researcher subjectivity influenced the research process is documented in Section 4.3.2.

Attempts to validate the analysis were made through the sharing of the process with my supervisor at different stages. This included sharing segments of interview audio for feedback on the integrity of the interviewing style, depth and formulation of questions, and sharing iterations of the thematic framework to support the validity of the organisation of themes and sub-themes.

4.3.1.3. Rigour of the research

The rigour of the research concerns the documentation of the research process and defence of the overall strategy. A clear discussion of the research process was provided in Section 2, including a detailed outline of the steps taken in data analysis to provide a replicable account of the method, and transparency in how themes were arrived at. In Section 3, a coherent narrative illustrates the themes alongside direct quotes from the raw interview data to ensure that results are grounded in the data.

Ethical issues were managed by providing information about the study to facilitate informed consent, and opportunities were available in the interview for participants to ask questions and give feedback about their experience, which was a reflexive addition to the interview process in response to awareness of the power dynamics related to questioning participants on issues they may be unfamiliar with, and may have felt criticised or uncomfortable about. Participants were also offered space to introduce themselves at the beginning of the interview process as a form of disclaimer, in recognition of my positioning of their expertise and to give another means for participants to acknowledge their relationship with public mental health and gaps in knowledge to orient the interview. Procedures were followed to ensure anonymity of participants.

4.3.2. Reflexivity

4.3.2.1. Personal reflexivity

Interview-generated data often does not attend to the contextual and interactional aspects of the interview process, for example the different meaning of the interview for the researcher and participant (Potter & Hepburn, 2005). Throughout the data collection phase I noticed a power dynamic playing out in the interviews, and

documented thoughts and feelings about this in a reflexive journal (Fischer, 2009; Appendix J). Firstly, there was a clear power dynamic between myself and the participants. I held a position of low professional status and expertise in relation to the participants, who I viewed as eminent professionals in their field. Due to my own ideas about authority and etiquette, I noticed there were moments during the interview process where I withheld further questioning so not to appear critical, which was linked to my own cultural beliefs about how to speak to senior professionals.

On the other hand, participants were often being asked by me to think critically about their discipline or workplace, which may have been experienced as exposing. I attempted to encourage openness from participants by voicing my naivete around public health and regularly asked for feedback on ending interviews as to their experience of the discussion (Willig, 2013). However, there was an uneasiness in some interviews when participants felt unable to elaborate on the definitions, concepts or models used in the teaching.

4.3.2.2. Epistemological reflexivity

The methodology was approached from a critical realist perspective, using thematic analysis. This approach assumes that there is an external 'reality' which can be apprehended imperfectly, according to the subjectivities of the knower. There are a likely to have been many ways in which my choices and partial viewpoint as a researcher impacted the claims made in this research. Those of which I am aware include firstly the different assumptive worlds of clinical psychology and public health, which shaped how I understood the discussion during interviews to impact the data. When I began the interviews, I assumed that there was a shared understanding of certain ideas between myself and the participants, notably the meaning of the medical model of mental health, which impacted the extent to which I asked for elaboration and the ultimate level of detail in the interviews.

For example, when I asked a participant about the ways in which mental health was understood in the teaching on their MPH course, they stated that "the medical model only goes so far". This would have been a useful point to ask for further elaboration about what they meant by this, what the medical model meant to them, and what they

viewed to be its limitations. In another interview, a participant referred to their experience of MPH content being focused on “the epidemiology of schizophrenia. It’s not about population mental health”. This highlighted to me the possibility that in other interviews myself and the participant might have been using shared terminology, like population or public mental health, and mean quite different things, as this quote indicates some public health educators approach the issue as explicitly or exclusively psychiatric while others take a different view. As I became aware of these differences, I used supervision to think about how different meanings of familiar terms, like medical model, might have impacted the data, and could be mindful of this when coming to the analysis stage.

My background as a trainee clinical psychologist, whose training has emphasised the importance of critical perspectives of mental health, likely impacted my sense of familiarity with and beliefs about the importance of critical debates for the training of public health trainees. This is likely to have impacted my selection of salient aspects of the interview data, and may be at the expense of alternative interpretations. The interpretive aspect of the analysis may also have been affected by the lack of explicit identification of theoretical orientations or frameworks by participants, which then needed to be inferred by me based on what was implied.

4.4. Conclusion

This is the first study to explore the mental health training of public health speciality trainees. The questions addressed by this study are timely, as the speciality public health workforce are increasingly positioned as key agents in the progression of an effective public mental health approach in the UK. The findings have implications for the development of expertise in this profession and highlight possibilities for the contribution of clinical psychology.

The lack of training available to trainees in their academic teaching and placement learning reflects a systemic de-emphasis of public mental health. Current permissive approaches to content coverage are unlikely to address this, indicating a need to

review the assumptions underpinning what is 'core' learning, a review of what is required coverage in STPs and the infrastructure to support learning opportunities.

Theoretical and conceptual issues perpetuate the marginalisation of public mental health from training and practice to higher levels of intervention design, strategy and resource allocation. Increased specificity about the assumptions made in public mental health, which affect training and practice, would benefit population-based approaches and support disciplinary independence from psychiatry. Working on the conceptual substance of the discipline may benefit from collaboration with fields of clinical psychology aligned to population approaches and primary preventative initiatives.

5. REFERENCES

- Albee, G. W. (1999). Prevention, not treatment, is the only hope, *Counselling Psychology Quarterly*, 12(2), 133-146, <https://doi.org/10.1080/09515079908254084>
- All Party Parliamentary Group. (2015). *The All Party Parliamentary Group on Mental Health's inquiry into parity of esteem for mental health*. <https://www.mind.org.uk/media-a/4405/appg-parity-in-progress-final.pdf>
- Andrews, G. & Henderson, S. (2004). *Unmet need in psychiatry: problems, resources, responses*. Cambridge University Press.
- Archer, M. (1995). *Realist Social Theory: The morphogenetic approach*. Cambridge University Press.
- Banister, P., Burman, E., Parker, I., Taylor, M., & Tindall, C. (1994). *Qualitative methods in psychology. Qualitative Methods in Psychology: A Research Guide*. Open University Press.
- Baumgartner, F. R., Berry, J. M., Hojnacki, M., Leech, B. L., & Kimball, D. C. (2009). *Lobbying and policy change: Who wins, who loses, and why*. University of Chicago Press.
- Bebbington, P. E., & McManus, S. (2020). Revisiting the one in four: the prevalence of psychiatric disorder in the population of England 2000–2014. *The British Journal of Psychiatry*, 216(1), 55-57. <https://doi.org/10.1192/bjp.2019.196>
- Bignall, T., Jeraj, S., Helsby, E., & Butt, J. (2019). *Racial disparities in mental health: Literature and evidence review*. Race Equality Foundation. <https://raceequalityfoundation.org.uk/wp-content/uploads/2020/03/mental-health>
- Bird, C. M. (2005). How I stopped dreading and learned to love transcription. *Qualitative Inquiry*, 11, 226-248. <https://doi.org/10.1177/1077800404273413>

Bhaskar, R. (1979). *The possibility of naturalism: A philosophical critique of the contemporary human sciences*. Humanities Press.

Bhaskar, R. (1998). Philosophy and scientific realism. In M. S. Archer, (ed.), *Critical Realism: Essential Readings*. (pp.16-47). Routledge.

Boyatzis, R. E. (1998). *Transforming qualitative information: Thematic analysis and code development*. Sage.

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, 3, 77–81. <https://doi.org/10.1191/1478088706qp063oa>

British Psychological Society. (2013). *Classification of behaviour and experience in relation to functional psychiatric diagnoses: Time for a paradigm shift*.
<https://www.bps.org.uk/sites/www.bps.org.uk/files/Member%20Networks/Divisions/DCP/Classification%20of%20behaviour%20and%20experience%20in%20relation%20to%20functional%20psychiatric%20diagnoses.pdf>

British Psychological Society. (2015). *Why Directors of Public Health need to know a Health Psychologist*.

British Psychological Society. (2019a). *A psychological manifesto for the next government*. <https://www.bps.org.uk/sites/bps.org.uk/files/Policy/Policy%20-%20Files/BPS%20Policy%20-%20A%20Psychological%20Manifesto.pdf>

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

Buck, D. (2017). *Chickens coming home to roost: local government public health budget for 2017/18*. Retrieved April 18, 2021, from

<https://www.kingsfund.org.uk/blog/2017/07/local-government-public-health-budgets-2017-18>

Campion, J. (2019). Public mental health: evidence practice and commissioning. *Royal Society for Public Health*.
https://www.researchgate.net/profile/Jonathan-Campion/publication/339927657_Campion_2019_Public_mental_health_-_evidence_practice_and_commissioning_Royal_Society_of_Public_Health/links/5e6caed592851c6ba700c5fe/Campion-2019-Public-mental-health-evidence-practice-and-commissioning-Royal-Society-of-Public-Health.pdf

Care Quality Commission. (2019). State of Care 2018/19.
https://www.cqc.org.uk/sites/default/files/20191015b_stateofcare1819_fullreport.pdf

Carr, S., Unwin, N., & Pless-Mullooli, T. (2007). *An Introduction to Public Health and Epidemiology* (2nd ed.). Blackwells.

Carvalho, A., I. (1996). From Public Health to Healthy Policies - Health and Citizenship in Postmodernity. *Public health science*, 1(1), 104-121.
<https://doi.org/10.1590/1413-812319961101572014>

Centre for Workforce Development. (2014). *Mapping the core public health workforce: Final report*.
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/507518/CfWI_Mapping_the_core_public_health_workforce.pdf

Costanza, R., Fioramonti, L., & Kubiszewski, I. (2016). The UN Sustainable Development Goals and the dynamics of well-being. *Frontiers in Ecology and the Environment*, 14(2), 59. <https://doi.org/10.1002/fee.1231>

Czeresnia, D. (1999). The concept of health and the difference between prevention and promotion. *Cadernos de saúde pública*, 15, 701-709.
<https://www.scielo.org/article/csp/1999.v15n4/701-709/en/>

Dahlgren, G., & Whitehead, M. (1991). *Policies and strategies to promote social equity in health. Background document to WHO-Strategy paper for Europe*. Institute for Futures Studies.

https://www.researchgate.net/publication/5095964_Policies_and_strategies_to_promote_social_equity_in_health_Background_document_to_WHO_-_Strategy_paper_for_Europe

Danermark, B., Ekström, M., Jakobsen, L., & Karlsson, J. C. (2002). *Explaining society: An introduction to critical realism in the social sciences*. Routledge

Davies, S. (2013). *Annual Report of the Chief Medical Officer 2013, Public Mental Health Priorities: Investing in the Evidence*. <https://mrc.ukri.org/documents/pdf/chief-medical-officer-annual-report-2013/>

Department for Communities and Local Government. (2014). *Local Authority Revenue Expenditure and Financing: 2014-15 Budget England (revised)*. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/365581/RA_Budget_2014-15_Statistical_Release.pdf

Department of Health. (2011). *No Health Without Mental Health: A Cross-Government Mental Health Outcomes Strategy for People of All Ages*. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/213761/dh_124058.pdf

Department of Health. (2012a). *No Health Without Mental Health: implementation framework*. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/216870/No-Health-Without-Mental-Health-Implementation-Framework-Report-accessible-version.pdf

Department of Health. (2012b). *The new public health role of local authorities*. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/213009/Public-health-role-of-local-authorities-factsheet.pdf

Department of Health. (2014a). *Annual Report of the Chief Medical Officer. Public mental health priorities: Investing in the Evidence.*

<https://mrc.ukri.org/documents/pdf/chief-medical-officer-annual-report-2013/>

Department of Health. (2014b). *Closing the gap: priorities for essential change in mental health.*

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/281250/Closing_the_gap_V2_-_17_Feb_2014.pdf

Department of Health and Social Care. (2019). *PHE remit letter: 2019 to 2020.*

<https://www.gov.uk/government/publications/phe-priorities-in-health-and-social-care-2019-to-2020>

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/the-future-of-public-health-the-national-institute-for-health-protection-and-other-public-health-functions>

Division of Clinical Psychology (2015). *Guidelines on language in relation to functional diagnosis.* British Psychological Society.

http://www.bps.org.uk/system/files/Public%20files/guidelines_on_language_web.pdf

Elliott, I. (2016). *Poverty and Mental Health: A review to inform the Joseph Rowntree Foundation's Anti-Poverty Strategy.* Mental Health Foundation.

<https://www.mentalhealth.org.uk/sites/default/files/Poverty%20and%20Mental%20Health.pdf>

European Commission. (2005). *Green Paper: Improving the Mental Health of the Population: Towards a Strategy on Mental Health in the European Union.* OOPEC.

<https://op.europa.eu/en/publication-detail/-/publication/5420b88c-690b-47df-8c89-c0d7112134c3>

Faculty of Public Health. (2014). *Functions and standards of a Public Health System*. https://www.fph.org.uk/media/3031/fph_systems_and_function-final-v2.pdf

Faculty of Public Health. (2015). *Public Health Specialty Training Curriculum*. https://www.fph.org.uk/media/3069/ph-curriculum-2015v4_final-20.pdf

Faculty of Public Health. (2016). *Better Mental Health for All: A Public Health Approach to Mental Health Improvement*. <https://www.fph.org.uk/media/1644/better-mental-health-for-all-final-low-res.pdf>

Fenwick-Smith, A., Dahlberg, E.E. & Thompson, S.C. (2018). Systematic review of resilience-enhancing, universal, primary school-based mental health promotion programs. *BMC Psychology*, 6(30). <https://doi.org/10.1186/s40359-018-0242-3>

Fereday, J., & Muir-Cochrane, E. (2006). Demonstrating rigor using thematic analysis: A hybrid approach of inductive and deductive coding and theme development. *International journal of qualitative methods*, 5(1), 80-92. <https://doi.org/10.1177/160940690600500107>

Fischer, C. T. (2009). Bracketing in qualitative research: conceptual and practical matters. *Psychotherapy Research*, 19(4-5), 583-590. <https://doi.org/10.1080/10503300902798375>

Fletcher, A. J. (2017). Applying critical realism in qualitative research: methodology meets method. *International journal of social research methodology*, 20(2), 181-194. <https://doi.org/10.1080/13645579.2016.1144401>

Friedli, L. (2009). *Mental health, resilience and inequalities*. WHO Regional Office for Europe. <https://apps.who.int/iris/bitstream/handle/10665/107925/E92227.pdf>

Friedli, L., & Parsonage, M. (2007). *Mental health promotion: building an economic case*. Northern Ireland Association for Mental Health. https://www.researchgate.net/profile/Michael-Parsonage/publication/308339133_Mental_health_promotion_building_an_economic

[_case/links/57e14e7d08ae9e353800836b/Mental-health-promotion-building-an-economic-case.pdf](#)

Galea, S., Riddle, M., & Kaplan, G. A. (2010). Causal thinking and complex system approaches in epidemiology. *International journal of epidemiology*, 39(1), 97-106. <https://doi.org/10.1093/ije/dyp296>

Gauffin, K., & Dunlavy, A. (2019). Finding common ground: how the development of theory in public health research can bring us together. *Social Theory & Health*, 19, 127–136. <https://doi.org/10.1057/s41285-019-00119-8>

Ginn, S. & Horder, J. (2012). “One in four” with a mental health problem: the anatomy of a statistic. *British Medical Journal*, 22, 344. <https://doi.org/10.1136/bmj.e1302>

Goldie, I., Elliott, I., Regan, M., Bernal, L., & Makurah, L. (2016). *Mental health and prevention: Taking local action for better mental health*. <https://www.mentalhealth.org.uk/sites/default/files/mental-health-and-prevention-taking-local-action-for-better-mental-health-july-2016.pdf>

Gordon, R. (1987). *An operational classification of disease prevention*. In J. A. Steinberg & M. M. Silverman (Eds.), *Preventing mental disorders: A research perspective* (p. 20–26). National Institute of Mental Health.

Green, H., McGinnity, Á., Meltzer, H., Ford, T., & Goodman, R. (2005). *Mental health of children and young people in Great Britain, 2004*. H. Palgrave Macmillan.

Greenhalgh, T., & Peacock, R. (2005). Effectiveness and efficiency of search methods in systematic reviews of complex evidence: audit of primary sources. *British Medical Journal*, 331(7524), 1064-1065. <https://doi.org/10.1136/bmj.38636.593461.68>

Greenhalgh, T., Thorne, S., & Malterud, K. (2018). Time to challenge the spurious hierarchy of systematic over narrative reviews? *European journal of clinical investigation*, 48(6). <https://doi.org/10.1111/eci.12931>

Guest, G., Bunce, A., & Johnson, L. (2006). How many interviews are enough? An experimental data saturation of variability. *Field Methods*, 18, 59-82.
<https://doi.org/10.1177/1525822X05279903>

Haraway, D. (1988). Situated Knowledges: The Science Question in Feminism and the Privilege of Partial Perspective. *Feminist Studies*, 14(3), 557-599.
<https://doi.org/10.2307/3178066>

Harper, D. (2016). Beyond individual therapy: Towards a psychosocial approach to public mental health. *The Psychologist*, 29, 440-444.
<https://thepsychologist.bps.org.uk/volume-29/june/beyond-individual-therapy>

Harper, D. (2017). The promise (and potential pitfalls) of a public health approach in clinical psychology. *Clinical Psychology Forum*, 297, 23-32.

Health and Social Care Act 2012.
<https://www.legislation.gov.uk/ukpga/2012/7/contents/enacted>

Heath, S. (2014). Local authorities' public health responsibilities (England). *House of Commons Library*. <https://commonslibrary.parliament.uk/research-briefings/sn06844/>

Humphreys, K. (1996). Clinical psychologists as psychotherapists: history, future, and alternatives. *American Psychologist*, 51(3), 190. <https://doi.org/10.1037/0003-066X.51.3.190>

Iacobucci, G. (2018). BMA urges government to reverse public health cuts. *British Medical Journal*, 16, 360. <https://doi.org/10.1136/bmj.k1245>

Institute of Medicine. (1988). *The Future of Public Health*. National Academy Press.
<https://www.ncbi.nlm.nih.gov/books/NBK218218/>

Johnstone, L. & Boyle, M. with Cromby, J., Dillon, J., Harper, D., Kinderman, P., Longden, E., Pilgrim, D. & Read, J. (2018). *The Power Threat Meaning Framework: Towards the identification of patterns in emotional distress, unusual experiences and troubled or troubling behaviour, as an alternative to functional psychiatric diagnosis*. British Psychological Society.

<https://www.bps.org.uk/sites/bps.org.uk/files/Policy%20-%20Files/PTM%20Main.pdf>

Jones, C.P. (2000). Levels of racism: A theoretic framework and a gardener's tale. *American Journal of Public Health*, 90, 1212–1215.

<https://doi.org/10.2105/ajph.90.8.1212>

Jorm, A. F., Patten, S. B., Brugha, T. S., & Mojtabai, R. (2017). Has increased provision of treatment reduced the prevalence of common mental disorders? Review of the evidence from four countries. *World Psychiatry*, 16, 90–99.

<https://doi.org/10.1002/wps.20388>

Kaplan, G. A. (2004). What's wrong with social epidemiology, and how can we make it better? *Epidemiological Reviews*, 26(1), 124-35.

<https://doi.org/10.1093/epirev/mxh010>

Keyes, C. L. M., & Lopez, S. J. (2002). Toward a science of mental health: Positive directions in diagnosis and interventions. In C. R. Snyder & S. J. Lopez (Eds.), *Handbook of positive psychology* (p. 45–59). Oxford University Press.

Kidney, D. (2019). *Understanding the UK's public health workforce*.

<https://ukphr.org/understanding-the-uks-public-health-workforce/>

Kings Fund & Public Health England. (2017). *Stocktake of local strategic planning arrangements for the prevention of mental health problems: Summary report*.

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/776856/27072017_Stocktake_of_local_strategic_planning_arrangements_for_the_prevention_of_mental_health_problems.pdf

Krieger, N. (1994). Epidemiology and the web of causation: has anyone seen the spider? *Social science & medicine*, 39(7), 887-903. [https://doi.org/10.1016/0277-9536\(94\)90202-X](https://doi.org/10.1016/0277-9536(94)90202-X)

Krieger, N. (2008). Proximal, distal, and the politics of causation: what's level got to do with it? *American journal of public health*, 98(2), 221-230. <https://doi.org/10.2105/AJPH.2007.111278>

Krieger, N. (2011). *Epidemiology and the people's health: theory and context*. Oxford University Press.

Krieger, N. (2012). Methods for the scientific study of discrimination and health: an ecosocial approach. *American journal of public health*, 102(5), 936-944. <https://ajph.aphapublications.org/doi/pdf/10.2105/AJPH.2011.300544>

Krieger, N. (2016). Living and dying at the crossroads: Racism, embodiment, and why theory is essential for a public health of consequence. *American Journal of Public Health*, 106, 832–833. <https://doi.org/10.2105/AJPH.2016.303100>

Lawson, T. (1998). Economic science without experimentation. In M. Archer, R. Bhaskar, A. Collier, T. Lawson, & A. Norrie (Eds.), *Critical realism: Essential readings* (pp. 144–169). Routledge.

Leeder, S. (2007). The scope, mission and method of contemporary public health. *Australian and New Zealand journal of public health*, 31(6), 505-508. <https://doi:10.1111/j.1753-6405.2007.00132.x>

Marmot, M., Allen, J., Goldblatt, P., Boyce, T., McNeish, D., & Grady, M. (2011). *Fair society, healthy lives. Strategic review of health inequalities in England post-2010*. <https://www.alpbach.org/wp-content/uploads/2013/04/Marmot-Michael.pdf>

Maton, K. (2003). Reflexivity, Relationism, & Research: Pierre Bourdieu and the Epistemic Conditions of Social Scientific Knowledge. *Space and Culture*, 6(1), 52-65. <https://doi.org/10.1177/1206331202238962>

McCrone, P., Dhanasiri, S., Patel, A., Knapp, M., & Lawton-Smith, S. (2008). *Paying the price: the cost of mental health care in England to 2026*. The King's Fund.
https://www.kingsfund.org.uk/sites/default/files/Paying-the-Price-the-cost-of-mental-health-care-England-2026-McCrone-Dhanasiri-Patel-Knapp-Lawton-Smith-Kings-Fund-May-2008_0.pdf

McCulloch, A., Muijen, M., Crepaz-Keay, D., & Goldie, I. (2005). The Mental Health Declaration for Europe: Implications for the UK. *Mental Health Review Journal*, 10, 39-42. <https://doi.org/10.1108/13619322200500039>.

McManus, S., Bebbington, P. E., Jenkins, R., & Brugha, T. (2016). *Mental Health and Wellbeing in England: the Adult Psychiatric Morbidity Survey 2014*. NHS digital.
<https://openaccess.city.ac.uk/id/eprint/23646/>

Meadows, G., & Tylee, A. (2013). Socioeconomic disadvantage and psychotherapy. *British Journal of Psychiatry*, 202(2), 86-88.
<https://doi.org/10.1192/bjp.bp.111.104489>

Michie, S., Johnston, M., Abraham, C., Lawton, R., Parker, D., & Walker, A. (2005). Making psychological theory useful for implementing evidence based practice: a consensus approach. *BMJ Quality & Safety*, 14, 26-33.
<http://dx.doi.org/10.1136/qshc.2004.011155>

Middleton, H., & Moncrieff, J. (2019). Critical psychiatry: a brief overview. *BJ Psych Advances*, 25(1), 47-54. <https://doi.org/10.1192/bja.2018.38>

Mind. (2014). Mind reveals 'unacceptably low' spending on public mental health. Mind. Retrieved October 20th, 2020, from <https://www.mind.org.uk/news-campaigns/news/mind-reveals-unacceptably-low-spending-on-public-mental-health/>

NHS England. (2014). *NHS Five Year Forward View*.
<https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf>

NHS England. (2015a). *Mental Health Taskforce Terms of Reference*.
<http://www.england.nhs.uk/wp-content/uploads/2015/03/mh-tor-fin.pdf>

NHS England. (2015b). *The Five Year Forward View Mental Health Taskforce: public engagement findings*. <https://www.england.nhs.uk/mentalhealth/wp-content/uploads/sites/29/2015/09/fyfv-mental-hlth-taskforce.pdf>

NHS England. (2016a). *Implementing the Five Year Forward View for Mental Health*.
<https://www.england.nhs.uk/mentalhealth/taskforce/imp/>

NHS England. (2016b). *The Five Year Forward View for Mental Health*.
<https://www.england.nhs.uk/wp-content/uploads/2016/02/Mental-Health-Taskforce-FYFV-final.pdf>

NHS England. (2018a). *Mental Health Five Year Forward View Dashboard Q4 2017/18*. <https://www.england.nhs.uk/publication/mental-health-five-year-forward-view-dashboard/>

O'Shea, N., & Bell, A. (2020). *A Spending Review for Wellbeing*. Centre for Mental Health.
https://www.centreformentalhealth.org.uk/sites/default/files/publication/download/CentreforMentalHealth_SpendingReviewForWellbeing.pdf

Parr, S. (2013). Integrating critical realist and feminist methodologies: Ethical and analytical dilemmas. *International Journal of Social Research Methodology*, 18, 193–207. <https://doi.org/10.1080/13645579.2013.868572>

Pilgrim, D., & Rogers, A. (2003). Mental disorder and violence: an empirical picture in context. *Journal of Mental Health*, 12(1), 7-18.

Ponterotto, J. G. (2005). Qualitative research in counseling psychology: A primer on research paradigms and philosophy of science. *Journal of counseling psychology*, 52(2), 126. <https://doi.org/10.1037/0022-0167.52.2.126>

Potter, J. & Hepburn, A. (2005). Qualitative interviews in psychology: Problems and possibilities. *Qualitative Research in Psychology*, 2(4), 281-307.

<https://doi.org/10.1191/1478088705qp045oa>

Public Health England. (2014). *Tackling the epidemic on non-communicable diseases*. <https://publichealthmatters.blog.gov.uk/2014/02/27/tackling-the-epidemic-of-non-communicable-diseases/>

Public Health England. (2015). *Public mental health leadership and workforce development framework: Confidence, competence, commitment*. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/736583/Public_Mental_Health_Leadership_and_Workforce_Development_Framework.pdf

Public Health England. (2016). *Mental health promotion and prevention training programmes: Emerging practice examples*. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/736580/Mental_health_promotion_and_prevention_training_programmes.pdf

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

Public Health England. (2017b). *Prevention Concordat for Better Mental Health; Prevention planning for local areas*. <https://www.gov.uk/government/publications/prevention-concordat-for-better-mental-health-planning-resource>

Public Health England. (2017c). *Psychosocial pathways and health equity*. <https://www.gov.uk/government/publications/psychosocial-pathways-and-health-outcomes>

Public Health England. (2018). *Public mental health leadership and workforce development framework: Call to action*.
[https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/736582/Call to Action 3.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/736582/Call_to_Action_3.pdf)

Public Health England. (2019). *The wider public health workforce: A review*.
[https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/783867/The wider public health workforce.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/783867/The_wider_public_health_workforce.pdf)

Public Health England. (2019b). *PHE Strategy 2020-25*.
[https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/831562/PHE Strategy 2020-25.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/831562/PHE_Strategy_2020-25.pdf)

Public Health England. (2020). *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>

Purtle, J., Nelson, K. L., Counts, N. Z., & Yudell, M. (2020). Population-based approaches to mental health: history, strategies, and evidence. *Annual review of public health*, 41, 201-221. <https://doi.org/10.1146/annurev-publhealth-040119-094247>

Rose, G. (2001). Sick individuals and sick populations. *International journal of epidemiology*, 30(3), 427-432. <https://doi.org/10.1093/ije/30.3.427>

Sarason, S. B. (1981). An asocial psychology and a misdirected clinical psychology. *American Psychologist*, 36(8), 827–836. <https://doi.org/10.1037/0003-066X.36.8.827>

Schwarzer, R., & Renner, B. (2000). Social-cognitive predictors of health behavior: action self-efficacy and coping self-efficacy. *Health psychology*, 19(5), 487.
<https://doi.org/10.1037/0278-6133.19.5.487>

Smail, D. (2005). *Power, Interest and Psychology: Elements of a Social Materialist Understanding of Distress*. PCCS Books.

Smith, L. S., & Wilkins, N. (2018). Mind the gap: approaches to addressing the research-to-practice, practice-to-research chasm. *Journal of public health management and practice*, 24(1), 6-11. <https://doi:10.1097/PHH.0000000000000667>

Spencer, L. and Ritchie, J. (2011). In Pursuit of Quality. In D. Harper & A.R. Thompson (Eds.), *Qualitative Research Methods in Mental Health and Psychotherapy*. <https://doi.org/10.1002/9781119973249.ch16>

Stokols, D., Hall, K. L., & Vogel, A. L. (2013). *Transdisciplinary public health: definitions, core characteristics, and strategies for success. Transdisciplinary public health: research, methods, and practice*. Jossey-Bass.

Susser, M. (1991). What is a cause and how do we know one? A grammar for pragmatic epidemiology. *American Journal of Epidemiology*, 133(7), 635-648. <https://doi:10.1093/oxfordjournals.aje.a115939>

Sweet, P. L. (2020). Who Knows? Reflexivity in Feminist Standpoint Theory and Bordieu. *Gender & Society*, 34(6), 922-950. <https://doi.org/10.1177/0891243220966600>

Synergi Collaborative Centre. (2018). *The impact of racism on mental health*. www.synergicollaborativecentre.co.uk

Tengland, P. A. (2010). Health promotion or disease prevention: a real difference for public health practice? *Health care analysis*, 18(3), 203-221. <https://doi.org/10.1007/s10728-009-0124-1>

Wallston, B. S., & Wallston, K. A. (1978). Locus of control and health: A review of the literature. *Health education monographs*, 6(1), 107-117. <https://doi.org/10.1177/109019817800600102>

Willig, C. (2013). *Introducing qualitative research in psychology* (3rd edn.). Open University Press.

World Health Organisation. (1986). *Ottawa Charter for Health Promotion: First International Conference on Health Promotion Ottawa, 21 November 1986*. https://www.healthpromotion.org.au/images/ottawa_charter_hp.pdf

World Health Organisation. (1998). *Health Promotion Glossary*.

World Health Organization. (2005). *Mental health: facing the challenges, building solutions: report from the WHO European Ministerial Conference*. WHO Regional Office Europe.

World Health Organization. (2006). *Constitution of the World Health Organization*. https://www.who.int/governance/eb/who_constitution_en.pdf

World Health Organization. (2013). *Mental health action plan 2013–2020*. <https://www.who.int/publications/i/item/9789241506021>

Yardley, L. (2008). Demonstrating validity in qualitative psychology. In J. A. Smith (Ed.), *Qualitative psychology: A practical guide to research methods* (2nd ed., pp.235-251. Sage.

6. APPENDICES

APPENDIX A: Study advertisement



Public Mental Health

Developing a Public Mental Health Workforce

Do you deliver teaching on a Master of Public Health course? Are you interested in the area of public mental health? Do you have thoughts on issues of curriculum development?

Are you interested in sharing your views?

We invite you to participate in a 1-hour online interview to explore the current landscape of mental health teaching in UK MPH courses. We would like to speak to a range of practitioners and academics with an interest in this area, as part of a doctoral research project.

For more information or to express interest please contact:
Hannah Frenken, Trainee Clinical Psychologist

Email: u1826613@uel.ac.uk

Twitter: @hannahfrenken

This study has been approved by the School of Psychology Research Ethics Committee at the University of East London

APPENDIX B: Interview schedules

Interview Schedule MaPH

Introduction

Confidentiality and use of camera on Teams, notify of recording audio

Opportunity for initial questions

1. Could we start by you telling me a bit about your background?
2. Do you know if there is any teaching on the course about mental health?

If no:

Why do you think that is?

If yes:

What sort of things are covered?

How do you think mental health is understood/ defined in the teaching?

What kind of theories or models are drawn on in the teaching?

3. What is the emphasis on wider determinants of mental health in the teaching?
How are they understood to impact mental health?
4. Do you think that (level of coverage, content) is widely covered across other courses?
5. What do you think the impact is of current teaching on practice? Does there need to be a different approach or different coverage?
6. What determines the kind of teaching available on the Masters courses?
7. What else is relevant to this area, or what have we missed?

Interview schedule regional programme/ public mental health professionals

Introduction

Confidentiality and use of camera on Teams, notify of recording audio

Opportunity for initial questions

1. Could we start by you telling me a bit about your background?
2. How are trainees supported to develop public mental health skills and knowledge?

Prompt: are there any additional taught components during this phase of training/ CPD? What are they?

3. What kind of placements might they be able to undertake in the area of public mental health?

4. What would a placement doing primary prevention work look like?

Prompt: stocktake paper indicated that most LAs doing work in secondary or tertiary prevention, would it be considered a mental health placement to be located in housing team for example?

4. Do you think that this (level of coverage, content) is similar across other regional programmes? Why do you think that is?
5. What do you think the impact is of current teaching and training on practice?
6. What determines the kind of placement experiences available?
7. What else is relevant to this area, or what have we missed?

APPENDIX C: Letter of ethical approval

School of Psychology Research Ethics Committee NOTICE OF ETHICS REVIEW DECISION

For research involving human participants
BSc/MSc/MA/Professional Doctorates in Clinical, Counselling and Educational Psychology

REVIEWER: Dominic Conroy

SUPERVISOR: David Harper

STUDENT: Hannah Frenken

Course: Professional Doctorate in Clinical Psychology

Title of proposed study: How are causes of mental health problems and preventative solutions conceptualised in teaching of the Public Health workforce? A thematic analysis of teaching content in the Public Health MSc and wider teaching programmes

DECISION OPTIONS:

1. **APPROVED:** Ethics approval for the above named research study has been granted from the date of approval (see end of this notice) to the date it is submitted for assessment/examination.
2. **APPROVED, BUT MINOR AMENDMENTS ARE REQUIRED BEFORE THE RESEARCH COMMENCES** (see Minor Amendments box below): In this circumstance, re-submission of an ethics application is not required but the student must confirm with their supervisor that all minor amendments have been made before the research commences. Students are to do this by filling in the confirmation box below when all amendments have been attended to and emailing a copy of this decision notice to her/his supervisor for their records. The supervisor will then forward the student's confirmation to the School for its records.
3. **NOT APPROVED, MAJOR AMENDMENTS AND RE-SUBMISSION REQUIRED** (see Major Amendments box below): In this circumstance, a revised ethics application must be submitted and approved before any research takes place. The revised application will be reviewed by the same reviewer. If in doubt, students should ask their supervisor for support in revising their ethics application.

DECISION ON THE ABOVE-NAMED PROPOSED RESEARCH STUDY

(Please indicate the decision according to one of the 3 options above)

2

Minor amendments required (for reviewer):

Happy for supervisor to oversee changes; I do not need to see this form again.

3.5 description of recruitment here quite vague - who are 'special interest groups? Think this could be easily clarified.

4.1-4.4 interview data should be 'anonymised and de-identified' throughout here.

Appendix B - this consent form is commendably brief, but could be a little more detailed (e.g. refer to awareness that data will be anonymised and de-identified) and might benefit from having tick boxes for individual bits of consent (e.g. awareness of withdrawal timeframe; etc) - I'm not sure if there is a model you could source to follow for this.

Major amendments required (for reviewer):

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

I have noted and made all the required minor amendments, as stated above, before starting my research and collecting data.

Student's name (*Typed name to act as signature*): Hannah Frenken

Student number: u1826613

Date: 17/05/2021

(Please submit a copy of this decision letter to your supervisor with this box completed, if minor amendments to your ethics application are required)

ASSESSMENT OF RISK TO RESEARCHER (for reviewer)

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

YES / ~~NO~~

Please request resubmission with an adequate risk assessment

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

☐

HIGH

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

☐

MEDIUM (Please approve but with appropriate recommendations)

☐

LOW

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

Reviewer (*Typed name to act as signature*): Dominic Conroy

Date: 19th May 2020

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

RESEARCHER PLEASE NOTE:

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

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

APPENDIX D: Participant information sheet



PARTICIPANT INFORMATION SHEET

You are being invited to participate in a research study. Before you agree it is important that you understand what your participation would involve. Please take time to read the following information carefully.

Who am I?

I am a postgraduate student in the School of Psychology at the University of East London and am studying for a Professional Doctorate in Clinical Psychology. As part of my studies I am conducting the research you are being invited to participate in.

What is the research?

I am conducting research into the teaching content about mental health within Public Health training programmes. My research has been approved by the School of Psychology Research Ethics Committee. This means that my research follows the standard of research ethics set by the British Psychological Society.

Why have you been asked to participate?

I am looking to involve anyone who is learning about Public Health through the MSc programme or local authority initiatives, as well as those who are involved in designing or delivering the teaching.

What will your participation involve?

If you agree to participate you will be asked to participate in an interview with me, which will take place over a video call using Microsoft Teams. For your privacy you will not share your video with me, but you will be able to see me as we discuss the issues at hand.

Your taking part will be safe and confidential

Your privacy and safety will be respected at all times. Participants will not be identified by the data collected, on any written material resulting from the data collected or in the write-up of the research. Quotes may be used anonymously in the write-up of the research to highlight certain issues. You do not have to answer all of the questions and may stop at any time.

What will happen to the information that you provide?

The information you provide will be stored securely on a password protected computer. Audio recordings of the interviews will be made. Transcripts of interviews will be anonymised, and audio recordings will be destroyed immediately once transcription has taken place.

Your anonymised data will be seen by myself, and may also be seen by the project supervisor, examiners and may be published in academic journals. Once the study has been completed, any data pertaining to the study will be destroyed.

What if you want to withdraw?

You are free to withdraw from the research study at any time without explanation, disadvantage or consequence, in which case any data you have provided will be destroyed. Separately, you may also request to withdraw your data even after you have participated, provided that this request is made within 3 weeks of the data being collected.

Contact Details

If you would like further information about my research or have any questions or concerns, please do not hesitate to contact me:

Hannah Frenken
u1826613@uel.ac.uk

If you have any questions or concerns about how the research has been conducted please contact the research supervisor Professor David Harper, School of Psychology, University of East London, Water Lane, London E15 4LZ,
Email: d.harper@uel.ac.uk

or

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

APPENDIX E: Consent form



UNIVERSITY OF EAST LONDON

Consent to participate in a research study

How are causes of mental health problems and preventative solutions conceptualised in teaching of the Public Health workforce? A thematic analysis of teaching content in the Public Health MSc and wider teaching programmes.

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

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

I hereby consent to participate in the study which has been fully explained to me. Having given this consent I understand that I have the right to withdraw from the study at any time without disadvantage to myself and without being obliged to give any reason. I also understand that if I wish to withdraw data beyond 3 weeks of participating, the researcher reserves the right to use my anonymous data where analysis of the data has begun.

Participant's Name (BLOCK CAPITALS)

.....

Participant's Signature

.....

Researcher's Name (BLOCK CAPITALS)

.....

Researcher's Signature

.....

Date:

APPENDIX F: Debrief form



PARTICIPANT DEBRIEF LETTER

Thank you for participating in my research study into the teaching content about mental health within Public Health training programmes. This letter offers information that may be relevant in light of you having now taken part.

What will happen to the information that you have provided?

The information you have provided will be stored securely on a password protected disc located on the University of East London site. Personal details including your name will not be requested as part of the survey, however if you should provide contact details for the purposes of the follow-up interview, these will be stored separately to additional data you provide. Transcripts of interviews will be anonymous and audio recordings will be deleted once transcription has taken place.

Your anonymised data may also be seen by the project supervisor, examiners and may be published in academic journals. Once the study has been completed, any data pertaining to the study including contact details will be destroyed.

What if you have been adversely affected by taking part?

It is not anticipated that you will have been adversely affected by taking part in the research, and all reasonable steps have been taken to minimise potential harm. Nevertheless, it is still possible that your participation – or its after-effects – may have been challenging, distressing or uncomfortable in some way. If you have been affected in any of those ways you may find the following resources/services helpful in relation to obtaining information and support:

The Samaritans offer 24-hour confidential support on freephone 116 123.

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

Contact Details

If you would like further information about my research or have any questions or concerns, please do not hesitate to contact me:

Hannah Frenken
u1826613@uel.ac.uk

If you have any questions or concerns about how the research has been conducted please contact the research supervisor Professor David Harper, School of Psychology, University of East London, Water Lane, London E15 4LZ,
Email: d.harper@uel.ac.uk

or

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

APPENDIX G: Coded transcript segments

Excerpts of two interviews are presented here, one from an MPH participant and one from a PH participant.

Interview transcript MPH participant	Code
<p>I: why do you think that [PMH] is not so widely covered?</p> <p>MPH2: I mean we do the “what is health” thing, so we run a session that's talking about what is health. And we do the, you know, the sort of health promotion definitions of health</p>	Mental health subsumed by health
so we covered that in my principles course, one of the principles is a sort of broad definition of health, and we talk about The WHO definition and then... I forget which health promotion Charter it came from, but you know some of the other definitions I've used...	Lack of clear definition of mental health
There's an exercise in the on-campus course where students- there's a kind of questionnaire thing that they do individually, and then they discuss it with peers and they're talking about what does health actually mean to them?	Mental health subsumed by health
And you could see lots of light bulbs coming on when you do that, but we don't have it, we don't specify that it's about mental health. Well, it's not. It isn't just about mental health,	Mental health teaching integrated with general health
so we and that's about as far as we go with that. And I think the reason we don't get into the detail is that	Don't get into detail about mental health
there's so much to cover in a MPH. Quite a lot of it's very technical.	Limited time to cover lots of content
You know we have set it up so students can have, do have choice, so they can explore these things.	PMH learning is self-directed
I mean particularly the, you know, I'm looking at... the this is not our course, the global burden of mental illness... it looks like it's more about illness than wellbeing, but it's not ours so I can't really speak much about it. I've actually, I mean, it, sort of. I've got one of our, one of my colleagues. We've got a new teaching fellow who's got a background in psychology, and we've had some discussion about perhaps having a course that will pick up some of this and look at it in a bit more detail. So we'll look at and mental illness and mental wellbeing.	Mental “illness” and wellbeing
And then there's a lot of other things we want to include in that course. So we have had some discussion about whether we should do that, but that	PMH teaching is additional not foundational

wouldn't be for all of the students that would be for students with a particular interest in mental health.	
<p>I: And you know... you have a limited amount of time. You've got a lot to cover, and that's sort of, you have to take a pragmatic approach in a way... But are there any broader issues impacting, why public mental health is not covered in most MPH courses?</p> <p>MPH2: It's exactly the same with child health or Women's Health or sexual health, they're all things that there are courses, only on the part time online program.</p>	PMH teaching is additional not foundational
So we, and lots of our students will take them. But there, it is not specific to mental health really. Yeah, yeah. And I suppose we will. I mean, I mean to emphasize, you know both in my [course title] course and the [course title] course, that is about overall wellbeing which includes mental wellbeing,	<p>Mental health teaching integrated with general health</p> <p>Mental health subsumed by health</p>
it's not just about, I mean hopefully by then the students have got the sort of got the message that it's not just about a medically defined definition of health, it is much broader than that. The things that we're talking about and the determinants are broader.	Mental "illness" and wellbeing
So I think that kind of message they'll get, but the sort of detail of the dual continuum is, really we don't talk about that at all. Maybe we should, maybe we should cover that in principles. Might be it may be a useful thing to do.	Dual continuum model

Interview transcript PH participant	Code
<p>I: And do you think that... What are they [trainees] missing in terms of their training or? Um, their experience to develop that more public mental health understanding?</p> <p>PH5: I would have thought a combination of things. I would have thought it's maybe what we just talked about, the way public health is taught... taught Masters courses, that's one thing.</p>	MPH is important setting for developing PMH knowledge
The placements that most trainees undertake are, you know, they'll spend some time in local authorities, they'll spend some time in local authorities and CCG's perhaps.	<p>Placements are important setting for developing PMH knowledge</p> <p>Placements in LA and CCGs</p>
But in terms of their external placement. I would have thought you know the tasks that they get to do: let's recommission a service for example, or let's focus on a health and well-being offer. I don't know...	Experiences of mental health prevention on placement are unknown or unclear

preventative offer. I think those are probably you know discrete pieces of work and they may well get to write a strategy. I don't know if they do that. That gives them the opportunity to spend a whole remit of, you know from prevention, right through to some kind of recovery,	
but I would have thought the things that they get to do more often, are discrete tasks. You know, commission a new service, or commission a new alcohol service – alcohol harm reduction service, and perhaps that there will be some mental health within that.	<p>PMH experiences on placement are service-oriented</p> <p>PMH experiences on placement incidental to work on other health issues</p>
And I suppose the third element is people like myself and their supervisors their educational supervisors, their placement supervisors, and how we are able, perhaps trained, perhaps competent, capable or able to have an influence on the way that they consider public mental health. I think, in terms of the overall training package. It's gotta be a combination of those things.	Expertise of placement supervisors
<p>You know, and I suppose within that to wrap it up in one level is the faculty curriculum as well, that kind of drives 'cause obviously the faculty curriculum ultimately drives my actions and therefore will drive their actions. You know, they're interested in their learning outcomes, passing exams and getting a CCT in 5 years.</p> <p>I: Yeah, yeah. I mean, I think it's probably a combination of those three things.</p>	Faculty curriculum

APPENDIX H: Extract of coding table

Example of Coding Table from Global Theme: The relationship between concepts, workforce and service structures. Please note not all codes are represented for each theme.

Sub-theme	Code	Excerpt
'Mental health' seen as lying in the domain of treatment rather than in the domain of promotion or primary or secondary prevention	Mental illness is the remit of "other people"	PH6: "other people can deal with that one" and I'll deal with... so I don't think it's a public mental health issue. I think it's a broader issue... Um? You know, in a sense, the separation between physical and mental health
	Mental health is domain of psychiatry	MPH5: in my undergraduate role I've been deeply concerned around where mental health sits within the curriculum and on the one side I kind of feel it's the psychiatrists who can take first dibs on it.
	Resources for mental health go towards secondary prevention or treatment	PH6: if you look at where the resources go, it's you know there's still a lot of service delivery there in terms of... you know tobacco, alcohol or, well, you know well-being services of one sort or another so some of that will encompass mental health
	Public mental health isn't doing prevention work	PMH1: all these people were doing public mental health work, but actually it was all about increasing treatment [...]I mean, the focus did seem to be on improving IAPT for people with anxiety and depression, you know? So it was all a little bit. I think in my experience actually, despite all the policy rhetoric about well-being promotion hardly any of it's done to scale, and there's actually no implementation of evidence based interventions.
The challenge of primary prevention and action on social determinants	Scope of public health	MPH4: it's always a tension with the public health program in particular, but it's the same for other interdisciplinary programs, I think, but for public health it's about the scope of public health

	Need for policy-level action	MPH3: look at the evidence base and it says that individual actions make no difference. It's actually policy level actions we need
	Conflict between aims of PMH and government	PH6: there is a tendency politically to look for an intervention. A neater intervention. You know, in terms of you know, increasing access to psychological therapies that the... you know health intervention is often politically the more popular choice than saying that some of our national policies are a problem here and we need to deal with the deeper issues than just putting more psychologists into the care system.
	Need for political buy-in	MPH1: And if you're working in a local authority and you've got one of the counsellors is dead keen on doing something in the local schools, it doesn't matter how much you want to work on food banks - you go and work on schools because you've got... you've got somebody there who's going to make the energy
	Pragmatic approach to change	you'll find in people in public health will. Um, certainly on a theoretical level will be more on the kind of wider determinants side, but you know, on a practical level of what they do in their day job may well focus a bit more on specific things that can be done.
Public mental health is seen as not having a valued status either in public health or NHS services	Public mental health not proper public health	PMH1: I think stigma. Is it conscious, probably not. But why isn't it thought about? It's a very interesting question. Is it because people think it's not proper public health? Maybe cardiovascular and you know, sort of. You know, emergencies, infection emergencies.
	Physical health placements more attractive to trainees	PH5: They wanna do other placements: Field Epidemiology, Health Protection, Colindale, you know specific interests in various, you know, infectious diseases and all the

		rest of it. But nobody's nobody said, you know what I want to do? A public mental health placement.
	Lack of visible leadership for public mental health	PH6: mental health professions don't seem to be visible in that sense, and I think sometimes although it's kind of a bit old fashioned because we're multidisciplinary, but sometimes having a point of leadership, you know, a professional voice that can kind of you know, advocate.
	Lack of mental health teaching further marginalises public mental health	MPH3: not having a mental health angle may well reduce the profile of mental health and peoples understanding that mental health is possibly equally as important as other public health topics like healthy eating and drinking, and things like that.
	Parity of esteem	PH6: broader issue about mental health versus physical health. That, and you know, and that the fact that people keep having to say parity of esteem shows in a way that there isn't parity of esteem so some of it perhaps relates to stigma and mental health and the way the services are separated.

APPENDIX I: Development of thematic framework

Three iterations of a thematic framework were developed to arrive at the final framework. The tables below show the development of the framework, and the initial organising of themes around the main areas of questioning in the interview, towards conceptually-organised themes in the final framework. The tables illustrate how sub-themes were increasingly elaborated, and how this led to a re-organisation of global themes in the final framework.

Initial framework

Global themes	Sub-themes
How is mental health defined?	Mental illness vs wellbeing Mental and physical health dualism
Division of labour	Lack of integration between public health departments and local authority Public mental health falls in the gap between psychiatry and public health Placement settings reflect division of labour between public health and mental health services
Conceptual frameworks informing curriculum	Medical model as the dominant conceptual framework Incorporation of wider determinants Depth of analysis and critique of public mental health theory
Structural causes of unsystematic and heterogeneous approach	Departmental expertise determines MPH content Lack of professional development and visible leadership in PMH Taking a pragmatic approach: doing what can be done

Second thematic framework

Global themes	Sub-themes
How is mental health defined?	In teaching content In practice
Division of labour	Mental health falls under treatment services The challenges of acting on wider determinants Marginalisation of mental health is reflected in the workforce
Conceptual frameworks informing curriculum	Prevalence of bio-social framework, psychological aspects are lacking Conceptualising mental health as incorporated by health and assuming the same causal frameworks apply A preference for integrated teaching rather than specific public mental health teaching
Structural causes of unsystematic and heterogeneous approach	Lack of sophisticated conceptualisations of public mental health Lack of psychologically sophisticated models, and lack of psychological thought leadership Unsystematic and ad hoc placement opportunities Teaching content contingent on interests of departmental staff Lack of incentives for public mental health approaches in policy and the wider outcome-driven culture Impact of austerity measures Unsystematic and ad hoc implementation of public mental health interventions

Third thematic framework

Global Themes	Sub-Themes
Lacking a coherent conceptualisation of mental	Implicit dualism in teaching content: Differentiating between 'mental health' and 'wellbeing'
	Implicit dualism in public mental health placements: Construed as relating either to treatment services or to services seen as promoting wellbeing
The relationship between concepts, workforce and service structures	'Mental health' seen as lying in the domain of treatment rather than in the domain of promotion or primary or secondary prevention
	The challenge of primary prevention and action on social determinants
	Public mental health is seen as not having a valued status either in public health or NHS services
Conceptual frameworks informing the curriculum	Health' seen as subsuming 'mental health'
	Integrated' versus 'segregated' approaches to coverage of mental health
	An emphasis on bio-social explanatory causal models
	A lack of conceptual frameworks of mental health and a lack of depth and sophistication in the coverage of debates
Structural causes of an unsystematic and heterogeneous approach	Curriculum content and choice of dissertation dependent on the interests and availability of staff
	Placement experience in Public Health Specialist training is dependent on the interests of trainees and supervisors
	Approaches to public mental health are influenced by conceptualisations of 'outcomes'
	The lack of a conceptual framework about mental health seen as reflecting a lack of psychological thought leadership within public health
	Impact of the political climate on public health

Final thematic framework

Global Themes	Sub-Themes
Lacking a coherent conceptualisation of mental health	Implicit dualism in teaching content: Differentiating between 'mental health' and 'wellbeing'
	Implicit dualism in public mental health placements
The relationship between concepts, workforce, and service structures	Public mental health falls in the gap
	The challenges of primary prevention and action on social determinants
	Public mental health is marginalised and excluded
Conceptual frameworks informing the curriculum	'Health' seen as subsuming 'mental health'
	'Integrated' versus 'segregated' approaches to coverage of mental health
	An emphasis on bio-social explanatory causal models
	A lack of depth and sophistication in the coverage of debates
Structural causes of an unsystematic and heterogeneous approach	Curriculum and dissertation topic dependent on interests and availability of staff
	Placements dependent on the interests of trainees and supervisors
	Conceptualisations of 'outcomes' shape approach
	Visibility and leadership from mental health professions
	Impact of the political climate on public health

APPENDIX J: Extract of reflexive journal

Presented here are reflections on the research process. Awareness of these issues developed over the course of initial interviews and as such do not belong to distinct episodes. The reflections are presented here in a narrative form to cover the two dominant themes arising from this journaling.

Becoming aware of power dynamics

From the recruitment phase, I noticed how uneasy I felt about contacting senior professionals who were likely to be extremely busy in their work, particularly given the global pandemic which was overwhelming the public health sector at the time. I felt anxious about being bothersome or that my invitation might be seen as audacious given the circumstances. I was particularly grateful when participants responded with willingness and interest in the area.

During some interviews, I struggled to go deeper into the theoretical aspects of what participants were saying; I particularly struggled to unpack the assumptions or theoretical ideas participants held about mental health. It felt important to make sure I understood what participants meant when using certain terms with little elaboration, but I wanted to avoid leading questions. In some interviews I found it hard to ask for further details. At times I believed I was sensing defensiveness of the part of the participant, and worried that they experienced my interview approach as interrogative or critical. I wondered if they experienced discomfort when being asked about areas of theory that was not their expertise.

I noticed that in response to this I was modifying my interviewing style to ask fewer requests for elaboration. Recognising that this would be impacting my findings, I attempted to manage this differently in subsequent interviews by pushing for elaboration, but asking for feedback at the end of the interview. One participant acknowledged that 'it was good to be challenged', and all participants I asked fed back that the discussion had felt useful and prompted them to think further about developing public mental health training in their remit.

Another aspect which I think impacted the interview process was that I was very aware of my limited knowledge of public health, and the seniority of my participants as producers and implementers of this kind of knowledge. I wondered about how this impacted my sense of entitlement to ask for further explanations or interrupt an answer to move the interview forward. I tried to manage my own anxiety around being 'exposed' as an imposter or illegitimate researcher by opening interviews with a clear introduction of my area of academia and my naivete about public health, making very clear the perspective I was approaching the questions from.



University of East London Psychology

REQUEST FOR TITLE CHANGE TO AN ETHICS APPLICATION

FOR BSc, MSc/MA & TAUGHT PROFESSIONAL DOCTORATE STUDENTS

Please complete this form if you are requesting approval for proposed title change to an ethics application that has been approved by the School of Psychology.

By applying for a change of title request you confirm that in doing so the process by which you have collected your data/conducted your research has not changed or deviated from your original ethics approval. If either of these have changed then you are required to complete an Ethics Amendments Form.

HOW TO COMPLETE & SUBMIT THE REQUEST

Complete the request form electronically and accurately.

Type your name in the 'student's signature' section (page 2).

Using your UEL email address, email the completed request form along with associated documents to: Psychology.Ethics@uel.ac.uk

Your request form will be returned to you via your UEL email address with reviewer's response box completed. This will normally be within five days. Keep a copy of the approval to submit with your project/dissertation/thesis.

REQUIRED DOCUMENTS

A copy of the approval of your initial ethics application.

Name of applicant: Hannah Frenken

Programme of study: Professional Doctorate in Clinical Psychology

Name of supervisor: Professor David Harper

Briefly outline the nature of your proposed title change in the boxes below

Proposed amendment	Rationale
Old Title: How are causes of mental health problems and preventative solutions conceptualised in teaching of the Public Health workforce? A thematic analysis of	Title too long and too specific to the understandings/ concepts in the teaching, whereas the study encompasses many other

teaching content in the Public Health MSc and wider teaching programmes	elements including coverage of teaching, rationale behind teaching content/ approaches, barriers and facilitators to teaching.
New Title: Mental health teaching in the training of public health professionals: A thematic analysis of interviews with key stakeholders	

Please tick	YES	NO
Is your supervisor aware of your proposed amendment(s) and agree to them?	x	
Does your change of title impact the process of how you collected your data/conducted your research?		x

Student's signature (please type your name): Hannah Frenken

Date: 15/3/2021

TO BE COMPLETED BY REVIEWER		
Title changes approved	YES	
Comments		

Reviewer: Glen Rooney

Date: 18/03/2021