Overrated: Our capacity to impact policy

Carl Walker, Ewen Speed and Danny Taggart believe that the nature of public policy means we can never be as influential as we'd like to be. They follow this with an article reminding us of the value of informal psychological caregiving.

In a May 2016 piece 'Are we punching our weight?', The Psychologist journalist Ella Rhodes noted that 'an evidence-based approach to human behaviour is central to mental health, education, healthcare, employment, crime and justice'. The British Psychological Society President Peter Kinderman went further in a 2017 blog, saying: 'Pretty much all the subject matter of politics is the subject matter of psychology… Policymakers working on manifesto pledges would do well incorporate psychological evidence.' There seems to be a collective appreciation that, despite being a relatively young science, psychology has much to say about the mind and the brain and should have a role in shaping public policy.

Policy is frequently mentioned in psychological research, usually right up there in the abstract and at the end of the discussion. The authors will note that key findings of the work have one or a range of policy implications. Exactly what policies should be changed or designed is often not addressed in depth or detail. Sometimes, the authors speak not only about policy as a 'thing' but invoke a group of people whom they name as 'policy makers'. They specifically note the responsibilities of these 'policy makers' to carry out or to consider carrying out certain acts as a result of their findings, almost as if policy is something that happens elsewhere, and always in the abstract.

Such a model is framed by an idea of rational policy makers (to use Sandra Nutley's terms) who:

- are in touch with the evidence;

- have some form of policy control in a top-down fashion;

- are able to, and have responsibility to, bring these forms of evidence into this system that they control; and autonomously pick up on and appropriate psychological research in an ethical, evidence-based and rigorous way.

In this imaginary world, psychology is itself bolstered by a sustained optimism not only in the ability of scientific experts to find technological solutions for societal ills (Learmonth & Harding, 2006), but also that psychologists themselves to have sufficient prestige that their work merits such inclusion. Needless to say, this does not necessarily bear any relation to the actual process of policy making (Petticrew et al., 2004).

In his 2015 book *The Politics of Evidence-based Policy Making* Paul Cairney suggested that academics very often engage with the policy process that they wish existed, rather than the process that actually exists. We believe psychologists are prone to this wishful thinking.

The policy process that does exist is a dauntingly complex and ideologically riven mess of relations, where the evidence of psychologists exists as one, not especially compelling, presence in a range of actors, agents, networks and pressure groups. Politicians will often pay little attention to evidence unless a well-worked through solution is available. Opportunity cost and political feasibility all play into the process, not least the

consideration of what other problems could be addressed by putting the same money elsewhere. It's a classic utilitarian logic.

There is also the further tendency of policy makers to decide what they want to do and then seek enough evidence to support it (thus producing policy-based evidence rather than evidence-based policy). There may even be the distortion or selective acquisition of forms of evidence that support a given inclination on an issue. Far from being objective and scientific, policy in this characterisation is shown to be a vested and motivated form of politics, rather than an objective science based on empirical measurement. Add in the work that lobbyists, special advisers and think tanks do, and it becomes apparent that the policy context is a multi-layered, multi-level hybrid structure that is not immediately amenable to the (well-intentioned) interventions of psychologists telling people (1) what they are missing and (2) what they should be doing.

Complexity is not the only barrier facing the psychologist eager for their research work to filter through to national or local policy. There is compelling evidence that outlines the way that policies are often driven by ideology and biases rather than evidence (e.g. see Bela Fishbeyn's 'When ideology trumps evidence: A case for evidence based health policies'). If the work of psychologists chimes with the ideologies of these policy subsystems and they 'play publicly' (in Cairney's phrase) then they may be incorporated into evidence/policy programmes that tend to be normatively driven by informed guesswork, expert hunches, political and other imperatives.

If we were in the unlikely position of being able to put aside the above challenges with the policy process, we still have real problems with policy contexts. Let us take the example of gambling. Several recent papers have concluded with altogether laudable policy recommendations, such as stating that problem gambling is a health issue and there is a need for the development of early intervention programmes, effective regulation and socially responsible policies (see Mulkeen et al., 2017, and Wardle et al., 2012, as examples). One thing that unites these and many other psychologists in the field of gambling is their conviction that the work that they carry out has implications for policy and should be treated as such. We would not necessarily argue with this conviction. However, it is instructive to think through the gambling policy context and regulation environment to which such recommendations are being pointed.

For instance, in their 2013 *Changing Behaviours: On the Rise of the Psychological State*, Rhys Jones and co-authors chart the development of what they call 'debtogenic' urban landscapes, where the gambling industry has exploited loopholes in the law since 2005 to turn whole areas into spaces where gambling is socially and spatially normalised and ambient. This has been enabled by planning law and regulations (or lack of them) that have meant that post offices, shops, banks and cafés can all be converted into betting shops without permission. Tottenham High Road in London most famously has 15 betting shops along its short span. Pawn shops, ATMs and other sources of easy credit have then sprung up around them. There is evidence that the gambling industry is targeting precisely those social groups that are more vulnerable to gambling in the first place. The challenges mounted by communities and councils have failed, suggesting a seemingly intractable political context. To make policy suggestions in academic papers in such circumstances, where concerted localised political action has failed and where the national policy context has moved and is moving toward a laissez-faire, political hyper-liberalism, could be read as a profoundly naive reading of the UK gambling policy context.

We also need to consider issues of consensus and validity. Psychologists often disagree about what they are doing, how they should do it, how they should (or should not) contribute to policy, how they should measure, what they should measure and the fundamental findings from their work. Issues with the psychological evidence base, publication bias, plus the so-called 'replication crisis', have all left Tom Farsides and Paul Sparks concluding in their 2016 article that 'psychology is liberally sprayed with bullshit'. It is tempting to suggest we need to focus on getting our own house in order.

To be clear, we are not suggesting the psychologists should not seek to impact policy. But we must accept that

our capacity to do so is vastly overrated, and is based on a naïve and unrealistic understanding of what policy is and how the policy context works.

Underrated: The psychological expertise in informal settings

Recent times have seen a steady increase in the provision of primarily individually focused mental health interventions: psychiatric medication and psychological therapy. In 2007 the Healthcare Commission noted that 92 per cent of their service-user sample had taken medication: it's still the default intervention in mental health (as Dave Harper has written in these pages). Despite significant increases in spending in this area, demand still outstrips supply.

During the same period, Frank Furedi suggests that in the West there has been a 'therapeutic turn' that has encouraged victims of past wrongs to frame their claims within the language of psychology. This has facilitated a corrosion of the dignity of 'lay' human selfhood (in Mark Rapley's terms), where people in the West no longer have any sense of public agency in the understanding and amelioration of their distress. The exclusion of non-professionals from the care of the hurt or sick has resulted in new demands for medical services, and some psychologists such as Craig Newnes have argued it has become almost impossible for non-professional people to be officially understood as having expertise in psychological care. However, there is growing evidence that non-psychologically trained people in informal settings can play a key role in helping to alleviate distress in ways that professional disciplines simply can't manage (Walker et al., 2017).

We therefore argue for a rethink in our approaches to mental health. Wellbeing is inherently social, contextual and relational and, rather than understand it as a set of entities to be acquired or internalised qualities of individuals, it can be useful to think of it as sets of effects produced in specific times, places and circumstances (see Sarah Atkinson's 2013 'Beyond components of wellbeing'). Subjective feelings of wellbeing result from complex and embodied arrays of social experiences that are embedded within specific historical, cultural, political and economic settings. These sometimes enable people to experience their lives positively, sometimes negatively, and sometimes both positively and negatively.

All manner of large-scale social forces and discrete local social experiences can come to be translated into poor wellbeing. We would suggest that life choices, ways of knowing the world and wellbeing are structured through experiences of social class, abuse, gender, race, sexuality, disability, exclusion and, for some, grinding poverty (to name but a few). To explain poor wellbeing, it is important to embed individual biographies in the larger matrix of culture, history and political economy. And what have been discussed as 'symptoms' that need treatment, can often be usefully understood as the attempts of everyday people to control, deflect or ignore the pain that accompanies these. There is strong and growing evidence, in the work of Jacqui Dillon, Jane Ussher and others, that the long-term impact of racism, bullying, poverty, inequality and the corrosive effects of dysfunctional families, social worlds and political regimes are reasons why people become distressed. Preventative, community-led approaches to mental health and emotional wellbeing can be crucial and often far more impactful than contemporary psychological approaches.

Many disparate community settings, spaces and projects can offer alternative social worlds where people can feel that they belong to a group and where different criteria of worth may be applied, making possible feelings of positive identities and status (Hall et al., 2002). Within these settings – either formally or informally – loss, guilt, isolation, social marginalisation and stigmatisation can be ameliorated by the psychological sense of community, emotional support, role models, practical information, opportunity to help others and mutually supportive relationships (Walker et al., 2017). People can experiment with social roles, imagine alternative futures, develop agency and active citizenship. Discourses of disability, victimhood, powerlessness and dependence can, for some, become recognition, belonging and a sense of control (Solomon et al., 2001).

Many of these informal spaces and settings can also offer conditions of possibility that give greater promise than more formal contexts. Such informal community activities include, but are not limited to, adult community learning (Lewis, 2012), developing cohesive social networks (Pearce et al, 2016), neighbourhood quality-of-

life improvement interventions (Biglan & Hinds, 2009), mutual support groups (Solomon et al., 2001), holiday groups (Pols & Kroon, 2007), group singing (Pearce et al., 2016), co-production with excluded groups and 'enabling places' for social inclusion and increasing connections between people (Duff, 2012; Mezzina et al., 2006; Parsfield, 2015). Such spaces and settings can help foster networks for groups of people in a way that local statutory services find difficult (Cigno, 1988).

In these informal settings and spaces it is possible for distress and suffering to be understood as everyday artefacts of modern life that do not require institutions of expertise to legitimate certain states of being at the expense of others. They often require no central reliance on a system of pharmaceutical treatments or therapeutic techniques to radically alter the way that distressed people feel and think about the world. Such settings do not share with the dominant discourses of the 'Psy-sciences', the requirement for people feeling distressed to be categorised and subject to the symbolic and material practices of othering that mental health service users often find themselves party to.

Could a focus on practices – rather than on experts, immutable clinical categories, technologies and fixed knowledges – allow us to appreciate the ways that knowledge, status, relief, atmosphere and solidarity come together effectively in informal practices? If we want to recognise the fluid and innovative nature of the many informal care practices then a future course for a psychology of distress could be to develop and celebrate methods that are sensitive to this. It is difficult to recognise fluidity using the static snapshots enabled by all quantitative and many qualitative methods. Care practices can be done, rather than known or told, and they may be silent and implicit, as well as explicit and recognisable (Singleton, 2010). We would argue for a social relational approach that embraces the complexity of misery.

Within the dominant paradigm of distress, there are clearly constituted care-givers and care-receivers. Certain forms of care are recognised, practised and legitimised. But we need a rethink. If care can only be understood as 'care' if practised by the correct people (e.g. psychologist, therapist or psychiatrist), then the practices that happen in informal settings will continue to be underrated.

Dr Carl Walker is in the School of Applied Social Science, University of Brighton
C.J.Walker@brighton.ac.uk

Dr Ewen Speed is in the School of Health and Social Care, University of Essex
esspeed@essex.ac.uk

Dr Danny Taggart is in the School of Health and Social Care, University of Essex
dtaggart@essex.ac.uk

Reading

Atkinson, S. (2013). Beyond components of wellbeing: The effects of relational and situated assemblage. Topoi, 32, 137–144.

Biglan, A. & Hinds, E. (2009). Evolving prosocial and sustainable neighborhoods and communities. Annual Review of Clinical Psychology, 5, 169–196.

Cairney, P. (2015). The politics of evidence-based policy making. London: Palgrave.

Cairney, P. & Geyer, R. (2015). Introduction. In R. Geyer & P. Cairney (Eds.) Handbook of complexity and public policy. Cheltenham: Edward Elgar.

Cigno, K. (1988). Consumer views of a family centre drop-in. British Journal of Social Work, 18, 361–375.

Dillon, J., Johnstone, L. & Longden, E. (2012). Trauma, dissociation, attachment and neuroscience: A new paradigm for understanding severe mental distress. Journal of Critical Psychology, Counselling and Psychotherapy, 12(3), 145–155.

Duff, C. (2012). Exploring the role of 'enabling places' in promoting recovery from mental illness: A qualitative test of a relational model. Health and Place, 18, 1388–1395.

Farsides, T. & Sparks, P. (2016). Buried in bullshit. The Psychologist, 29(5), 368–371. https://thepsychologist.bps.org.uk/volume-29/may-2016/buried-bullshit

Fishbeyn, B. (2015). When ideology trumps evidence: A case for evidence based health policies. American Journal of Bioethics, 15(3), 1–2.

Furedi, F. (2014). Is it Justice? Therapetuci history and the politics of recognition. In E. Speed, J. Moncrieff & M. Rapley (Eds.) De-medicalizing misery II: Society, politics and the mental health industry. Basingstoke: Palgrave Macmillan.

Hall, S. & Cheston, R. (2002). Mental health and identity: The evaluation of a drop-in centre. Journal of Community and Applied Social Psychology, 12(1), 30–43.

Harper, D. (2016). Beyond individual therapy. The Psychologist, 29(6), 440–444. https://thepsychologist.bps.org.uk/volume-29/june/beyond-individual-therapy

Healthcare Commission (2007). Talking about medicines: The management of medicines in trusts providing mental health services. London: Author.

Jones, R., Pykett, J. & Whitehead, M. (2013). Changing behaviours: On the rise of the psychological state. Cheltenham: Edward Elgar.

Learmonth, M. & Harding, N. (2006). Evidence-based management: the very idea. Public Administration, 84(2), 245–266.

Lewis, L. (2012). The capabilities approach, adult community learning and mental health. Community Development Journal, 47(4), 522–537.

Mezzina, R., Davidson, L., Borg, M. et al. (2006). The social natures of recovery: Discussion and implications for practice. American Journal of Psychiatric Rehabilitation, 9, 63–80.

Mulkeen, J., Hussain, A. & Parke, J. (2017).A three stage analysis of motivational and behavioural factors in UK internet gambling. Personality and Individual Differences, 107, 114–125.

Newnes, C. (2011). Toxic psychology. In E. Speed, J. Moncrieff & M. Rapley (Eds.) De-medicalizing misery II: Society, politics and the mental health industry. Basingstoke: Palgrave Macmillan.

Nutley, S., Walter, I. & Davies, H.T.O. (2009). Promoting evidence-based practice: Models and mechanisms from cross-sector review. Research on Social Work Practice, 19(5), 552–559.

Parsfield, M. (Ed.) (2015). Community capital: The value of connected communities. London: RSA.

Pearce, E., Launay, J., Machin, A. & Dunbar, R.I. (2016). Is group singing special? Health, wellbeing and social bonds in community-based adult education classes. Journal of Community and Applied Social Psychology, 26, 518–533.

Petticrew, M., Whitehead, M., Macintyre, S.J. et al. (2004). Evidence for public health policy on inequalities: 1. The reality according to policymakers. Journal of Epidemiology and Community Health, 58(10). doi:10.1136/jech.2003.015289

Pols, J. & Kroon, H. (2007). The importance of holiday trips for people with chronic mental health problems. Psychiatric Services, 58(23), 262.

Prinja, S. (2010). Role of ideas and ideologies in evidence-based health policy. Iranian Journal of Public Health, 39(1), 64–69.

Rapley M. (2014). Introduction. In E. Speed, J. Moncrieff & M. Rapley (Eds.) De-medicalizing misery II: Society, politics and the mental health industry. Basingstoke: Palgrave Macmillan.

Rhodes, E. (2016). Are we punching above our weight? The Psychologist, 29(5), 350–353. https://thepsychologist.bps.org.uk/volume-29/may-2016/are-we-punching-ou...

Rhodes, E. (2016). Replication – latest twists. The Psychologist, 29(5), 334–335.

Singleton, V. (2010). Good farming: Control or care? In A. Mol, I. Moser & J. Pols (Eds) Care in practice: On tinkering in clinics, homes and farms. Bielefeld: Transcript Verlag.

Solomon, M., Pistrang, N, & Barker, C. (2001). The benefits of mutual support groups for parents of children with disabilities. American Journal of Community Psychology, 29(1), 113.

Ussher, J.M. (2011). The madness of women: Myth and experience. London: Routledge.

Walker, C., Hanna, P. & Hart, A. (2017). Building a new community psychology of mental health. Basingstoke: Palgrave Macmillan.

Wardle, H., Griffiths, M., Orford, J. et al. (2012). Gambling in Britain: A time of change? Health implications from the British Gambling Prevalence Survey 2010. International Journal of Mental Health and Addiction, 10(2), 273–277.