**A Political Spectator Sport or Policy Priority?**

**A Review of Sport, Physical Activity and Public Mental Health Policy**

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**Abstract**

In the context of policy and political claims about the benefits of encouraging participation in sport, physical activity (PA) and exercise for physical and mental health, and for improving the effectiveness of prevention, early intervention and treatment services for people with mental illness, this paper provides, for the first time, a critical overview of policy related to community sport, PA and public mental health (PMH). Focusing on England, the paper analyses 18 key policy documents published between 1995 and May 2016. We explain that the promotion of PMH and prevention and treatment of mental illness through participation in PA or exercise, as a formal goal of mental health policy, has been generally absent from the public health policy landscape. Until very recently, PMH and illness are also shown to be neglected as core priorities of community sport and PA policy in England. Even where PMH is discussed explicitly in national policy, the clear definition of specific and measurable goals which can be used to determine the efficacy, effectiveness and comparative effectiveness of policy in addressing PMH outcomes is notably absent. The paper concludes by suggesting that, at present, the improvement of PMH and tackling mental illness through community sport and PA appears to be more of a political spectator sport than a clearly thought-out, sustained and long-term commitment of public policy.

**Introduction**

There is increasing global concern about the substantial health problems which arise from mental, neurological and substance disorders (MNS)1 (Whiteford et al. 2015), and especially about the association of these mental illnesses with the scale of social (especially relative income and wealth) inequalities in different countries (e.g. Wilkinson and Pickett 2010; Marmot 2015; Pickett and Wilkinson 2015). Data from Wilkinson and Pickett’s (2010) *The spirit level: why equality is better for everyone* suggest that the prevalence of mental illness is higher in more unequal rich countries such as the USA, Australia, the UK, Canada and New Zealand (where around one-in-four people will at some point in any given year experience mental illness), and much lower in more equal countries such as Germany, Italy, Japan and Spain (where fewer than one-in-ten experience mental illness each year).

Despite the skewed social distribution of mental illness, MNS disorders are the leading cause of the global disease burden (Whiteford et al. 2015), and exceed the burdens associated with each of four other major categories of non-communicable diseases (NCDs): cardiovascular diseases, chronic respiratory diseases, diabetes, and cancer (Bloom et al. 2011). The findings of the Global Burden of Disease Study 2010 (GBD 2010) conducted in 187 countries revealed that mental and substance disorders accounted for 183.9 million disability adjusted life years (DALYs), a rise of 37.6 per cent since 1990 (133.6 million) which is associated with the long-term shift in burden from communicable to non-communicable diseases (Whiteford et al. 2013). In 2010, mental and substance disorders represented 7.4 per cent of the world’s measurable burden of disease (and the fifth leading cause of DALYs) and included 8.6 million years of life lost due to these disorders. The highest proportion of DALYs was reported by 10-29-year-olds, and depressive disorders were the most prevalent in all regions represented in the study, followed by anxiety, illicit drug use and alcohol use (Whiteford et al. 2013). Particularly significant was the almost three-fold increase in DALYs for depressive disorders between age 5-9 and 10-14, and near four-fold increase between age 5-9 and 20-24 (the peak age band for depressive disorders) (Whiteford et al. 2013).

Globally, depression is experienced by an estimated 350 million people, and is predicted to make one of the greatest contributions to global disease burden by 2020 (WHO, 2015). Depression is also a significant risk factor for suicide, which accounts for approximately 800,000 global deaths annually and is currently the second leading cause of death among 15-29-year-olds (WHO 2015). Although important national variations exist (see NCISH 2015), data from the UK – where mental illness is the single largest cause of disability and costs approximately £105 billion annually (roughly the cost of the entire National Health Service budget) (Davies 2014; Mental Health Taskforce 2016) – also indicate that suicide is a significant public health problem. In 2014, there were 6,109 suicides in the UK of which 76 per cent were by men (n=4,623) (CALM 2015). This means approximately 12 men in the UK die every day by suicide, making it the single biggest cause of death by men under the age of 45 (CALM 2015). Mental illness is also common among children and young people, with one-in-ten 5-16-year-olds in England having a mental health disorder, 5.6 per cent are estimated to have a conduct disorder, and 3.6 per cent experience emotional disorders (Public Health England [PHE] 2015). Half of all adult mental illnesses (excluding dementia) are also first experienced by age 14, and approximately 75 per cent of mental illnesses experienced by adults were first present by the age of 18 (HMG/Department of Health [DH] 2011; DH 2015).

These introductory remarks represent the starting point for this paper, the central objective of which is to provide, for the first time, a critical overview of policy related to community sport, physical activity (PA) and public mental health (PMH)2 and illness in England. It does so in the context of policy and political claims about the benefits of encouraging participation in sport, PA and exercise for physical and mental health, and for improving the effectiveness of prevention, early intervention and treatment services for people with mental illness. The next section examines PMH and illness as global policy problems and some of the major policy responses to those problems by the World Health Organization (WHO). We then focus particularly on national PMH policy priorities in England before reviewing the content of over 20 years of community sport and PA policy which, as we shall discuss, have until very recently largely ignored PMH and illness as key policy priorities.

**Mental health and illness as a global policy problem**

Despite policy and political claims that PMH is equally as important as physical health (WHO 2001, 2008; HMG/DH 2011; Social Care, Local Government and Care Partnership Directorate 2014), in very many countries there remains a considerable lack of parity of esteem between physical and mental health policy (Becker and Kleinmann 2013; Davies 2014; All Party Parliamentary Group on Mental Health 2015). Indeed, the lack of parity of esteem between physical and mental health policy and associated failure of many countries to integrate PMH sufficiently into all aspects of health care, policy, and practice, has resulted in a global neglect and marginalization of mental health (Becker and Kleinmann 2013).

This having been said, since 2000, there have been several important milestones in the development of an alleged global commitment to improving PMH, enhancing mental health care provision, and addressing the costs of mental illness. The *World Health Report* (WHR) 2001, for example, focused on public health approaches to mental health, the burden of mental and behavioural disorders, solving mental health problems, and PMH policy and service provision (WHO 2001). Its purpose was to enhance public and professional awareness of the actual burden and human, social and economic costs of mental disorder (WHO 2001), and help break down barriers such as stigma, discrimination and inadequate services which prevent many people worldwide from receiving treatment (WHO 2001). The report made 10 recommendations for international action which included: the provision of treatment in primary care and communities; educating the public about mental health to tackle stigma and discrimination; establishing national policies, programmes and legislation for mental health; and involving communities, families and consumers in the development and decision-making of policies, programmes and services (WHO 2001).

In 2002, the WHO mental health Global Action Programme (*mhGAP*) was endorsed by the 55th World Health Assembly which emphasized the need for Member States to improve their health care systems to deliver better quality and standards of care to people with MNS disorders. While this formal commitment strengthened the position of PMH on the global public health agenda, the *mhGAP* was only introduced in 2008 to: (i) reinforce all stakeholders’ commitment to increasing the financial and human resources needed to support care of MNS disorders; and (ii) to enhance the coverage of MNS interventions, particularly in low and lower middle income countries where large proportions of the global burden of MNS disorders are found (WHO 2008). These interventions focused on those mental illnesses (e.g. depression, schizophrenia, suicide, dementia, disorders due to alcohol and illicit drug use, and mental disorders in children) which cause the greatest burden in terms of morbidity, mortality and disability, and have the highest economic costs and human rights violations (WHO 2008).

The WHO commitment to addressing PMH and illness was further articulated in *Investing in Mental Health: Evidence for Action* (WHO 2013a) and *Mental Health Action Plan 2013-2020* (WHO 2013b). In the first of these, the WHO outlines the clear socio-economic case and supporting evidence base for investing in PMH, while the second provided guidance for national plans and sought to avoid duplicating the work of the *mhGAP* programme (WHO 2013b). More particularly, in adopting a comprehensive and multisectoral approach to PMH with an emphasis on promotion, prevention, treatment, rehabilitation, care and recovery, the action plan has at its heart the ‘globally accepted principle that there is “no health without mental health”’ (WHO 2013b, p. 6). In doing so, it identifies a series of actions for Member States and associated partners as well as numerous indicators and targets that can be used to evaluate the success of implementation, progress and impact of PMH policy (WHO 2013b).

The comprehensive and multi-sectoral approach described by the WHO is intended to achieve the main goal of the plan, namely: to ‘promote mental well-being, prevent mental disorders, provide care, enhance recovery, promote human rights and reduce the mortality, morbidity and disability for persons with mental disorders’ (WHO 2013b, p. 9). This theme was further addressed in the *Social Determinants of Mental Health* (WHO 2014) which built upon previous work on the social determinants of health (e.g. Commission on the Social determinants of Health 2008; WHO 2013c), and introduced the principle of *proportionate universalism* and the importance of adopting a *life course approach* to mental health. As Allen et al. (2014) and Marmot (2010, 2015) have noted, these seminal (and other) investigations into the social determinants of health make clear how the conditions in which people lead their lives are the main influences on their health. These conditions are however unequally distributed and the clear social gradient in health they produce are seen as avoidable, unjust and require sustained social action and political will to reduce them (Wilkinson and Pickett 2010; Allen et al. 2014; Marmot 2015; Pickett and Wilkinson 2015). In relation to mental illness, which becomes progressively more common further down the social class structure, the impact of the social determinants of PMH become especially significant because people with mental illness typically have a life expectancy between 10 and 20 years shorter than those who do not have mental illness (Marmot 2015). For Marmot (2015), this reduced life expectancy is associated with a complex interaction of physical, psychological and social processes which are, in turn, related to the significant inequities people experience in the conditions in which they are born, grow, live, work and age, and in the inequities in power, money and resources that influence them.

Given the global burden posed by the increased incidence of mental illness in many population groups, it is perhaps not surprising that the promotion of positive PMH was recently included as one of the Sustainable Development Goals of the United Nations (UN) (UN 2015). In particular, the UN (2015) now seeks to promote mental wellbeing and reduce by one-third premature mortality from non-communicable diseases through improved prevention and treatment by 2030. An additional goal is the prevention and treatment of drug abuse (including alcohol and narcotic drugs) as part of the UN’s broader commitment to promoting physical and mental health, and to extending life expectancy for all (UN, 2015).

**Public mental health policy in England: no health without mental health?**

The global policy landscape for mental health and illness outlined above provides the context for PMH policy in England where one of the most recent population-based mental health policies to have been introduced is *No Health Without Mental Health: A Cross-Government Mental Health Outcomes Strategy for People of All Ages* (HMG/DH 2011). In addition to the rising incidence of mental illness, the strategy was introduced to build resilience, promote mental health and wellbeing, and tackle health inequalities. It also sought to prevent mental illness, intervene early when it develops, and improve the quality of life of people with mental illness and their families (HMG/DH 2011).

In this regard, the promotion of PMH was described as being ‘everyone’s business’ that could be achieved only through multi-sectoral and multi-partner working oriented towards the achievement of six objectives, locally and nationally. These objectives, intended to improve the mental health of individuals and the whole population, are: (i) More people will have good mental health; (ii) More people with mental health problems will recover; (iii) More people with mental health problems will have good physical health; (iv) More people will have a positive experience of care and support; (v) Fewer people will suffer avoidable harm; and (vi) Fewer people will experience stigma and discrimination (see HMG/DH 2011). The promotion of community sport was identified as being important to the achievement of Objective 1 – More people will have good mental health – for which the Department for Culture, Media and Sport (DCMS) was to be responsible. More specifically, it was suggested that improving the proportion of people with good mental health could be achieved through the creation of a School Games event to promote competitive sport and by developing a mass participation/community sport legacy programme from the London 2012 Olympic Games (HMG/DH 2011). While not explicitly stated, the use of exercise also appeared to be endorsed as part of the Improved Access to Psychological Therapies programme, and the percentage of adults meeting the recommended PA guidelines (5 x 30 minutes per week) was cited as an indicator of progress made in relation to the promotion of PMH (HMG/DH 2011).

*No Health Without Mental Health* is supported by an implementation framework intended to bring about long-term change in mental health (Centre for Mental Health et al. 2012), and by the recommendations of *Closing the Gap: Priorities for Change in Mental Health* (hereafter, ‘*Closing the Gap*’) (Social Care, Local Government and Care Partnership Directorate 2014). *Closing the Gap* identified 25 aspects of mental health care and support as policy priorities for shorter-term action, which were clustered into the following categories of activity: increasing access to public mental health services, integrating physical and mental health care, starting early to promote mental wellbeing and prevent mental health problems (e.g. focusing on mothers and children), and improving the quality of life of people with mental health problems (Social Care, Local Government and Care Partnership Directorate 2014). To help improve the quality of life of people with mental illness, *Closing the Gap* noted – albeit in passing – the role which might be played by PA by emphasizing the role mental health support workers and carers can play in encouraging people to reduce and stop smoking, and become more physically active (Social Care, Local Government and Care Partnership Directorate 2014).

The need for structural change leading to improved efficiency and effectiveness (among other outcomes) in public health, including PMH, was also emphasized in the 2014 *NHS Five Year Forward View* (NHS 2014). The *Forward View* argued that there needs to be a closer integration of patient-focused health and social care, primary and specialist care, and physical and mental health care, to meet the increasingly complex health problems presented by the population (NHS 2014). A number of ‘ambitions’ (e.g. improved access to services, new waiting times for mental health, increased number of beds for young people) were stated to achieve by 2020 a genuine parity of esteem between physical and mental health (NHS 2014). Although significant challenges remain (see The King’s Fund 2016), the ambition to integrate physical and mental health care was endorsed by the Mental Health Taskforce in its *Forward View for Mental Health*, the purpose of which was to ensure a cross-system commitment to improving mental health outcomes across the health and care system which had yet to be achieved despite the introduction of *No Health Without Mental Health* (Mental Health Taskforce 2016). The Taskforce made a series of recommendations (requiring an additional £1 billion investment) to achieve parity of esteem between mental and physical health, including: the need for better prevention and early intervention services, improved access to crisis care, and better integration of mental and physical health care.

Unlike the broader *NHS Five Year Forward View* (NHS 2014), which made no mention of sport, PA or exercise, *Forward View for Mental Health* noted that people with mental illness (who are at greater risk of poor physical health) should get access to primary and secondary prevention and screening programmes, including interventions for physical activity and other health conditions (e.g. obesity, diabetes, heart disease, and cancer) (Mental Health Taskforce 2016). In light of what the Chief Executive of the NSPCC, Peter Wanless, has described as the impending ‘time bomb of mental health problems’ among young people (NSPCC 2015), the Mental Health Taskforce (2016) also identified children and young people as priority groups for PMH promotion, prevention and early intervention. It also recommended the full implementation of policy reforms suggested by the Children and Young People’s Mental Health and Wellbeing Taskforce in its publication, *Future in Mind: Promoting, Protecting and Improving Our Children and Young People’s Mental Health and Wellbeing* (hereafter, ‘*Future in Mind*’) (DH 2015). *Future in Mind* made a whole series of recommendations, including the need to build resilience, promote good mental health, and adopt prevention and early intervention strategies during childhood (DH 2015). In doing so, *Future in Mind* emphasized – in its only reference to sport (PA and exercise are not mentioned) – the scope available for general practitioners and other professionals to offer social prescribing of activities such as sport to improve wellbeing and mental health in children and young people (DH 2015).

***Physical activity and exercise: neglected features of mental health policy***

Having reviewed some of the major recent mental health policy pronouncements in England, it is clear that few systematic attempts have been made to consider the potential contribution that sport, PA and exercise might make to the promotion of good PMH and the prevention and treatment of conditions such as depression and anxiety. The general absence of PA and exercise, in particular, from the mental health policy landscape in England is especially noteworthy for conditions such as depression, which is the first and only mental illness for which PA is recommended as an evidence-based treatment (Ekkekakis 2015). Indeed, for depression, PA has been regarded as an efficacious intervention which has global accessibility, few adverse side-effects, is relatively low cost, and represents an attractive cost-effective option for health care systems and organizations (Ekkekakis 2015).

In some countries (including England) which adopt ‘stepped care’ models of health care, PA is also ‘recommended in clinical practice guidelines as one of the options that should be offered to patients with subthreshold depressive symptoms or mild to moderate levels of depression’ (Ekkekakis 2015, p. 21). This is because there is now strong evidence linking PA and exercise (particularly of low to moderate intensity) to many elements of PMH (Callaghan 2004; Rosenbaum et al. 2015), and to the prevention and treatment of mental illness. For adults, in particular, there is substantial evidence that exercise (particularly aerobic exercise) is as effective in reducing depressive symptomology as pharmacotherapy and psychotherapy (Smith and Blumenthal 2013), and that being physically active is preventive in the onset of, and contributes to reductions in, mild to moderate depression (Mammen and Faulkner 2013; Rosenbaum et al. 2014; Ekkekakis 2015; Schuch et al. 2016). PA has also been shown to make a significant reduction to symptom severity among people with schizophrenia (Faulkner and Biddle 1999; Faulkner et al. 2013; Rosenbaum et al. 2015), and is thought to be more effective compared to control conditions at decreasing Post-Traumatic Stress Disorder (PTSD) and depressive symptoms in people with PTSD (Rosenbaum et al. 2015).

The evidence base for exercise and PA as an intervention for anxiety in adults is more mixed and less developed than for depression, though a review of cross-sectional, longitudinal and randomized studies concluded that both exercise and PA can reduce risk factors for the development of anxiety disorders and symptoms for specific and generalized anxiety (Utschig et al. 2013). The study also concluded that anxiety disorders are associated with lower levels of PA, and that the relationship between PA and anxiety may be bi-directional (Utschig et al. 2013; see also Stonerock et al. 2015). A more recent systematic review of 12 Randomized Control Trials and five meta-analyses found that exercise, as a treatment for elevated anxiety or anxiety disorders, can be as beneficial as established treatments including medication, but noted that most studies suffered from a range of significant methodological limitations (Stonerock et al. 2015). In this regard, the authors noted that the evidence base for exercise is not of sufficient scientific rigor to recommend it as a form for treatment for people with clinically elevated anxiety (Stonerock et al. 2015).

In comparison to adults, the impact of exercise and PA on the mental health of children and young people has received considerably less attention, with depression, anxiety, self-esteem and cognitive functioning being the most widely studied conditions in the limited evidence which exists (Larun et al. 2006; Biddle and Asare 2011; Brown et al. 2013; Smith and Blumenthal 2013). In a review of reviews, Biddle and Asare (2011) concluded that PA: (i) has potentially positive effects for reduced depression; (ii) has small beneficial effects for reduced anxiety; (iii) can improve self-esteem, at least in the short-term; and (iv) can be associated with improved cognitive functioning, including academic performance, but these associations are usually small and inconsistent. In each case, however, the evidence was reported to be limited, and many studies were mainly cross-sectional and regarded as involving low quality intervention designs (Biddle and Asare 2011).

A follow-up systematic review and meta-analysis found a small, but significant, treatment effect for PA on depression in children and adolescents, which suggests that PA may play a role in the prevention and treatment of depression (Brown et al. 2013). Greater treatment effects were observed in studies where reductions in depression was the only programme outcome, where a PA intervention was complemented by an educational component, and where programmes targeted key participant characteristics (e.g. males or females, overweight or obese populations). The study concluded that more outcome-focused studies are needed to inform the implementation of programmes which seek to reduce depression among young people (Brown et al. 2013). Investigations of Dutch adolescents have also found that the intensity, frequency duration or nature of PA does not predict a major depressive episode onset among males and females (Stavrakakis et al. 2013), and that declines in PA over a one-year period does not predict changes in depressive symptoms and self-esteem (Van Dijk et al. 2016). In this regard, changes in mental health were more likely to be affected by baseline levels of mental health, rather than declines in PA, and PA was thus considered as being particularly beneficial for adolescents with moderate to severe depression (Van Dijk et al. 2016).

While it is important to remain mindful of the limitations of the existing evidence base, PA and exercise are now often recommended by researchers as important components of interventions for people with mental illness (especially adults). They are also frequently identified as having a dual benefit for physical and mental health in the general population, as well as those with specific mental illnesses (Callaghan 2004; Rosenbaum et al. 2014; Ekkekakis 2015; Schuch et al. 2016). However, as Callaghan (2004) has noted, despite its potential effectiveness exercise appears to be a largely neglected intervention in mental health care, is rarely recognized by those in mainstream mental health services, and together with PA, exercise remains largely absent from the mainstream PMH policy landscape. The next section also indicates that PMH and mental illness have also – until very recently – been largely overlooked in policy related to community sport and PA in England.

**Public mental health and community sport and physical activity policy in England**

Given the longstanding, and now routinely and uncritically expressed, ideology which links sport and PA with good health (Waddington 2000), we might have expected PMH and mental illness to feature prominently in community sport and PA policy in England. In this section, we provide a critical overview of the content of 18 key documents related to national community sport and PA policy published in England between 1995 and May 2016, a time frame which begins with the publication of only the second ever sport policy released by a British government (the other was in 1975) and when PA promotion began to be considered a government responsibility (Milton and Bauman 2015). While there are some clear overlaps between the policies analysed, for ease of presentation we shall divide the documents into two broad kinds of policy: PA and sport.

***Community physical activity policy***

Not surprisingly, during the review period, PA policy was primarily oriented towards public health concerns and most commonly published by the DH. Perhaps the most substantial discussions of PMH and illness were to be found in policies authored by the Chief Medical Officer (CMO), including *At Least Five a Week: Evidence on the Impact of Physical Activity and its Relationship to Health* (hereafter, *‘At Least Five a Week’*), published by the DH (DH 2004). *At Least Five a Week* devoted a whole chapter to PA, psychological wellbeing and mental illness in adults, and noted the benefits of PA for the mental health of older people, children and adolescents. Overall, the evidence review concluded unambiguously that PA and exercise are effective in promoting mental health in the general population, in both the prevention and treatment of some mental illnesses such as depression, and as an adjunctive measure in lifestyle interventions. For adults, PA was said to be effective in the treatment of mild, moderate and severe clinical depression and can be as successful as psychotherapy or medication, particularly in the longer term. PA was also cited as being beneficial for people with generalised anxiety disorder (by reducing state and trait anxiety), those who experience phobias, panic attacks and stress disorders (via reducing physiological reactions to stress), and can have a positive effect on psychological well-being in people with schizophrenia as well as improving self-esteem, particularly in those with initial low self-esteem. Improved sleep and – in older people – aspects of cognitive function were among the other cited benefits of PA (DH 2004).

Despite the positive endorsement of PA and exercise in *At Least Five a Week*, it was activity of a particular kind and intensity which was cited as being particularly beneficial to the promotion of PMH and prevention and treatment of mental illness. In particular, it was claimed that:

Regular moderate intensity activity can improve psychological well-being. Evidence is strongest for activity which lasts between 20 and 60 minutes. However, shorter bouts (10-15 minutes) of moderate intensity walking can induce significant positive changes in mood. Rhythmic aerobic forms of exercise – such as brisk walking, jogging, cycling, swimming or dancing – appear to be most consistently effective. Resistance exercise may be useful for enhancing self-perceptions, as it can have rapid effects on how the body feels and functions. (DH 2004, p. 6)

Competitive sport and vigorous exercise were also regarded as important sources of psychological well-being for people who are already accustomed to those activities (DH 2004), while group recreational sports were said to bring social and mood benefits for participants. In children and adolescents, the then evidence was described as indicating that PA interventions can have a generally positive impact on mental health but a weak effect on reducing stress, anxiety and depression in adolescents. Sport and exercise were also regarded as important contexts for young people to experience positive effects on self-esteem and self-perceptions of competence and body image, with a stronger effect being noted for those already low in self-esteem (DH 2004).

Five years later, in *Be Active, Be Healthy* (DH 2009), the former CMO, Professor Sir Liam Donaldson, re-emphasized the aforementioned benefits of regular moderate intensity PA for mental health. The report further noted, however, that these benefits are frequently overlooked and that in some cases PA can be offered to patients with mild to moderate depression as an alternative to pharmaceutical treatment (DH 2009). The National Institute for Health and Care Excellence (NICE) clinical guidelines for depression were also endorsed, with the report recommending that all patients with mild depression should be advised of the benefits of following an exercise programme which is structured and supervised (DH 2009).

The third CMO-authored report included in the review period was the 2011 publication *Start Active, Stay Active: Report on Physical Activity in the UK* (DH 2011), which superseded *At Least Five a Week* and included – for the first time – a common set of PA recommendations across the UK. Among other things, it was suggested that, for adults, 30 minutes of at least moderate intensity PA on at least 5 days each week plays an important role in preventing mental illness, promoting mental health and well-being, and improving the quality of life of those with mental illness (DH 2011). In particular, participating in this kind of PA was described as beneficial for reducing the risk of depression, dementia and Alzheimer’s disease, as well as enhancing psychological well-being via improvements in self-perception and self-esteem, mood and sleep quality, and reductions in levels of anxiety and fatigue (DH 2011).

The promotion of PA in helping to reduce the prevalence and incidence of dementia among older adults (specifically 65-74-year-olds) was identified in *Everybody Active, Every Day* (PHE 2014) as one of seven public health priorities for 2014-2024. This was prompted by the estimate that approximately800,000 people in the UK currently experience dementia and evidence that being physically active can help reduce the risk of vascular dementia as well as having a positive impact on non-vascular dementia (PHE 2014). Once again, it was moderate PA lasting 30 minutes each day (such as taking a brisk walk, swimming, gardening, or cycling to the shops or to work) which was regarded as being particularly effective for promoting PMH. While no specific strategies for enhancing PMH, or preventing or treating mental illness are mentioned, another report published by PHE – which focused on PA promotion in schools and colleges – suggested that improved mental wellbeing, self-esteem and reduced levels of anxiety and stress are amongst some of the benefits of PA for children and young people (PHE 2015). None of the other documents which focused on PA mentioned PMH or mental illness.

***Community sport policy***

In contrast to policy broadly oriented towards PA, reference to PMH and the prevention and treatment of mental illness has very rarely been the focus of community sport policy in England. Indeed, despite regularly extolling the alleged health benefits of sport participation, neither mental health nor mental illness were mentioned in *Sport: Raising the Game* (DNH 1995), *A Sporting Future for All* (DCMS 2000), *Before, During and After: Making the Most of the London 2012 Games* (DCMS 2008), *Playing to Win: A New Era for Sport* (DCMS 2008), or *Creating a Sporting Habit for Life: A New Youth Sport Strategy* (DCMS/Sport England 2012). Even in what has been regarded as one of the more comprehensive government statements on sport and PA in England – *Game Plan: A Strategy for Delivering Government’s Sport and Physical Activity Objectives* (DCMS/Strategy Unit 2002) – only two references were made to mental health. Firstly, it was claimed that research has ‘found a consistent link between exercise and anxiety reduction; and protection against the development of depression’ (DCMS/Strategy Unit 2002, p. 45), and secondly, Professor William Haskell of Stanford University Medical School was quoted as saying that ‘Exercise isn’t a panacea, but it has consistently been shown to relieve both depression and anxiety’ (DCMS/Strategy Unit 2002, p. 51).

Over a decade of Sport England policy has similarly produced just a handful of references to mental health, including in 2004, when it was claimed that ‘participation in sport and physical activity contributes positively to overall personal health and fitness levels, and also to mental health with a positive effect on anxiety, depression, mood and emotion, self-esteem, and cognitive functioning’ (Sport England 2004, p. 29). Four years later, in *Healthier Communities: Improving Health and Reducing Health Inequalities through Sport*, the claim that sport can contribute to improved mental health and wellbeing (Sport England 2008) was the only direct reference made to PMH.

It is clear, then, that throughout almost all of the review period there has been a near complete absence in published community sport policy of the mental health of children, young people and adults, and of mental illness in these population groups. However, between the end of 2015 and May 2016, two significant policy documents – *Sporting Future: A New Strategy for a Sporting Nation* (hereafter, ‘*Sporting Future*’) (HMG 2015) and *Towards an Active Nation* (Sport England 2016) – identified ‘mental wellbeing’ (rather than PMH, which is not identified but conflated with ‘mental wellbeing’) as one of five outcomes to be addressed as part of the Conservative Government’s concern with delivering social outcomes through participation in sport and PA, as well as increasing the proportion of physically active and inactive people.

Published by the DCMS in December 2015, *Sporting Future* makes clear how the enhancement of mental wellbeing and the other four outcomes will ‘define who we [government] will fund, what we fund and where our priorities lie in the future’ (HMG 2015: 9). To provide evidence of sport’s contribution to each overall outcome, various other ‘high-level outcomes’ (measured at a national level) are identified alongside three broad ‘outputs’ which are to be assessed by a number of population-level ‘Key Performance Indicators’ (KPIs) (HMG 2015). In relation to mental wellbeing, the high-level outcome is ‘improved subjective wellbeing’ (HMG 2015, p. 74) which consists of four key elements: feelings of life satisfaction, worthiness, happiness and anxiety. The main output is ‘more people taking part in sport and physical activity’ (HMG 2015, p. 77) which is aligned to KPI 3 – ‘Increase in the percentage of adults utilising outdoor space for exercise/health reasons’ (HMG 2015, p. 78).

While the increased attention paid to mental wellbeing in *Sporting Future* is notable, this part of the strategy is also characterized by some significant confusion and contradiction. Not only is mental *wellbeing* treated synonymously and misleadingly as being the same as mental *health*, it is also unclear – because no supporting evidence is cited – why increasing only adults’ (and, interestingly, not children’s and young people’s) use of particular settings (i.e. outdoor space), for particular motivations (i.e. exercise/health reasons), is prioritised over participation in other settings and for other motivations. Claims made about the respective evidence bases for sport, PA and exercise are similarly confused and lacking in internal coherence. On the one hand, it is suggested that the ‘evidence for sport’s impact on physical and mental health, building social capital, educational attainment and employability and economic growth is *well-established*’ (HMG 2015, p. 72; emphases added), and that it is in each of these five areas ‘where sport can make its greatest contribution’ (p. 72). In addition, a variety of other benefits to mental health and illness are simultaneously claimed for *sport* (i.e. ‘Sport is, for many people, a hugely enjoyable experience’), *PA* (i.e. ‘Physical activity can reduce stress and anxiety’), and *exercise* (i.e. ‘Research has shown that exercise can be as effective as anti-depressants for those with mild clinical depression’) (HMG 2015, p. 74). Collectively, these positive outcomes are regarded as being ‘every bit as important as the physical benefits from taking part in sport, and evidence is clear on the mental as well as physical health benefits of meeting the CMO [physical activity] guidelines’ (HMG 2015, p. 74).

On the other hand, despite claims of the clear and well-established evidence base for sport’s contribution to positive mental wellbeing, *Sporting Future* suggests that the links between them are not well understood. Indeed, it is suggested that in comparison to the benefits of meeting *PA* guidelines, ‘less is known about the precise links between mental wellbeing and sporting behaviours’ (HMG 2015, p. 74). Together with individual development and social and community development, it is also claimed that ‘more work will be needed over the coming years to understand and evidence the exact impact that sport and physical activity can make’ (HMG 2015, p. 72) on mental wellbeing. Another more cautious assessment of the evidence base made clear that ‘where causality is *less well understood* or the evidence base *does not yet exist* (*mental wellbeing*, individual development, social and community development) we will work to develop a robust understanding of how sport contributes that will then form the basis for how impact is measured in the future’ (HMG 2015, p. 73; emphases added).

In response to *Sporting Future*, Sport England – which in 2015 collaborated with the mental health charity, Mind, to launch the three-year *Get Set to Go* programme to promote sport participation among 75,000 people with mental illness (Sport England 2015) – published its own 2016-2021 strategy, *Towards an Active Nation* (Sport England 2016).Not surprisingly, since *Sporting Future* made very clear the expectations the DCMS now have of Sport England, *Towards an Active Nation* sets out how Sport England will work to help achieve the key outcomes and policy trajectory identified in *Sporting Future*. In doing so, Sport England suggest that it will need to ‘develop new ways of evaluating the broader outcomes of sport, especially mental wellbeing, individual development and social and community development’ (Sport England 2016, p. 7) to enable it and other organizations to show how they are contributing to the Government’s policy priorities and helping to strengthen the rationale for continued public investment in sport (Sport England 2016).

At first glance, the claims made in *Sporting Future*, in particular, might seem to indicate that the benefits to mental wellbeing from engaging in sport, PA and exercise are overwhelming, but it is important to note that the available evidence – including the findings of the studies reviewed earlier – refer not to sport, but to PA or exercise. But these are not the same thing, and while there is certainly widespread acceptance of the idea that ‘sport is good for health’ (Waddington 2000), the conflation of sport with PA and exercise (and their respective evidence bases) in *Sporting Future* is significant in policy and public health terms. As noted elsewhere (Mansfield and Malcolm 2015; Waddington 2000), sport varies in several important ways from PA and exercise, including in the degree to which sport: (i) is inherently more competitive and institutionalized; (ii) can be associated with higher rates of injury and violence (especially at higher levels of sport); (iii) is characterized by different kinds of social relationships which make the intensity, frequency and timing of participation more difficult to control; (iv) and is more commonly associated with a whole range of values and behaviours which may compromise (mental) health. At the very least, a recognition of these important differences – which are contested, historically dynamic and culturally variable (Mansfield and Malcolm 2015) – sound a clear warning against accepting without question the presumed and inherently positive relationship between PMH and sport, PA and exercise as articulated in *Sporting Future* and associated policies.

It is also clear that while the scientific evidence may provide a strong case for promoting PMH through engagement in PA and exercise, and including these in the routine delivery of interventions to people with mental illness (Callaghan 2004; Rosenbaum et al. 2014), the evidence base for sport is presently much less developed and robust than is perhaps assumed in *Sporting Future*. Indeed, until recently comparatively less emphasis has been placed on exploring sport participation and its association with PMH outcomes (Faulkner and Tamminen 2016). According to Faulkner and Tamminen (2016), there are several reasons for this, including the propensity for researchers investigating the links between PA and PMH to be primarily concerned with controlling the dose of exercise undertaken by participants while eliminating any potentially confounding variables (such as social interaction) to explore potential associations, which is considerably difficult in sporting contexts. Researchers have also frequently devoted more attention to examining the health compromising behaviours (some of which relate to mental illness) associated with sport, and investigated the PMH benefits of PA and exercise which, by comparison to traditional forms of sport, become progressively more popular over the life course for a larger proportion of the population (Faulkner and Tamminen 2016).

Since the current evidence base in this area is more complex and nuanced than is perhaps commonly assumed, policy makers and practitioners face a number of challenges in seeking to provide government with evidence of the contribution made by sport participation (though the same applies to PA and exercise) to PMH. Central among these is the tendency for different kinds of sports participation to generate different mental health outcomes, among different groups of participants, in different social contexts where sports-based community-focused projects are delivered. Closer attention will thus need to be paid to understanding the contexts, mechanisms and processes (see Coalter 2007; Whitelaw et al. 2010; Mansfield et al. 2015; Coalter 2016) which are associated with sport participation and the differential PMH outcomes generated by it. An understanding of the problem of self-selection in sport participation, the quality of participation experiences, and the other constraints which impact on mental health are among the other complex issues which need to be considered by bodies such as Sport England (2016) if they are to develop more robust and consistent evaluation practices which help identify the progress they make towards the government’s outcomes. In this regard, on the basis of the current evidence, it is perhaps more balanced and realistic to suggest that participating in sport *may* make a positive contribution to aspects of mental health (or mental wellbeing, in *Sporting Future* parlance), and *may* be a helpful component in preventing and treating mental illness, but this is likely *only to occur under specific circumstances which as yet are not well understood* (Whitelaw et al. 2010).

**Conclusions**

In this paper we have sought to provide, for the first time, a critical overview of sport, PA and PMH policy via an analysis of key policy documents published in England between 1995 and May 2016. It was clear that there has been increased but gradual interest (however rhetorical) among those in key policy communities in the contribution which sport, PA and exercise might make to PMH and mental illness. While some of the policy documents contained (often rather vague) references to the importance of sport, PA and exercise for PMH and illness, the clear definition of specific and measurable goals which can be used to determine the efficacy, effectiveness and comparative effectiveness of national policy in addressing PMH outcomes was notably absent. Even in the most explicit discussion of PMH in community sport policy – namely, *Sporting Future* – reference was made only to ‘mental wellbeing’ as a desired outcome without identifying any clearly defined targets or policy goals against which to judge progress. In this regard, the absence of any discussion about what constitutes policy effectiveness, about how progress is to be monitored and evaluated, and about how to identify the differential contribution participation in different kinds of sports, physical activities and exercises might make to any observed changes in mental wellbeing are significant oversights. Similarly, while making more regular, detailed and systematic reference to the evidence base which exists for the impact of PA and exercise on PMH and illness, community PA policy in England has also failed to include specific and measurable population targets which can be used to determine the progress made by policy in which PA and exercise are used to affect positive change in PMH and illness through community-based programmes and interventions.

It is unclear why these details were absent from the various policy documents analysed, but claims made about the need to encourage population level engagement in community-based sport, PA and exercise for mental health benefit need to be balanced against real term reductions in funding and services for PMH in England. This may be particularly significant for those in community sport who, in the battle for public funding and support, appear willing to present sport as an important contributor to overall PA, and as a vehicle for addressing current concerns about PMH and illness. Attempts to do so, as revealed very clearly in *Sporting Future*, provides further evidence of the marginal status of community sport as a policy sector relative to other, generally more secure and powerful (e.g. health and medicine), policy communities. Indeed, that those in the sport policy community appear so keen to generalize their interests to other policy areas which bolster their legitimacy in the eyes of others, and helps justify their work as a legitimate area of activity worthy of political support and funding, may be seen as further evidence of the status anxiety and marginality experienced by those in the sector. While there may be genuine interest in addressing concerns about PMH and illness through community sport and PA, might the association with PMH also be a vague, convenient, and largely symbolic one unlikely to stimulate any long-lasting and real change in policy and practice? Or will the allegiance between those in community sport and PA on the one hand, and PMH on the other, help strengthen considerably their ability to lobby more effectively for resources, legitimacy and status within the political and policy hierarchy? These are questions for which there are as of yet very few answers.

Finally, the policy developments examined in this paper may be indicative of the gradual (and as yet partial) convergence of the community sport and PA policy communities, and an increasing intersection between the fields of sport, health and medicine which supports the increasingly decentralized, and locally-determined, approach to the delivery of public services. However, as developments in the provision of health care services indicate, the devolvement of responsibility for policy decisions to local government and services in contexts of austerity is more likely to increase, rather than help breakdown, local variations in mental health service provision and use, and skew even further the unequal social distribution of (mental) health outcomes across communities. It is also likely to strengthen the dominant but largely ineffective neo-liberal approach towards policy in which disproportionate emphasis is placed on exercising independence and personal choice, individual behaviour change, self-responsibilization, and self-governance. For reasons explained elsewhere (e.g. Marmot 2010; Wilkinson and Pickett 2010; Marmot 2015; Pickett and Wilkinson 2015), such an approach not only detracts attention from the very significant social processes associated with unequal health outcomes, but most often contributes to widening socially structured inequalities in PMH. Many of the inequalities associated with poor PMH outcomes also typically precede inequalities in sport and PA participation in many countries (Coalter 2007, 2016), so the simple promotion of sport and PA – whether on their own or in combination with other activities – is considerably unlikely to tackle effectively the increasing prevalence of mental illness, or promote good PMH, unless the deep-seated roots of corrosive forms of social inequality are tackled first. Regardless of whether one accepts these conclusions, they at the very least merit more serious attention by those with a genuine commitment to better understanding and tackling the inequalities which contribute to the global burden of mental illness and the considerable human costs associated with it. Recognizing the importance of these issues may be a first step in ensuring that the improvement of PMH and tackling mental illness through community sport and PA becomes less of a political spectator sport, and more of a clearly thought-out, sustained and long-term commitment of public policy.

**Notes**

1 MNS disorders exist in all countries, but are often underpinned by Western-based definitions that take insufficient account of the importance of cultural contexts in understanding their development, presentation and treatment. The Global Burden of Disease Study 2010 is not immune from these weaknesses and the data presented below should be interpreted accordingly (see Whiteford et al. 2015).

2 Following the UK’s Chief Medical Officer (Davies 2014), we have adopted the term ‘public mental health’ where appropriate to refer to those ‘mental health variations of importance exhibited by populations’ and which consists of ‘mental health promotion’, ‘mental illness prevention’ and ‘treatment and rehabilitation’ (Davies 2014, p. 12), for which there is a good deal of persuasive evidence compared to the vaguer notion of ‘wellbeing’ as it relates to mental health.

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**Table 1 Key documents related to national physical activity and community sport policy in England, 1995-May 2016**

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| **Policy or policy-related document** | **Organisation** |
| Sport: Raising the Game, 1995 | DNH |
| Strategy Statement on Physical Activity, 1996 | DH |
| A Sporting Future for All, 2000 | DCMS |
| Game Plan, 2002 | DCMS/Strategy Unit |
| At least Five a Week, 2004 | DH |
| The Framework for Sport in England, 2004 | Sport England |
| Before, During and After: Making the Most of the London 2012 Games, 2008 | DCMS |
| Healthier Communities, 2008 | Sport England |
| Healthy Weight, Healthy Lives, 2008 | DH |
| Playing to Win, 2008 | DCMS |
| Be Active, Be Healthy, 2009 | DH |
| Start Active, Stay Active, 2011 | DH |
| Creating a Sport Habit for Life, 2012 | DCMS/Sport England |
| Everybody Active, Every Day, 2014 | PHE |
| Moving More, Living More, 2014 | HMG/Mayor of London |
| Sporting Future, 2015 | HMG |
| What Works in Schools and Colleges to Increase Physical Activity?, 2015 | PHE, Youth Sport Trust and Association of Colleges Sport |
| Towards an Active Nation, 2016 | Sport England |