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PREVENTION AND EARLY INTERVENTION

Companion Note

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This report is a complementary note to the report, 'Prevention in Scottish Public Service Reform', by Des McNulty and published by Enlighten in June 2026. It reflects on the public debate around public service reform, Scottish government action and looks ahead to the 2026 Programme for Government.

1. Purpose

The June 2026 Enlighten paper 'Prevention in Scottish Public Service Reform' distinguishes two conceptions of prevention at work in current Scottish policy: the Christie Commission's structural-transformation model, and the public health tripartite model (primary/secondary/tertiary) adopted in the Scottish Government's Preventative Spend Guidance. Both traditions, however, also use the phrase 'early intervention' — often paired with 'prevention' rather than clearly separated from it. This note asks two questions. First, what does the literature say about how 'early intervention' relates to 'prevention' within each of the two framings the paper identifies? Second, does that literature reinforce or undermine the paper's central claim, that a budget classification tool is not equivalent to Christie's reform agenda, and where does it complicate or push back against the paper's argument?

2. 'Early Intervention' in the Public Health Framing

In the epidemiological tradition the paper describes (Leavell and Clark), 'early intervention' is not usually treated as a fourth category alongside primary, secondary and tertiary prevention. It is instead absorbed into secondary prevention. Public Health Scotland defines secondary prevention as action focused on early detection of a problem, 'to support early intervention and treatment and reduce the level of harm' [1]. The Scottish Government's own Prevention Unit, in the Prevention Toolkit published in June 2026, after the paper's completion, makes the same mapping explicit: secondary prevention is defined as 'targeted action to identify and respond to early signs of a problem to prevent escalation' [2]. On this reading, 'early intervention' and 'secondary prevention' are near-synonyms: both refer to intervention once early signs of a problem are detectable in an identified at-risk group, as distinct from primary prevention (population-wide, before any risk is evident) and tertiary prevention (once a problem is established).

This mapping is not as settled as it appears, however. Scottish Government guidance on the 25-year record of preventative interventions defines the two terms slightly differently in kind rather than degree: 'prevention' refers to activities that stop a problem arising in the first place, while 'early intervention' is activity aimed at halting the development of a problem that is 'already evident' [3]. That formulation is closer to the public health distinction, but the same source, and others, concede that in practice the terms 'are sometimes referred to interchangeably, which can lead to confusion over what is actually meant' [4]. A 2018 scoping study for the Big Lottery Fund goes further, concluding that there is no consistent distinction in the literature at all: whether an activity counts as 'prevention' or 'early intervention' often depends on convention rather than a principled rule. Mental health support for a child already in care for example is typically labelled 'early intervention', while parenting support for a first-time mother is typically labelled 'prevention', despite both being targeted, sub-population interventions [5].

A separate, and only partially compatible, taxonomy comes from prevention science rather than public health medicine. The Institute of Medicine's influential 1994 framework (Mrazek and Haggerty, building on Gordon) organises intervention along a continuum of universal, selective and indicated prevention, followed by a distinct 'early intervention' stage that sits between prevention

and treatment, targeting individuals with detectable, but sub-clinical symptoms, who do not yet meet full diagnostic criteria for a disorder [6]. On this account 'early intervention' is not a synonym for secondary prevention at all, but a different stage of a different continuum: prevention, then early intervention/treatment, then maintenance. The practical effect is that a term the Scottish Government's tripartite model treats as roughly equivalent to secondary prevention is treated, in the international prevention science literature the tripartite model itself draws on, as something that happens after prevention has already failed to work. This is a second, independent instance of the definitional instability the paper identifies for 'prevention', but one located inside the public health tradition rather than between the public health tradition and Christie.

3. 'Early Intervention' in the Christie Framing

Christie's own report, and the Scottish Government's 2011 response to it, generally use 'prevention and early intervention' as a single paired phrase rather than as two analytically separated concepts [7]. This is consistent with the Enlighten paper's account of Christie's prevention as an investment logic, a structural-transformation logic, and an empowerment logic operating together: within that framing, the operative contrast is not between prevention and early intervention but between both these taken together and reactive, crisis-driven, siloed provision. Christie did not, in other words, appear to intend a sharp boundary between the two terms; his usage suggests they are two labels for the same underlying commitment to acting before, rather than after, harm has become entrenched.

A distinct UK policy tradition, however, has given 'early intervention' a more specific and more institutionally developed meaning than Christie's paired usage implies. Graham Allen's 2011 reviews, Frank Field's Foundation Years report, and the subsequent creation of the Early Intervention Foundation define early intervention primarily around the timing of neurological and social development, especially conception to age two, and justify it chiefly in economic terms: earlier action produces a higher return on investment and avoids the higher cost of 'late intervention' [8]. The Family Nurse Partnership, which the paper cites as one of the more Christie-aligned elements of the 2026 child poverty delivery plan, sits squarely within this tradition: a nationally designed, centrally commissioned, standardised home-visiting programme for a defined at-risk population (first-time mothers under 20) [9].

This matters for the Enlighten paper's argument. The Allen/EIF conception of early intervention is agnostic about governance, partnership and the distribution of power. It can be, and typically is, delivered as a top-down, professionally led, nationally standardised programme, evaluated against a 'what works' evidence bar rather than against Christie's tests of empowerment and local control. A programme can therefore be genuinely 'early' in Allen's sense, and evidence-based in EIF's sense, while remaining organisationally indistinguishable from the acute, professionally driven, non-empowering delivery model that Christie wanted to move away from. In other words, the paper's central claim about the public health tripartite tool, that classification by timing is not the same as transformation in governance, applies with almost equal force to spending that is labelled 'early intervention' in the Allen/EIF sense. Family Nurse Partnership expansion, cited in the paper as a positive, Christie-aligned step, should be tested against the paper's own Structural Prevention Test (does it shift power to communities, build capability rather than manage dependency, and disrupt rather than reinforce silo structures) rather than be accepted as Christie-aligned simply because it is 'early' and evidence-based. The paper's recommendations already imply this; the early-

intervention literature gives an independent reason to apply the Test consistently to programmes carrying the 'early intervention' label, not only to programmes carrying the 'prevention' label.

4. Literature That Strengthens the Paper's Argument

Several strands of recent and near-contemporaneous literature independently support the June 2026 paper's core distinction between a timing-based classification and a governance-based reform agenda.

First, on the public health model's underlying metaphor: McMahon's 2022 review of the 'upstream–downstream' metaphor in health inequalities literature finds that the metaphor was originally, in McKinlay's foundational formulation, a device for describing the timing of intervention — acting before people 'fall into the stream' — rather than a claim about the nature, level or governance of intervention [10]. This is an independently sourced confirmation of the argument in Section 3.2 of the paper: a framework organised around when an intervention occurs in the problem-formation cycle is not equipped to answer Christie's questions about how services are organised, who holds power, and how communities are involved, because it was never designed to answer them.

Second, on the implementation gap: a 2026 Public Management Review article by Strokosch and colleagues, examining health and social care delivery in Scotland, finds an 'enduring implementation gap' between preventive rhetoric and preventive practice, citing a cluster of recent academic work (Boswell, Cairney and St Denny; Cairney and colleagues; Finch, Wilson and Bibby; Walsh, Wyper and McCartney) that reaches the same conclusion by different routes [11]. This corroborates, from a range of credible academic sources rather than only from Audit Scotland, the paper's claim that Christie's implementation gap is real, persistent and recognised well beyond this paper.

Third, and most immediately, a February 2026 SPICe briefing examines three Scottish Government health strategy documents published in 2025 — the Operational Improvement Plan, the Population Health Framework and the Health and Social Care Service Renewal Framework — and finds the prevention chapters 'muddled': despite prevention framing and language, the substantive content of these chapters 'can only be read under the headings of tertiary or, at best, secondary prevention, not primary (structural) prevention approaches' [12]. This is close to a live case study of the Enlighten paper's central warning, produced in the same policy area and the same year: prevention language operating at the level of political communication while the underlying activity remains reactive or narrowly targeted.

Fourth, the 'lifestyle drift' literature in public health policy studies — originating with Katikireddi, Bond and Hilton's 2013 analysis of English tobacco policy, and since extended in a 2025 scoping review — describes exactly the dynamic the paper worries about in relation to child poverty: policy that begins with an upstream, structural framing but drifts, in implementation, toward downstream, individually targeted delivery [13]. Naming this pattern gives the paper's warning about Scottish Child Payment potentially crowding out capability-building investment a recognised conceptual home in the wider policy studies literature, rather than treating it as a claim specific to the June 2026 Enlighten paper or the earlier paper advocating a balanced approach to tackling child poverty by the same author [14].

Fifth, the Scottish Government's own June 2026 Prevention Unit definition confirms, in terms close to the paper's own description, that its classification proceeds by 'target population' and 'primary purpose' (intent) rather than by governance criteria or outcome evidence, and explicitly states that an activity assessed as 'not preventative' can still be reframed as 'contributing to a preventative system' [15] — a mechanism that lends some support to the paper's concern that the tool is structured to make as much existing activity as possible describable as preventative.

5. Literature That Complicates the Paper's Argument

Other literature qualifies, rather than simply supporting, the Enlighten paper's argument — particularly it's more positive treatment of capability-building as the Christie-aligned alternative to income transfer.

Strokosch and colleagues (2026) argue that both the 'deficit model' of service delivery and the 'asset-based', capability-building alternative that has emerged partly in response to it can function as forms of responsibilisation: framing service users as 'autonomous, individualised, self-responsible, self-acting, self-directing' agents who should change their own circumstances, while leaving the structural, resourcing and power questions Christie raised unaddressed [16]. This is a direct qualification of the argument in Section 4.3 on the June 2026 paper, which treats capability-building services (Family Nurse Partnership, Whole Family Support, universal early years education) as more clearly Christie-aligned than Scottish Child Payment because they build agency rather than simply supplement family income.

The literature suggests this is not guaranteed: if not used correctly, capability-building language becomes a way of shifting responsibility onto families and communities without redistributing power or resources, reproducing the same 'classification is not transformation' problem the paper identifies for the public health tool, but under a Christie-sounding label rather than a public-health-sounding one. However, where the language is accompanied by service redesign that responds to the needs of families and communities and meets the criteria set out in the Structural Prevention Test, which asks whether spending shifts power, builds capability rather than manages dependency, and challenges rather than reinforces silos, this risk is avoided. While the critique does not overturn the paper's argument, it does suggest that the paper's own remedy is doing necessary work that a simple prevention/mitigation or cash-transfer/service dichotomy would not do on its own and that the Test should be applied to capability-building programmes as well as to prevention and early intervention.

A second, more fundamental challenge comes from critiques of the upstream metaphor itself. McMahon's review notes that the metaphor has been criticised (citing Krieger, and others) for implying a passive, unidirectional, hierarchical flow of causation from 'upstream' structural factors to 'downstream' outcomes, which struggles to account for feedback loops, complex system interactions and individual agency [17]. This critique is aimed at public health rhetoric, but it also applies with some force to Christie's own language of eliminating 'the underlying conditions generating demand', a formulation that similarly implies a linear causal chain running from root cause to presenting problem. If causation in social systems is genuinely more reciprocal and complex than either metaphor allows, then Christie's framework, and not only the public health tripartite model, may understate the difficulty of identifying which interventions are truly 'structural' as opposed to merely occurring further upstream in a chain that is, in reality, a web of interconnected processes changing over time (and the life course).

Third, the definitional landscape turns out to be more fragmented than a two-framework contrast (Christie versus public health) suggests. Alongside the public health tripartite model and Christie's structural-transformation model, we have identified in this note at least three further, non-equivalent uses of 'early intervention' or 'prevention' in active circulation: the IOM/prevention-science continuum (universal/selective/indicated prevention, then early intervention/treatment, then maintenance); the UK early-intervention policy tradition associated with Allen, Field and the Early Intervention Foundation (organised around child development timing and economic return rather than governance); and the purpose-based typology from McKendrick and Sinclair that the paper itself uses to reclassify Scottish Child Payment as 'direct reduction' rather than 'prevention' [18].

Each of these frameworks classifies the same activity differently. A programme like Family Nurse Partnership could plausibly be called primary prevention (population-level antenatal support), secondary prevention (targeted at an at-risk group), early intervention in the Allen/EIF sense (acting in the earliest years), and 'enabling reduction' in McKendrick and Sinclair's typology, depending on which framework is applied. This suggests the paper's Recommendation 1 — that the Scottish Government be explicit about which definition of prevention it is using — is vitally important but may be harder to satisfy than the paper's two-framework contrast implies, since several live definitional traditions, not two, are already embedded in different parts of the Scottish policy landscape. In this context, being clear and specific about the objectives of policy, and especially about what it is intended to prevent (and how the chosen instrument(s) are expected to work), is a vital component of system as well as programme design, especially in a highly constrained funding environment where difficult decisions are required between competing options.

6. The Boundaries of the Prevention Lens: Institutional Mandate & Scope

One issue not addressed in the original paper is whether, and how far, the prevention lens can properly extend from the scrutiny and assessment of spending and programmes into assessment of public services whose primary statutory purpose is not prevention. The paper's Structural Prevention Test, like the tripartite model it critiques, is built to evaluate a slice of activity — a spending line, an intervention, a programme — against criteria of governance, power and capability-building. It is not constructed to answer a prior and different question: whether a whole public service institution, such as schools or the police force, should be judged, in whole or in part, against its contribution to prevention outcomes that lie outside its core mandate. A school's main purpose is educating children and young people; policing's is public safety and the enforcement of law. Reduced future offending, ill-health or poverty may follow from good schooling or good policing, but neither institution exists primarily to produce these outcomes, and neither is resourced, staffed, trained or held to account, in the first instance, on that basis. This is, in part, a targeting-versus-universalism question in different dress: schools and the police are universal, non-selective institutions, and asking them to differentiate practice by need without redefining their statutory purpose raises the same boundary question that recent Scottish guidance on proportionate universalism grapples with in a health context: how far a universal institution's offer should scale with need before it becomes, in effect, a parallel targeted system [19].

Public administration literature on goal ambiguity offers reasons for caution here. Work on 'mandate stretch' in public organisations (Chun and Rainey [20]) finds that adding loosely related objectives to an agency's remit tends to dilute accountability for its core function rather than

improve performance on the added objective, because staff, budgets and performance systems are not built to serve two purposes at once; a 2025 review of accountability design under wicked-problem conditions reaches a similar conclusion [21]. A related literature on 'wicked problems' and collaborative governance (Rittel and Webber; Head and Alford [22]) argues that some problems genuinely require several agencies to work together because no single mandate covers them, and much of this literature proposes coordination structures built around and between existing mandates rather than the redefinition of each agency's own performance criteria around the shared goal. That is not a settled position, however: recent work argues that collaborative governance may not be a feasible response to wicked problems at all, since 'wickedness' reflects disagreement and power inequality among the actors involved rather than a coordination failure that shared structures can resolve [23], while a separate 'collective impact' and place-based funding literature argues for exactly the redefinition of agencies' own performance criteria around shared outcomes that the caution above warns against [24].

Christie's own report is ambiguous on this point. 'Eliminating the underlying conditions generating demand' can be read either as a call for better joint working across existing institutional purposes, or as a call for a more fundamental shift in what outcomes schools, the police or primary care should prioritise to limit 'failure demand'. While these are issues that arise in the context of public service reform discussion, the paper's structural-transformation reading of Christie does not require that ambiguity to be resolved. It is, however, important to register it: the further the budgetary prevention lens is pushed toward whole-institution performance assessment, the more it risks confusing matters e.g. by treating the reframing of institutional purpose as if it were a matter of degree rather than a substantive and contestable choice.

A workable arrangement involves scoping the prevention lens rather than abandoning it. The Structural Prevention Test is properly applied to spending and programmes within a service, and to the shared, cross-cutting problems for which multi-agency collaboration is identified as the most appropriate mechanism to achieve the policy objective — reducing youth offending as a joint schools-police-social work goal, for example — and even there as one dimension of performance among others, not a substitute for the institution's core accountability. Applied beyond that scope, to the general performance of single-purpose statutory services, the lens risks the goal-ambiguity problem the literature describes: real accountability for education or public safety diluted in the name of a shared outcome where the institution may not have control of the necessary levers and is not adequately resourced, either financially or in terms of competences, to deliver. This boundary question is flagged here rather than resolved; it falls outside the literature review this note undertakes and would benefit from its own dedicated treatment.

7. Summary Assessment

Taken together, the literature reinforces the Enlighten paper's central claim. Independent academic and parliamentary sources: on the origin and limits of the upstream metaphor; on the persistence of Scotland's implementation gap; and on the gap between prevention rhetoric and prevention practice in 2025-26 health strategy documents specifically; point towards the same conclusion the paper reaches by a different route. Classifying spend by the timing of intervention is not equivalent to, and does not reliably track, transformation in governance, power and service design. The 'lifestyle drift' literature gives the paper's warning about Scottish Child Payment crowding out capability-building investment a recognised conceptual basis in public health policy studies.

At the same time, the literature suggests two refinements. First, the same scrutiny the paper applies to public-health-classified 'preventative' spend can be applied to spend classified as 'early intervention', since that label — whether drawn from the public health, prevention-science or Allen/EIF traditions — is at least as capable of describing centrally-commissioned, non-empowering programmes as the primary/secondary/tertiary classification is. Second, the paper's more favourable treatment of capability-building services relative to cash transfer should be sensitive to the responsibilisation critique: capability-building is Christie-aligned only to the extent that it is accompanied by a genuine shift in power and resource, associated with service redesign, user engagement and improved information sharing, which is precisely what the paper's own Structural Prevention Test is designed to establish, and what a label of 'early intervention' or 'capability-building', on its own, does not guarantee.

One further question raised in the course of this note, but not resolved by it, is how far a prevention lens can properly extend from the assessment of spending and programmes into the assessment of those whole public services whose core statutory purpose is not prevention (Section 6). Where that boundary should sit, and how a caveat limiting the lens's application should be worded, is flagged here as an area for further work rather than folded into the paper's existing recommendations.

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