The promise (and potential pitfalls) of a public health approach in clinical psychology

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David Smail's work provided an excellent example of how one might view individual distress within its social context, a context which ranged from the level of interpersonal relationships to the forces of global capital. In this paper, I review how individualised solutions to emotional distress are increasingly preferred over collective or structural approaches. Within medicine the discipline of public health has proved to be a useful counter-balance to this tendency. I discuss some of the benefits offered by adopting such an approach in mental health, while also acknowledging the need to address some of its problems (e.g. the rather uncritical use of heterogeneous diagnostic categories of varied validity and reliability).

DAVID SMAIL'S work provided an excellent example of how one might view individual distress within its social context, a context which ranges from the level of interpersonal relationships to the forces of global capital. In this article, I will discuss the way in which individual 'technical' solutions (medication and individual psychological therapy) are increasingly used in response to psychological distress. I will briefly review long-standing criticisms of this approach, in particular that such interventions are reactive (rather than preventative) and assume that causes (and thus remedies) lie within the individual (rather than in the structural conditions of society). Within medicine, the discipline of public health has proved to be a useful counter-balance to this tendency. Such population-based and preventative approaches are relatively rare within British clinical psychology. In this article, I will discuss some of the potential benefits offered by adopting such an approach in mental health. I will examine some of the obstacles which might be faced in adopting a public health orientation in clinical psychology, and consider the potential pitfalls of such an approach. Lastly, I will discuss how we might move forward, considering, in particular, implications for the training both of clinical psychologists and of public health practitioners.

The increasing use of individualised and reactive mental health interventions

Throughout the last three decades, prescriptions of psychiatric medication have been increasing, both for adults and children, well above the rates of growth of the population. Figure 1 shows how the costs of prescription for two classes of drugs rose in the 1990s, especially anti-depressants – well above the rate of inflation. Ilyas and Moncrieff (2012) report that in England, prescriptions of anti-depressants alone rose from 15,000 in 1998 to over 40,000 in 2010. Prescriptions of methylphenidate (trade name: Ritalin) rose from 6000 in 1994 (Timimi, 2004) to just under a million in 2014 (Health & Social Care Information Centre, 2015).

If we treat the numbers of clinical psychologists as a proxy measure, there has also been a large increase in the amount of individual psychological therapy received. Figure 2 shows the increase in membership of the Division of Clinical Psychology (DCP) over the last few decades. There were 362 members in 1970 (Hall et al., 2002) and 10,202 by 2011 (British Psychological Society, 2012). There were 11,279 clinical psychologists registered with the Health and Care Professions Council in January 2015 (HCPC, 2015). Despite this, the demand for psychological therapy continues to outstrip

Figure 1: Net ingredient cost of prescription items dispensed in the community (from Social Exclusion Unit, 2004).

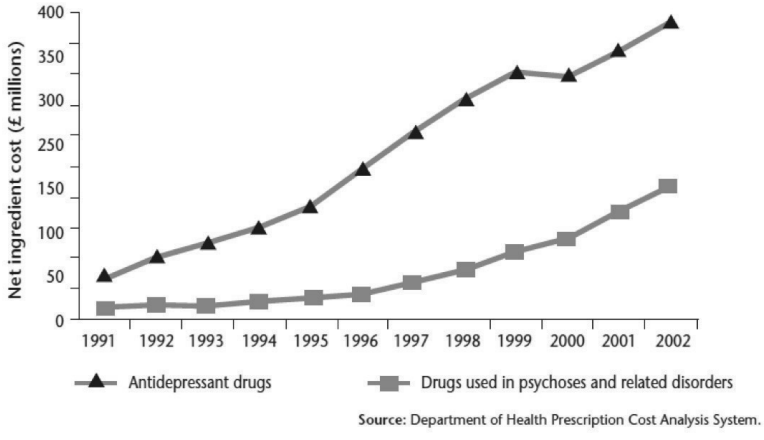
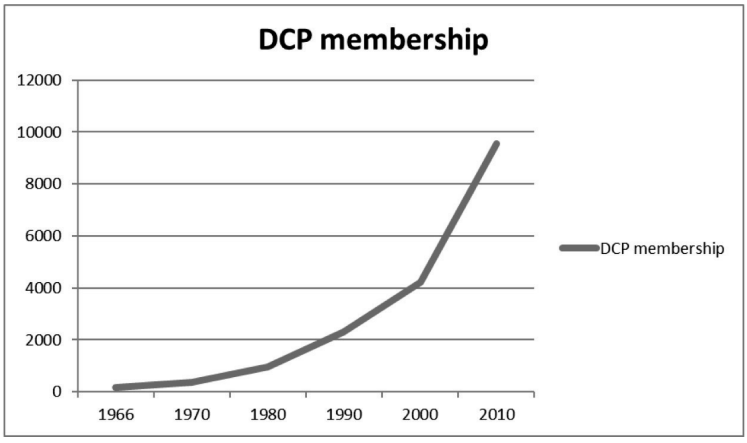


Figure 2: The growth in the membership of the British Psychological Society's Division of Clinical Psychology (DCP) from its inception in 1966.



supply (Mental Health Taskforce, 2016; We Need to Talk Coalition, 2013). For example, although the NICE guideline for schizophrenia recommends that all those with this diagnosis should be offered cognitive behavioural therapy (CBT), the National Audit of Schizophrenia found that, even when using a very inclusive definition of CBT, only 18 per cent of service users reported having received it (Royal College of Psychiatrists, 2014).

What might account for such increases in demand? Certainly, one explanation is that, over time, problems of living have become increasingly medicalised (Illich, 1976). Is there now just more psychological distress? Busfield (2012) argues that there is little evidence of change when similar data sets are examined over long periods of time. She notes, however, that changes in diagnostic thresholds (for example, the lowering of thresholds in the revisions of the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* or *DSM*) have large effects. Rose (2006, p.479) suggests that each of a number of potential hypotheses play a part, including the way in which mental health professionals act as 'moral entrepreneurs' advocating for new diagnoses and new treatments, the role of the pharmaceutical industry in constructing the way we view distress and the best way to address it and what he terms 'the psychiatric reshaping of discontents'. Busfield (2010) suggests that the increasing use of psychiatric medication can be accounted for by the strategies the pharmaceutical industry deploys to generate demand for their products, the role of doctors as researchers of – and gatekeepers to – medicines, the role of the public as consumers of medicines, and the way in which the actions of governments and insurance companies indirectly facilitate such expansion.

Bracken et al. (2012) argue that the popularity of both biomedical and cognitive psychotherapeutic interventions reflect the assumptions of what they term a 'technological paradigm' which assumes that distress arises from 'faulty mechanisms or processes of some sort, involving abnormal physiological or psychological events occurring within the individual', that 'these mechanisms or processes can be modelled in causal terms' which are not viewed as context-dependent, and that these technological interventions are 'instrumental and can be designed and studied independently of relationships and values' (p.430).

This is not a new critique. Indeed, a number of scholars, including, of course, David Smail, have made similar arguments over the last few decades. In the US, for example, the late George Albee (1986, 1990, 1999) and Seymour Sarason (1981) criticised clinical psychology for its focus on the individual rather than the social, and for its failure to move towards a more preventative focus. As Sarason has argued:

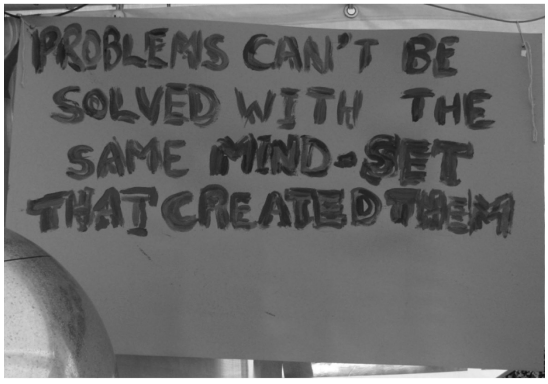
> *The therapeutic endeavour needs no justification, but when that endeavour becomes nearly all-encompassing in focus and policy, one must suspect not only the crippling role of parochial thinking but also the failure to examine and confront the nature of the society itself.* (Sarason, 1981, p.835)

Individual therapy focuses on resolving problems at an individual level rather than at the level of the population as a whole. Similarly, it is reactive – it addresses problems once they have arisen – rather than preventative. Where preventative approaches are adopted in clinical psychology, they tend to be in the domain of secondary prevention – targeting intervention through the early identification of problems – rather than in the domain of primary prevention, i.e. addressing the primary causes of distress so that problems do not arise (Harper, 2016). In the 1990s, Keith Humphreys made similar criticisms:

> *The effectiveness of psychotherapy for most of those who receive it is no longer in doubt but neither is the fact that psychotherapy can only reach a small portion of society.* (Humphreys, 1996, p.193)

If we were to sit down with a blank sheet of paper and decide on the best way to reduce population-wide distress with the most urgency, would the best solution be individual psychological therapy? Albee (1999) would argue not: '[i]ndividual psychotherapy is available to a small number only. No mass disorder has ever been eliminated by treating one person at a time' (p.133). Although the Increasing Access to Psychological Therapies project has increased the numbers of people receiving psychological therapy, the therapy offered is relatively short-term and its design necessitates this otherwise the service would grind to a halt due to increasing demand. Is it ethically and economically feasible to continue to expand the use of medication and therapy?

Figure 3: Graphic at Tent City University' at Occupy London, St Paul's (2011–2012). Photograph by Helen Spandler.



If we are to try to find a different way of thinking about and responding to psychological distress beyond individual therapy, there is a range of potential alternatives within psychotherapeutic traditions, including interpersonal and group therapy approaches, systemic family therapy and narrative therapy, especially its community work inflection (Denborough, 2008; Freedman & Combs, 2009; White, 2003). There is also innovative work going on in the service user movement – see the range of perspectives in the 30th anniversary issue of the independent mental health magazine *Asylum: An International Magazine for Democratic Psychiatry* (http://www.asylumonline.net/). For clinical psychologists, one of the most obvious alternative traditions is that of community psychology. We could also look outside the discipline of psychology for inspiration. Within medicine, the tradition of public health aims to target interventions at the level of the population and to develop primary preventative approaches. Thus, rather than simply treat the health effects of smoking, we aim to prevent people taking up smoking or encourage smokers to give up. What might be the mental health analogues of such an approach?

Potential benefits of a public health approach

Public health practitioners tend to have initial trainings in other professions (e.g. medicine, nursing, etc.) followed by further post-graduate training in public health (e.g. a Master's degree in Public Health). Previously, they worked in Public Health departments in Strategic Health Authorities, informing the commissioning of services. Following the 2012 Health and Social Care Act, commissioning and public health are now clearly separated. Public health is now the responsibility of local authorities, whereas health services are now commissioned by clinical commissioning groups (CCGs). Commissioning is supposed to be informed by local Health and Wellbeing Boards which include representatives from social services, the CCG, the public health department and others.

Peter Kinderman (2014) has critiqued the continued dominance of a medical approach to mental health in the NHS and has advocated that clinical psychologists might be better placed in local authorities and thus be more able to develop a psychosocial approach in collaboration with other agencies – an approach first developed in the UK by Mike Bender and colleagues in Newham Social Services department over 30 years ago (Bender et al., 1983; Burton & Kagan, 2003; Burton et al., 2007). Now that public health is located within local authorities there is, perhaps, much more of an opportunity to focus on the social context of psychological distress given the well-established links between distress and inequality (e.g. Friedli, 2009; Psychologists Against Austerity, 2015; Social Exclusion Unit, 2004; Wilkinson & Pickett, 2009). Public health practitioners are used to identifying social causal influences on physical health and using evidence of this to change policy and legislation (e.g. the 2007 ban on smoking in enclosed public spaces). There are a number of ways in which clinical psychologists might help in such an endeavour (Harper, 2016).

The public health tradition has previously had little impact on British clinical psychology. A few years ago, I searched for this topic in back issues of *Clinical Psychology Forum* but identified only two relevant articles: a review of the Black report on health inequalities (Black, 1982) by Peter Sturmey (1986); and a short article by the late Steve Baldwin (1993) – one of the few British clinical psychologists to gain a qualification in public health. However, public health might be a natural home for community psychology which might be advantageous given that the lack of an institutional niche has been one of the factors identified as restricting its growth in the UK (Burton & Kagan, 2003; Burton et al., 2007). There is a very well established tradition of community psychology in the UK, with many theoretically informed practice examples

(Bostock, Noble & Winter, 1999; Cromby, Harper & Reavey, 2013; Holland, 1991, 1992; Holmes, 2010; Kagan et al., 2011; Orford, 1992), and recent new innovations, including liberation psychology (Afuape & Hughes, 2015). These approaches could be combined with insights from researchers who are experienced in considering population-level health interventions (e.g. Hepworth, 2004). Moreover, there are a range of well-evidenced interventions to improve public mental health (Division of Clinical Psychology, 2014; Friedli, 2009; Newton, 2013; Taylor et al., 2007), including improving the quality of life in neighbourhoods (Biglan & Hinds, 2009) – a major causal influence on distress at community level. Such a move would also be timely as public mental health has been seen as a recent government priority (as evidenced by, for example, Public Health England, 2015).

Potential obstacles to adopting a public mental health approach

There are, however, a number of objections which are often raised in discussions about clinical psychology adopting a more preventative, psychosocial, population-level focus:

Clinical psychologists are primarily individual psychological therapists and don't have the skills for this work

This ignores the fact that many psychological skills are transferable and generalisable. Many clinical psychology programmes include teaching on a range of interventions beyond psychological therapy – like community psychology – and many foster placements where trainees can learn how to work with a range of bodies – for example in the third sector. Indeed, an increasing number of clinical psychology programmes are placing trainees in public health departments (Jenkins & Ronald, 2015), some in specialist public mental health placements.

Many clinical psychologists see the profession as synonymous with the provision of individual therapy, and yet the focus on this as our main intervention has arisen gradually over recent decades and results from a number of influences: the wish to develop non-medical interventions autonomously from psychiatry (moving away from the profession's initial role in providing technical support to the diagnostic process); the increasing popularity of psychological, especially cognitive behavioural, therapies in popular culture; the continued failure of biomedical psychiatry to find simple bio-genetic explanations of, and interventions for, distress; government acknowledgement of the rise of consumerism and the service-user movement, a major demand of which has been access to talking therapies and choice of treatments; and the way in which rise of the evidence-based practice movement coincided with the availability of the results of randomised controlled trials for a number of, predominantly cognitive behavioural, individual therapies.

British clinical psychology has traditionally adopted a pluralistic approach to psychological therapies. Even with the increasing dominance of CBT, clinical psychology training accreditation guidelines promote the learning of CBT plus an additional approach. This enables clinical psychologists to innovate, drawing on a range of theories. The report by the Management Advisory Service (1989) introduced the idea of there being three levels of psychological skill. Single-model therapy would belong at Level 2 but adopting a public health approach would require the employment of skills associated with the third level in this hierarchy. For example, clinical psychologists could integrate epidemiological and population-level data with models from community psychology, systemic approaches, interpersonal and intra-psychic traditions together with insights gained from clinical practice to develop more sophisticated models and interventions. Of course, with increasing numbers of people trained on single-model training programmes (e.g. Master's degrees in CBT) there will be increasing competition for Level 2 work.

Figure 4: Management Advisory Service levels of psychological skill*.

Level	Activities
Level 1	Basic 'psychology' – activities such as establishing, maintaining and supporting relationships with patients and relatives, and using some simple, often intuitive techniques, such as counselling and stress management.
Level 2	Undertaking circumscribed psychological activities (such as behaviour modification). These activities may be described by protocol. At this level, there should be awareness of the criteria for referral to a psychologist.
Level 3	Activities which require specialist psychological intervention, in circumstances where there are deep-rooted underlying influences, or which call for the discretionary capacity to draw on a multiple theoretical base, to devise an individually tailored strategy for a complicated presenting problem. Flexibility to adapt and combine approaches is the key to competence at this level, which comes from a broad, thorough and sophisticated understanding of the various psychological theories.

*Adapted from Management Advisory Service (1989, p.6).

This is community development/social work/economics, not psychology

This is a related objection but it rather begs the question of who gets to define the nature of 'psychology'. For example, if we were to ask a clinical psychologist for their definition of the discipline in the 1950s it might have been almost entirely focused on psychometrics and diagnosis. Disciplines evolve over time and respond to changing circumstances. Indeed, clinical psychology has shown remarkable adaptability over time and has moved through a variety of stages like psychometrics (1950s), behaviour therapy (1960s), psychotherapeutic eclecticism (1970s) and managerialism in the 1980s (Pilgrim & Treacher, 1992). It could, therefore, develop a public health approach given the right conditions. Interestingly, although we might view income inequality, for example, simply as a matter of economics, some researchers argue that economic policies are driven by assumptions and beliefs, concepts which are arguably well within the domain of psychology:

> *In the world's richest countries injustice is caused less and less by having too few resources to share around fairly and it is increasingly being maintained by widespread adherence to beliefs that actually propagate it.* (Dorling 2011, p.1)

Of course, if we are to do anything about the structural causes of inequality, we need policies to achieve this. Given the extent to which many members of the public have inaccurate perceptions of poverty and inequality and accept many myths (for instance, that welfare benefit fraud is widespread) there is a need for campaigns to address these perceptions. Social and psychological research may be of use in such a venture (Bamfield & Horton, 2009; Delvaux & Rinne, 2009; Harper, 2016; Psychologists Against Austerity, 2016).

Clinical psychologists are paid to provide therapy, not engage in community psychology or develop preventative mental health interventions

The introduction in the NHS of Payment by Results and other commissioning initiatives means that, increasingly, clinical psychology services are paid only for the provision of direct psychological therapy. In correspondence in the *American Psychologist* following Humphreys' (1996) article (e.g. Hamburg, 1997; Lieberman, 1997), the question was raised: who would pay for clinical psychologists adopting a more community preventative focus? Clearly, the development of a new approach will require a significant change in commissioning arrangements and incentives. Of course, the provision of individual psychological therapy didn't just happen. Indeed, in the UK, the increased provision of psychological therapy has been the result of concerted lobbying by alliances like the New Savoy Partnership and the We Need to Talk Coalition both of which the British Psychological Society is a member. Humphreys (1997) suggests that we need to advocate within the policy arena for funding in these areas, much as we and others did to raise the profile of psychological therapies. We need advocacy for a psychosocial approach to public mental health. As Jim White has argued, psychologists 'are worth the money as long as we exploit all our skills, not just the therapeutic ones' (White, 2008, p.847).

It is frustrating that, just at the time that we need to be moving beyond a reactive and individual focus, services are increasingly focused on this work because of perverse commissioning priorities. Senior clinical psychology posts, especially those involved in management, consultation, community liaison, service development and innovative projects have been cut and a whole layer of institutional memory about the shaping of policy has been lost. In contrast, clinical psychology posts at band 7 are much less likely to be cut. As clinical psychology is increasingly being seen as synonymous with the provision of individual therapy, the danger is that only those interested in individual therapy will apply to train as clinical psychologists.

Mental health prevention and promotion are not sufficiently evidence-based

The government's Chief Medical Officer has recently suggested that there is an insufficient evidence base for preventative approaches in mental health (Davis, 2014). This ignores the fact that there is some good evidence out there (Friedli, 2009; Newton, 2013; Taylor et al., 2007). It is, perhaps, no surprise that there is less literature on prevention than on individual treatment, when one examines the priorities of research funders. One recent report examined the relative amounts spent on research on depression and psychosis (MQ, 2015). For depression, £2.71m was spent on aetiology, £1.05m on treatment but only £0.3m on prevention. For psychosis, £1.67m was spent on aetiology, £0.3m on treatment but only £0.19m on prevention. Clearly, there is a significant mismatch here. One suspects that much of the aetiological research consists of fairly speculative bio-genetic research rather than being based on the much firmer evidence for social causal influences on distress.

This sounds too political. Psychologists aren't allowed to be political

Psychologists tend to be comfortable in looking at what David Smail called the proximal causes of distress but, as he often argued, they are less comfortable in examining distal causes like poverty and inequality, despite the substantial evidence base which exists (e.g. Friedli, 2009; Psychologists Against Austerity, 2015; Social Exclusion Unit, 2004; Wilkinson & Pickett, 2009), and Mary Boyle (2011) has documented the varied ways in which the discipline of clinical psychology has tended to avoid the social context. This is illustrated by debates within the Brit-

ish Psychological Society about the extent to which it can become involved in influencing policy, a situation complicated by the Society's composition of a variety of sub-disciplines, some of which (e.g. practitioners) are keen to influence policy-makers. It is also complicated by the fact that the Society is governed by regulations relating to its status as an organisation with a Royal Charter and its status as a charity regulated by the Charities Commission. One or both of these aspects is often referred to in Society debates where a common refrain has been whether a proposed action is 'ultra vires' – i.e. beyond the Society's authority. This refers to whether the action is consistent with the Society's aim, as stated in its Royal Charter:

> *(i) to promote the advancement and diffusion of a knowledge of psychology pure and applied and especially to promote the efficiency and usefulness of Members of the Society by setting up a high standard of professional education and knowledge.* (British Psychological Society, 2002, p.3)

As the Society is both a charity and a professional organisation recognised by the Privy Council, its policy work also needs to be consistent with this aim. The discussion and dissemination of research evidence on the social context of distress, including the effects of inequality seems to me, to be well within the objects of the Society, specifically the 'advancement and diffusion of knowledge of psychology pure and applied'. The Society has, in the past, provided information on the psychological effects of a whole range of social issues – for example, it commissioned and published James Thompson's (1985) *Psychological aspects of nuclear war* at the height of the Cold War. Moreover, the DCP website refers to the International Union of Psychological Science's (2008) Universal Declaration of Ethical Principles for Psychologists. Principle IV (Professional and Scientific Responsibilities to Society) includes the following statement:

> *Psychology functions as a discipline within the context of human society. As a science and a profession, it has responsibilities to society. These responsibilities include contributing to the knowledge about human behavior and to persons' understanding of themselves and others,* ***and using such knowledge to improve the condition of individuals, families, groups, communities, and society.*** *[emphasis added]*

The Universal Declaration also refers to the discipline's 'responsibility to increase scientific and professional knowledge in ways that allow the promotion of the wellbeing of society and all its members'. It seems to me that policy advocacy in pursuit of improving the psychological wellbeing of the population is consistent both with the Society's aims and with international psychological ethical standards. Of course, this does not necessitate campaigning for or against a particular political party but it does require us to act not only as individual citizens, but also as part of our public duty. The DCP's statement about the core purpose of the profession, for example, includes this aim:

> *Clinical psychology aims to reduce psychological distress and to enhance and promote psychological wellbeing by the systematic application of knowledge derived from psychological theory and data.* (Division of Clinical Psychology, 2010, p.2)

Potential pitfalls of a public health approach

There are likely to be challenges in adopting a new orientation in clinical psychology and I'll focus on three potential pitfalls in particular.

Uncritical use of diagnostic categories

No doubt because it is still largely a medical discipline, the literature in public health tends to adopt a somewhat uncritical approach to psychiatric diagnostic categories, despite the fact that many functional psychiatric categories are heavily contested. As Bentall (2004) has noted, for example, the diagnosis of schizophrenia does not predict prognosis, outcome or treatment. Moreover, while many assume that reliability problems with psychiatric diagnosis lie in the past, the field trials of *DSM-5* tell a different story with an editorial in the *American Journal of Psychiatry* accepting far lower levels of reliability than would previously have been the case, with agreement 50 per cent of the time presented as 'good agreement' (Freedman et al., 2013). Allen Frances (Chair of the committee which drafted *DSM-IV*) has commented:

> *[The American Psychiatric Association] flunked – instead of admitting that its reliability results were unacceptable … the goalposts were moved. Declaring by fiat that previous expectations were too high, DSM-5 announced it would accept agreements among raters that were sometimes barely better than two monkeys throwing darts at a diagnostic board.* (Frances, 2013, p.175)

Some other examples of the reliability and validity problems of these categories can be seen in Figure 5. Unfortunately, much epidemiological research uses these categories fairly uncritically but this need not necessarily be the case as many of the national epidemiological surveys collect data on particular experiences (or 'complaints' or 'symptoms') which could be analysed at this level rather than grouped into the more problematic heterogeneous categories. Moreover, clinical psychologists could improve the situation by conducting epidemiological research with constructs with good reliability and validity, taking account of population base rates and so on (Harper, 2016). A related problem is the problematic concept of 'psychiatric literacy' (or 'mental health literacy') which appears implicitly to assume a biomedical model of psychological distress. Of course, clinical psychologists could contribute to the development of a more psychosocially informed approach.

Figure 5: Some problems with 'functional' psychiatric diagnostic categories.

Problem	Examples
Reliability	*DSM-5* field trial results report low inter-rater reliabilities. For example, the diagnosis of schizophrenia had a K value of 0.46 (Freedman et al., 2013).
Validity	
Diagnostic thresholds not based on empirical analysis of base rates	Delusions still regarded as major indicators of psychosis and yet Van Os et al. (2000) found 3.3 per cent of 7000 Dutch general population sample met all diagnostic criteria for a delusion.
	Grant et al (2004) state that '[o]verall 14.79 per cent of adult Americans ... or 30.8 million, had at least one personality disorder' (p.948). This seems high for phenomena regarded as a 'disorder'.
Categories lack clear boundaries	Cluster analyses of population-wide symptom surveys do not map onto psychiatric diagnostic categories (Mirowsky & Ross, 2003).
	Heterogeneity of categories: two people with the same diagnosis can present with totally different symptom profiles.
	High co-morbidity of categories (e.g. approximately 50 per cent of those with a diagnosis of major depression also meet the criteria for anxiety: Hirschfield, 2001).

Problematic concepts

Another area of concern lies in the way in which certain concepts have been taken up in public health, particularly notions of 'vulnerability', 'empowerment' and salutogenic (i.e. focusing on determinants of health rather than illness), asset-based approaches typified, for example, by notions like 'resilience'. There is insufficient space to deal with these concepts in detail but, in short, notions of vulnerability run the risk of focusing on the victims of harm rather than the systems, people and processes that do the damage (Boyle, 2003), while notions of resilience can obscure structural causes and collective solutions (Friedli, 2013; Harper & Speed, 2012). David Smail (1994) warned of the dangers of psychologising empowerment – in some articles, for example, it seems to be a gloss for simply feeling better about oneself rather than reflecting any actual change in power relationships. Of course, these problematic concepts are also present in clinical psychology itself and, once again, psychologists can engage in research, scholarship and debate to help develop more useful approaches.

Reductions in public expenditure

Moving responsibility for public health from the NHS to local authorities could have been a transformative move had it not been simultaneously accompanied by substantial cuts to central government funding for Councils (on a much larger scale than cuts experienced in the NHS). In a study of public health departments a year after their move into local authorities, over half of respondents reported that their budgets were not ring-fenced in practice and they were being affected by cuts to Council budgets (Royal Society for Public Health, 2014). Given the announcement to cut spending on public health by £200m in 2015–2016 (Price, 2016), it seems this situation is likely to worsen.

While the time is perhaps not yet right for a wholesale move of clinical psychologists into public health departments or, as Kinderman (2014) suggests, into local authorities, if psychologists successfully advocated for a change in commissioning and research priorities, then they could begin to adopt a much more preventative role from within the NHS. It should be noted here that I am not necessarily arguing that there should be no funding for individual psychological therapy. Rather, I am arguing for a new funding stream explicitly focused on prevention. If the Greater Manchester trial of integrating health and social care services (BBC News online, 2015) works, then the direction of travel may be towards greater integration with potentially more opportunity to engage in more preventative work, though only if there are sufficient resources allocated.

Governmental policies often include contradictory imperatives and priorities, giving mixed messages. Public Health England (2015), for example, appears to signal clearly that prevention is a priority while cuts to public health budgets give the opposite impression. Psychologists and others need to advocate for more consistency so that we can develop a more psychosocially informed approach to public mental health. To prepare for this, we need to consider how we train the workforce. In the final section of this article, then, I'll focus on this important aspect.

How do we take things forward? Implications for policy advocacy and for training

Surprisingly, there is relatively little focus on mental health within public health, with only some departments having a public mental health specialist. An indication of mental health's relatively low priority in the public health system can be seen in the content of public health curricula:

> *There are academic courses at both undergraduate and postgraduate level for public health specialists and practitioners. However, our desktop study found that only 45 per cent of undergraduate and 20 per cent of postgraduate courses have a public health curriculum that clearly includes mental health.* (Public Health England, 2015, p.7)

Given the potential to make a difference at scale to populations, there is clearly a significant need for psychologists to become much more engaged both with public health departments and with the training of public health practitioners.

If we are to facilitate the development of preventative approaches, there are implications for the training of clinical psychologists. Humphreys (2000) noted that most US clinical psychology internships (i.e. placements) were in traditional clinical settings, and he suggested that programmes offer internships in new settings: preventative interventions; public policy; and community service and action. There are examples of clinical psychology programmes organising such placements – Jenkins and Ronald (2015) describe their experience as trainee clinical psychologists on placement in a public health department, and a number of clinical psychology programmes are currently organising placements in public health departments including in public mental health specialisms. These are exciting developments. Moreover, given the relative lack of focus on mental health in public health departments, a clinical psychology training placement could be mutually beneficial for those departments (who can learn what clinical psychology has to offer on a low- or no-cost basis) and for trainee clinical psychologists. Such placements would enable trainees to use their skills in gathering and disseminating useful research. They would also enable trainees to learn new skills in working with policy-makers. A number of public health researchers have noted that influencing policy in this arena requires the development of pragmatic advocacy skills (Carey & Crammond, 2015; Humphreys & Piot, 2012; Wardle & Steptoe, 2005). Indeed, Mallinckrodt et al (2014) have recently described the scientist-practitioner-advocate model of training. Such models have the potential to equip a new generation of clinical psychologists with the skills to advocate for greater social justice and so shape a more psychosocially informed approach to public mental health.

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