

contribute to enhancing understanding of local food consumption and health. The findings indicate important avenues for further research, such as the role that food borrowing may play in ensuring dietary diversity in these regions.

On behalf of the CFaH Team.

Thursday 10 September

Health Policy I

OP59

STAKEHOLDER NARRATIVES OF 'PROBLEMS' AND 'SOLUTIONS': ANALYSING THE 2018 HEALTH AND SOCIAL CARE COMMITTEE ANTIMICROBIAL RESISTANCE SUBMISSIONS IN THE UNITED KINGDOM

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Background Antimicrobial resistance (AMR) is an area of global policy attention. Antibiotic resistance is often characterised as a 'wicked problem', because it (i) affects, and requires simultaneous action by, public, private, and third sector stakeholders, (ii) requires local, regional, national, and supranational buy-in (and implementation of strategic change) across low, middle, and high-income countries, and (iii) spans human, animal, and environmental health. The corollary to AMR being described as a wicked problem is that 'crisis' narratives have been adopted by public health policymakers and practitioners to marshal resources, attention, and public engagement. This AMR narrative has been co-opted at times, in order to privilege solutions promoted by and involving the private sector; with the co-optation of these solutions comes the risk of sequestering public sector funds to subsidise private sector work – in particular, in the pharmaceutical and medical diagnostics industries.

Methods There were 72 written submissions made to the 2018 'Antimicrobial resistance' House of Commons Health and Social Care Committee. The sectors represented in these submissions were industry, trade associations, non-governmental organisations, professional associations, academia, government, public private partnerships, and homeopathy proponents. We accessed these documents and extracted relevant data according to the theoretically-informed critical discourse analysis (CDA) framework that we developed. Once this was complete, two researchers collaboratively coded the findings. A third researcher randomly coded a sample of the documents in order to determine reliability.

We identified the dominant and biosecurity narratives that were used by the various actors who submitted evidence. We then compared the narratives, framing, and language used by the private sector with public and third sectors, and academia. We subsequently analysed the three main promoted 'remedies' to the AMR problem and categorised them within a 'market paradox' framework.

Discussion We found that, irrespective of sector, the submissions presented the problem of AMR similarly. The solutions, however, diverged dramatically. The relevant industries use particular discursive strategies to achieve their aims, including the development of market paradoxical positions; on the one hand, asking for subsidies and incentives, but on the other

hand explaining that regulation would be detrimental to 'innovation'. We expand on these paradoxes, and catalogue the tactics used to achieve them discursively, including: obfuscating funding sources, stake inoculation, and lobbying for influence. Learnings from the unhealthy commodities industry allowed us to critically appraise the framing of industries involved in AMR.

Conclusion Overall, our CDA demonstrates that commercial interests deploying the crisis narratives do so in order to lobby heavily for self-serving solutions, namely deregulation and public subsidies. Discursive choices shaped by a technocratic-industry complex are redefining the pathways to success, monitoring, and decision-making in the global AMR arena.

OP60

NATIONAL IMPLEMENTATION OF AN INTEGRATED DIABETES PROGRAMME IN IRELAND: REALIST EVALUATION

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Background 'Integrated care' for chronic conditions is considered central to international health system reform. However, models of integrated care work differently in different circumstances. In Ireland, the National Diabetes Programme aimed to integrate diabetes care across primary, secondary and tertiary settings based on patient complexity through the introduction of new clinical posts and guidance for diabetes care. We conducted a realist evaluation to determine *how and why* the implementation of the programme worked (or not) across the country.

Methods Through documentary analysis and qualitative interviews (n=19) with a purposive sample of national stakeholders, we developed an initial theory on how the programme was expected to work. We then refined this theory in semi-structured interviews (n=39) with professionals purposively sampled to represent different clinical disciplines involved in implementation. We applied a realist logic of analysis and synthesis to iteratively build CMO configurations.

Results National stakeholders assumed that: 1) introducing guidance would formalise and standardise how care was provided, 2) that professionals would 'buy in' and align their work with new ways of working, and 3) that the new clinical posts would become catalysts for service changes at local level. At a national level, important contexts included varying levels of awareness about the programme, no plan for communicating service changes, and no established approach to implementation or professional oversight. Locally, experience delivering diabetes care, resource demands and familiarity with the intended purpose of the new clinical posts were important contextual factors. The extent to which integrated care was adopted and implemented depended on judgements made by health professionals (GPs, nurses, specialists and podiatrists) working in these contexts, specifically; judging the relative advantage of the programme and whether to engage in negotiations to legitimize their roles in diabetes care.

Conclusion Theory-based evaluations are better equipped to deal with the complexity of introducing multi-component interventions into dynamic health systems. This study suggests that, given a disconnect between responsibility for programme design and implementation, in the absence of systematic communication about the nature of changes and lack of clarity around governance and reporting structures, professionals used their judgment to adopt, implement and adapt interventions to match their priorities and circumstances.

OP61

MEDIA ANALYSIS OF THE TERM 'NANNY STATE' IN UK PRINT AND ONLINE NEWSPAPERS: IMPLICATIONS FOR PUBLIC HEALTH ADVOCACY

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Background The term 'Nanny State' has become a more prominent theme in debates on public health and policy across all media platforms. Arguments reflect both valid and less valid concerns about the government's role to protect and promote the public's health. However, there is limited research on how the term is portrayed in the media and how this may influence public opinion and thus political action. To better understand the role of the media in this debate, we therefore analyzed the portrayal and usage of the term 'Nanny State' in UK print and online media articles in relation to food, alcohol and tobacco; in order to identify key messages, and determine the implications for public health policy and advocacy.

Methods Using the Nexis UK Database, we conducted a systematic media analysis of all relevant articles that mentioned 'Nanny State', 'Nanny Statism' or synonyms in the 5.5-year period from January 2014 to June 2019. Articles that met the inclusion criteria were coded in Excel using a pre-piloted, two-part coding framework. We undertook a content analysis to examine and compare the major themes, key messages, prominence and slant, and how Nanny State was argued *for* or *against* in the articles.

Results We identified 265 articles published between January 2014 and June 2019 in 13 different mainstream national newspapers and their Sunday counterparts. 186 articles met full inclusion criteria and 79 (30%) were excluded for lack of relevance. Coverage was greatest in 2016, with three peaks coinciding with major public health announcements. Fiscal (20%) and Other Legislative Measures (26%) to reduce consumption of harmful commodities including sugar, alcohol and tobacco were the two leading main themes, with Freedom and Autonomy (43%) and Health Outcomes (47%) identified as prominent subthemes. The majority of articles (62%) were negatively slanted towards 'Nanny Statism', and approximately half (48%) negatively framed policies and interventions already in place.

Conclusion The recent UK media dialogue using the term 'Nanny State' in relation to food, alcohol and tobacco interventions was consistently pejorative. The term should generally be avoided, or perhaps rephrased as 'The Canny State'. Furthermore, government announcements relating to implementation of public health interventions and policies such as the

'Sugar Tax' can lead to more positive reporting of Nanny State perspectives. Such events may present opportunities for public health advocates to frame positive messages in the media and highlight potential health benefits.

OP62

MINDFULNESS-BASED PROGRAMMES FOR MENTAL HEALTH PROMOTION IN ADULTS IN NON-CLINICAL SETTINGS: A SYSTEMATIC REVIEW AND META-ANALYSIS OF RANDOMISED CONTROLLED TRIALS

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Background There is an urgent need for mental health promotion strategies in non-clinical contexts. Mindfulness-based programmes (MBPs) are being widely implemented, but evidence is weak with scattered small trials. High-quality systematic reviews and meta-analyses are lacking. We conducted one to assess the effectiveness of non-clinical MBPs for promoting mental health among community adults compared with no or other interventions.

Methods Thirteen databases were searched using keywords and controlled vocabulary in January 2020 for randomised controlled trials examining in-person, expert-defined non-clinical MBPs (PROSPERO CRD42018105213). Primary outcomes were psychological distress, anxiety, depression and mental wellbeing at 1–6 months after programme completion. Secondary outcomes, meta-regression and sensitivity analyses were pre-defined. Two researchers independently selected, extracted and quality-appraised trials using the Cochrane Risk-of-Bias Tool 2.0. Pairwise random-effects meta-analyses were used. Multiple testing was corrected using $p=0.0125$ for significance.

Results 10,703 records were identified, 1,372 required full-text screening, and 137 trials were included (29 countries, mean sample size=85). Preliminary main outcome results suggest that compared to no intervention, MBPs improve wellbeing (standardised mean difference (SMD)=0.21 [95%CI 0.07,0.35], p -value=0.003, $I^2=27\%$) and may improve distress (SMD -0.40 [95%CI-0.55,-0.24], p -value<0.001, $I^2=71\%$) and depression (SMD=-0.72 [95%CI-1.17,-0.27], p -value=0.002, $I^2=91\%$), with no clear support for anxiety (SMD=-0.78 [95%CI-1.40,-0.15], p -value=0.015). Against interventions without specific effects on outcomes, MBPs improve depression (SMD=-0.40 [95%CI-0.67, -0.13], p -value=0.003, $I^2=22\%$), with no clear support for distress (SMD=-0.25 [95%CI-0.47,-0.03], p -value=0.027) or anxiety (SMD=-0.74 [95%CI-1.39,-0.09], p -value=0.025) (no data for wellbeing). Compared with specific-effect interventions, MBPs