



Public Health  
England

**The Kings Fund** >

**Stocktake of local strategic planning  
arrangements for the prevention of  
mental health problems**  
Summary report

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## Executive summary

The *Stocktake of local planning arrangements for the prevention of mental health problems* is to provide a high-level summary of how local areas are currently incorporating mental health promotion and prevention of mental health problems in their planning processes.

The stocktake was based primarily on a content analysis of key strategic and operational planning documents in 35 local authority areas, including a random sample of 16 areas across England, and 19 areas selected as possible examples of good practice. Documents reviewed included health and wellbeing strategies, clinical commissioning group (CCG) planning documents, a range of planning documents relating to other local authority functions, and system-wide documents such as sustainability and transformation plans, local transformation plans and crisis care concordat plans. In extracting relevant information from these documents, the review focused on planned actions that were linked explicitly to the goal of delivering better mental health or emotional/psychological wellbeing.

### Key findings

All 35 local areas had included promotion of mental health and/or prevention of mental health problems in their planning processes to some degree. The overall level of priority given to this varied significantly between sites.

There was also variation within sites, with different stakeholders placing greater emphasis on different levels of prevention. For example:

- Health and wellbeing strategies tended to include an upstream perspective, focusing on primary prevention and promoting positive mental health in the population
- CCG planning documents tended to have less content on prevention, and often gave more emphasis to secondary or tertiary prevention, for example preventing mental health crisis
- Planning documents relating to other local authority functions (eg housing) often acknowledged the importance of mental health and wellbeing to the policy area in question, but rarely put forward specific proposals in relation to this

In line with national guidance, all of the local transformation plans (LTPs) for children and young people's mental health included a public mental health focus, often placing significant emphasis on this. Other documents reviewed, including sustainability and transformation plans and crisis care concordat plans, were highly variable in terms of their coverage of promotion of mental health and/or prevention of mental health problems.

Preventative interventions at the start of life were included most frequently (including during pregnancy). All areas had identified perinatal and infant mental health, early years support, and family- and school-based interventions as areas to focus on as part of their planned work on public mental health. Other issues commonly focused on included:

- reducing social isolation and loneliness
- creating healthy workplaces and reducing unemployment (among people experiencing mental health problems and in the wider population)
- improving public awareness of mental health and tackling stigma
- supporting self-care (eg through the '5 ways to wellbeing' model)

There was a less consistent picture in relation to other social determinants such as housing, debt, poverty, green spaces, violence or abuse. In most areas there was a recognition of the importance of social determinants of mental health and wellbeing, but there was less evidence of specific actions identified to tackle these.

Approaches being taken typically combined universal approaches directed at the whole population with targeted approaches focusing on high-risk groups. The balance between the two varied between areas. In areas where there was a particular focus on targeted interventions, this was often framed as being part of a wider commitment to reduce health inequalities in the local population. In some areas we found an explicit connection had been drawn between public mental health objectives and the goal of reducing wider health inequalities, with documents arguing that tackling one will also require making progress on the other.

In some areas planning documents and priorities were structured in terms of stages of life eg 'starting well', 'living well' and 'ageing well', reflecting an appreciation of the impact of mental health and wellbeing across the life course. However, we found limited evidence of other components of a life course approach, for example a focus on key transitions in life, critical/sensitive periods or accumulation of risk factors.

## Implications

The stocktake highlights four issues that will need to be addressed in strengthening prevention planning arrangements:

1. Prevention planning in relation to mental health is highly variable across England. While the content of prevention plans should always be flexible and responsive to local circumstances (for example in terms of the specific interventions prioritised), there is scope for national support in relation to the processes used to develop and implement plans and the conceptual frameworks deployed in doing so.
2. It is not clear that the key stakeholders in a given local area are always fully aligned in terms of the approaches being taken towards prevention planning. Public Health England and other national partners in the Prevention Concordat for Better Mental Health programme should explore actions to support closer partnership working at the local level.
3. Outcomes measurement is an area where there appears to be particular uncertainty, and an appetite for support from national organisations.
4. Guidance should also cover practical questions about how to translate high-level strategy into deliverable commitments, and how to develop appropriate leadership and governance arrangements around these commitments. We found evidence that this has been challenging to do in practice.

These four observations were used to inform the design of the accompanying practice resource document, 'Together for better mental health: Preventing mental problems and promoting good mental health'. Local areas are encouraged to use the resource document to help guide action and build on the progress described in the stocktake, strengthening work already underway and covering the gaps identified.

# Introduction

The purpose of the stocktake was to develop a high-level view of how local areas are currently incorporating mental health promotion and prevention of mental health problems in their planning processes. The stocktake does not provide a comprehensive assessment, but gives key insights based on triangulating information from a variety of sources.

This work was commissioned as part of the development of the Prevention Concordat for Better Mental Health programme, and the findings used to inform the structure of 'Together for better mental health: Preventing mental problems and promoting good mental health: A practice resource for local areas' which has been developed to support local areas across England to put in place effective arrangements to promote good mental health and prevent mental health problems.

## Terminology

Throughout this summary we use the term 'public mental health' to refer to mental health promotion and prevention of mental health problems. References to prevention refer to prevention at all levels, including primary, secondary and tertiary prevention:

**Primary prevention** – preventing mental health problems before they occur, including promoting positive mental health and wellbeing in the general population

**Secondary prevention** – reducing the impact and progression of mental health problems through detection of early symptoms and rapid intervention

**Tertiary prevention** – supporting people experiencing ongoing mental health problems to live well, prevent crisis and deterioration in health or wellbeing

We have defined 'planning arrangements' as the formal processes through which local strategies and plans are developed and agreed by the NHS, local government and other partner agencies, usually involving the production of a written strategy or plan, such as a health and wellbeing strategy

For the purposes of this document, we use the term 'local area' to refer to the area covered by an upper tier local authority.

# Methodology

The stocktake was based primarily on a content analysis of key planning documents from 35 areas<sup>1</sup>. The areas included:

- 16 areas selected at random
- 19 areas selected as possible examples of good practice (based on a number of sources – see Appendix A)

In each area we reviewed a wide range of planning documents, summarized in Table 1 below. The exact set of documents reviewed in each site varied in part because we took an iterative approach and found that the most relevant documents were often site-specific. For example, in some areas there was a dedicated prevention plan (incorporating mental health), in others there were system-wide mental health plans (incorporating prevention/promotion) and so forth.

For all documents, we reviewed the most recent version we were able to obtain and did not review earlier iterations. The majority of documents reviewed were published between 2013 and 2016, with the exception of a small number of five-year strategies initially published in 2012 or 2011. We did not review suicide prevention strategies as this is part of other work supported by Public Health England<sup>2</sup>.

Table 1: Documents included in the stocktake	
Core documents reviewed in all areas (number reviewed)	Supplementary documents reviewed in a sample of areas (number reviewed)
<ul style="list-style-type: none"> <li>• Health and wellbeing strategies (34)</li> <li>• Core CCG strategic/operational planning documents (58)</li> <li>• Local transformation plans for children and young people’s mental health (34)</li> </ul>	<ul style="list-style-type: none"> <li>• Mental health strategies (CCG-led or whole-system) (24)</li> <li>• Other relevant local authority strategies eg housing, education, drug and alcohol, and business strategies (36)</li> <li>• Director of Public Health annual reports (22)</li> <li>• Public health plans (5)</li> <li>• Crisis care concordat (8)</li> <li>• Sustainability and transformation plans (5)</li> <li>• Better care fund documents (3)</li> </ul>

<sup>1</sup> Upper tier local authorities were used as the basis for site selection. In sites where local authority boundaries were not co-terminous with CCG boundaries, we looked at CCG planning documents from one CCG falling within the local authority boundary, chosen at random.

<sup>2</sup> Available at: <https://www.gov.uk/government/collections/suicide-prevention-resources-and-guidance>



In extracting relevant information from these documents, we only included content that was explicitly linked to mental health or emotional/psychological wellbeing. For example, if a local authority was doing work on poverty reduction to serve other strategic objectives, but did not specifically link this to the goal of improving population mental health, this was not included. Our justification for this is that the purpose of the stocktake was not to survey all local activities that could potentially have an impact on public mental health, but rather to understand what local areas are doing *consciously and deliberately* to recognise and incorporate promotion of mental health and prevention of mental health problems within their planning processes. Furthermore, widening the review to include *any* actions that could have had an impact on public mental health in local areas, including as an unstated secondary benefit, would have been impractical due to the very wide range of factors that could potentially influence population mental health and wellbeing.

We supplemented the document review with a small number of qualitative interviews with public health leads in selected local areas to gain a richer understanding of contextual factors, approaches used, and the key challenges faced. We also conducted an analysis of financial data returns sent by local authorities to the Department for Communities and Local Government (DCLG), including planned spend on public mental health (see section 11).

Full details on the methodology used are provided in appendix A.

## Strengths and limitations of the methodology

The stocktake provides the first systematic national overview of how local planning arrangements in England have incorporated public mental health. The methodology used for site selection was designed to ensure that the sample of local areas included in the stocktake is broadly representative of the diversity of populations and local government structures that exists across the country. Within each site, we reviewed a wide range of planning documents to capture planning at different levels.

In conducting the stocktake we found that the archiving of key strategic documents was sometimes imperfect, and it was not always possible to obtain all of the potentially relevant documents. In addition, most planning documents are only refreshed periodically and different planning cycles within a local system are not always concurrent, meaning that the documents reviewed may not always reflect the current strategic priorities within a local system. In the context of these constraints it is possible that the stocktake may not give a complete picture of all prevention planning activities within local areas.

It is important to note that the approach used was primarily descriptive and does not enable us to pass judgement on the effectiveness or impact of prevention planning arrangements in any given area. Although it would be helpful to explore whether the documents reviewed led to action in practice, this was beyond the scope of the stocktake and is not something we can comment on based on the work conducted.

## Overview of coverage in key planning documents

All 35 local areas had included promotion of mental health and/or prevention of mental health problems in their planning processes to some degree. In terms of the overall level of priority given to this across the areas reviewed, there was significant variation between sites, in both the random and purposive samples.

The following provides a summary of the kind of content typically included in key planning documents. It should be acknowledged that there is often variation within these general trends, as discussed below.

### Health and wellbeing strategies

All of the health and wellbeing strategies reviewed included some content on promotion of mental health or prevention of mental health problems. In six of the 16 areas included in the random sample, improving mental health and wellbeing was included as one of the top overarching priority areas addressed in the strategy. In the remainder, it was addressed as a component of one or more priority areas with a wider focus, for example within programmes of work on 'improving the quality of life', 'starting well' or 'ensuring that children are ready for school physically, emotionally and developmentally'.

The Local Government Association has compiled a database of health and wellbeing board priorities. According to this, 85 of the 152 health and wellbeing boards have identified mental health and wellbeing as one of their headline priorities – around 56%. The results of the stocktake suggests that the strategies produced by most of the remaining 44% are also likely to contain something on public mental health, albeit to varying extents.

We found that health and wellbeing strategies tend to reflect an upstream perspective to mental health, with most of the content devoted to primary prevention and promoting mental health and wellbeing in the whole population and/or within high-risk groups. Particular emphasis is given to the mental health and wellbeing of children and young people, and also to the issue of social isolation, particularly among older people (see section 4).

### Mental health strategies

We identified some form of mental health strategy or action plan in the majority of local areas included in the review (12 of 16 areas in the random sample). The ownership of mental health strategies varied between sites – in around half, a joint strategy had been produced by two or more local partners. As a minimum this involved joint working between CCGs and local authorities, and in some cases involved a wider set of partnerships (for example, signatories to the mental health strategy for North Yorkshire include the county council, district councils, CCGs, the police, Healthwatch and Age UK). In the remaining sites we reviewed mental health strategies that had been produced by CCGs.

All of the mental health strategies reviewed included some content on prevention. In contrast to the focus on primary prevention seen in health and wellbeing strategies, the emphasis in these strategies was largely on secondary prevention (early intervention), and tertiary prevention (enabling people with existing mental health diagnoses to live well).

Primary prevention was also included in some strategies. For example, the Warwickshire public mental health and wellbeing strategy places a significant emphasis on interventions designed to promote positive mental health and wellbeing in the population (see box one). However, overall more weight was given to improving the availability and quality of services than to health improvement at the population level.

### **Box 1: Warwickshire public mental health and wellbeing strategy**

The Warwickshire Public Mental Health and Wellbeing Strategy 2014-16 was developed by the public health team in Warwickshire County Council, in conjunction with colleagues from across the council and partner organisations including district and borough councils, clinical commissioning groups, NHS mental health providers and voluntary sector organisations.

The strategy lays out shared objectives and actions at three levels:

- universal interventions to build resilience and promote wellbeing at all ages
- targeted prevention of mental health problems and early intervention for people at risk of mental health problems
- early intervention and physical health improvement for people with mental health problems

Key areas for action are identified at each level with reference to Warwickshire's joint strategic needs assessment and national priorities.

The strategy describes the economic rationale for investment in public mental health, provides a summary of evidence-based interventions, and lists proposed priority investment areas for years one and two of the strategy.

The strategy is available at: <http://publichealth.warwickshire.gov.uk/files/2012/08/MENTAL-HEALTH-AND-WELLBEING-STRATEGY.pdf>

## Other CCG planning documents

In addition to mental health strategies produced by CCGs, the stocktake also included 34 wider CCG planning/strategic documents (eg operational plans; commissioning intentions). In general, where these documents covered mental health it was from a treatment and recovery perspective rather than a prevention one. This is perhaps unsurprising given that the 2012 Health and Social Care Act moved lead responsibility for much preventative work (particularly primary prevention) from the NHS to local authorities.

There was some content on secondary or tertiary prevention, for example interventions to improve employment support for people living with mental health problems as a means of enabling recovery and preventing further deterioration in health and wellbeing. Where reference was made to primary prevention, this often took the form of references to partnership work being done with the local authority to develop a prevention strategy.

## Local transformation plans for children and young people's mental health

In response to the recommendations of the 2015 'Future in mind' report, local areas are mandated to produce a local transformation plan (LTP) for children and young people's mental health. In line with national guidance, all of the LTPs reviewed included a public mental health focus, often placing significant emphasis on this within the document. Within this general trend, the emphasis varied between areas – some LTPs took an upstream perspective with significant emphasis given to primary prevention, whereas others focused more on making improvements to child and adolescent mental health services (CAMHS).

## Other local authority planning documents

21 housing strategies were reviewed and all made some reference to mental health, for example in relation to the need to develop appropriate supported accommodation for people living with mental health problems. In relation to primary prevention, there was some discussion of the role of good quality housing in promoting positive mental health and wellbeing in the wider population. However, this was only included in a minority of the strategies reviewed, and where it was included this tended to be limited to acknowledging the link in general terms, rather than putting forward any specific proposals to address it.

In a random sub-sample of sites we also reviewed other local authority strategic/planning documents, including drug and alcohol strategies, children and young people's plans, and education/schools policies. We found some brief coverage of public mental health in these documents, sometimes in the form of cross-references to priorities identified by other strategic documents (eg health and wellbeing strategies or joint strategic needs assessments). For example, each of the drug and alcohol strategies we reviewed included reference to the association between drug/alcohol misuse and poor mental health, and the importance of early intervention to limit the detrimental impact on mental wellbeing. The extent of this coverage and the level of detail included was varied.

In some areas, public mental health featured prominently in annual reports from the Director of Public Health (DPH). In areas such as London Borough of Camden<sup>3</sup> and Cornwall<sup>4</sup>, the DPH had focused one year's report specifically on public mental health. In these documents, a significant focus was on the social determinants of mental health, and the case for intervening upstream to shape these determinants. In contrast to this, we found that public mental health received much more limited coverage in DPH reports for some of the other areas included in the stocktake.

The crisis care concordat plans reviewed were variable in their coverage of prevention and promotion of mental health. Some had sections focusing on "support before crisis point" or "preventing future crises". For example, the plan for Hertfordshire includes an explicit commitment from concordat partners to share and disseminate information/advice on promoting mental and emotional wellbeing<sup>5</sup>. In Leeds, the action plan for 2015<sup>6</sup> included addressing the wider social determinants of mental health through social prescribing. Suicide prevention featured in many of the plans. However, in some plans prevention was not addressed in any form.

## Planning arrangements across wider geographical areas

In recognition of the fact that planning happens at multiple levels, and that health and social care organisations are increasingly being asked to plan across wider geographical footprints, we included in the stocktake a sample of 8 sustainability transformation plans (STPs) and one regional devolution plan.

The STPs reviewed were highly variable, but almost all included some statement of intent in relation to promotion of mental health and/or prevention of mental health problems. In some, this consisted of a relatively brief reference to an objective(s) to improve population mental wellbeing or reduce the prevalence of suicide. In others, there was more specific content, including:

The STP for Lancashire and South Cumbria includes annexes describing transformation programmes on adult mental health, and children and young people's emotional wellbeing<sup>7</sup>. The STP for north-east London<sup>8</sup> describes a number of actions intended to promote the psychological wellbeing of the population, including through social determinants such as work, housing, education and leisure

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<sup>3</sup> Available at:

<http://www.islingtonccg.nhs.uk/Downloads/CCG/BoardPapers/20150506/5.2.2%20Annual%20Public%20Health%20Report%202015.pdf>

<sup>4</sup> Available at: <https://www.cornwall.gov.uk/health-and-social-care/public-health-cornwall/director-of-public-healths-annual-report/2014-director-of-public-health-annual-report/>

<sup>5</sup> Available at: <http://www.crisiscareconcordat.org.uk/areas/hertfordshire/>

<sup>6</sup> Available at: <http://www.crisiscareconcordat.org.uk/areas/leeds/>

<sup>7</sup> Available at: <http://www.lancshiresouthcumbria.org.uk/>

<sup>8</sup> Available at: <http://www.nelstp.org.uk/>

To explore the inclusion of public mental health within regional devolution plans, we also reviewed the 2016 Greater Manchester mental health and wellbeing strategy<sup>9</sup>. This puts forward a whole-system approach towards improving the mental health and wellbeing of individuals and families, supported by resilient communities and inclusive employers. The intention is to use the opportunities created through devolution to collectively improve mental health at the population level, with a particular focus on children and young people’s mental health.

## Discussion of issues and interventions featured

Despite the high degree of variation observed between different local areas in terms of the approach being taken towards public mental health and the overall level of priority given to it, there was a degree of convergence in terms of the issues and interventions being selected as priorities. Table 2 illustrates the relative frequency with which different issues featured as priorities for public mental health in local planning documents.

<b>Table 2: Issues being addressed in local planning documents included in the stocktake</b>	
<b>Public mental health issue</b>	<b>Percentage of areas included in the stocktake identifying this as an issue to focus on as part of local work on public mental health</b>
Children, early years, families & schools	100%
Perinatal mental health	100%
Social isolation	73%
Workplaces/employment	73%
Public awareness, tackling stigma	60%
Improving personal wellbeing / self-care	53%
Housing	40%
Violence/abuse	20%
Debt	13%
Poverty	13%

<sup>9</sup> Available at: <http://www.gmhsc.org.uk/assets/GM-Mental-Health-Summary-Strategy.pdf>

## Children, early years, families and schools

Interventions focusing on children, early years, families and schools received significant emphasis in all areas. Specific interventions that were highlighted in planning documents included the following:

In schools:

- School-based programmes on emotional resilience, mental health awareness or life skills that promote positive mental wellbeing (eg interpersonal skills, problem-solving)
- Incorporating mental health within the scope of Healthy Schools programmes (eg through an emotional health and wellbeing award scheme in Bristol)
- Ensuring that all children are emotionally, behaviourally and cognitively ready for school and supporting transition to secondary schools
- Anti-bullying initiatives
- Improving health behaviours among young people (eg through Healthy Schools programmes), with a particular focus on reducing smoking, drug and alcohol misuse and improving weight and sexual health in order to support positive mental health and wellbeing
- Better links between CAMHS and local schools (eg establishing a CAMHS link worker for each school; building on learning from the Schools Link pilot scheme )
- 'Whole school' approaches to wellbeing that combine action on multiple fronts, often including elements of the above (eg building on the Headstart programme)

In families:

- Parenting programmes (eg group-based parenting skills training such as Triple P or Incredible Years)
- Enhanced health visiting services to support high-risk families (eg the Nurse Family Partnership model)
- Ensuring children are protected from violence and abuse through safeguarding arrangements

Access to mental health support:

- Expanding counselling and psychological therapy services aimed at children and young people (eg schools-based counselling)
- Improving access to specialist CAMHS (eg through redesigned referral pathways or investment in new services targeted at high-risk communities)
- Developing new ways of accessing support and self-management advice for young people, including using digital and online interventions (eg peer support delivered through social media networks; computerised cognitive-behavioural therapy)

In multiple settings:

- Strengthening mental health skills among staff working in schools and other universal services such as children's centres and early years services, for example through training in mental health awareness / mental health first aid (see section 9)
- Self-harm reduction strategies for children and young people



## Perinatal and infant mental health

Closely related to the above (and in-line with national policy priorities), improving the prevention, detection and treatment of perinatal mental health problems was also a significant priority in all of the areas reviewed. Specific actions included the following:

- Reviewing perinatal and infant mental health services and pathways, and ensuring these are in line with NICE guidance
- Strengthening mental health capabilities in midwives and health visitors
- Implementing routine screening for postnatal depression

## Social isolation

Reducing social isolation was identified as one of the main priorities in relation to public mental health in the majority of local areas included in the stocktake (11 of 16 sites in the random sample). In most cases the principal target group was older people, although sometimes this extended to include anyone in the population at risk of isolation. Examples such as the Richmond upon Thames Prevention Strategy and the London Borough of Haringey Better Care Fund and Local Authority Corporate Plans demonstrate a common approach being taken is to support social connections and targeted intervention through community and voluntary sector organisations.

## Workplaces/employment

Work featured in most areas' plans in relation to public mental health, in at least one of the following three ways (collectively, these were mentioned in 11 of 16 sites in the random sample):

- Including mental wellbeing within the scope of Healthy Workplace programmes with local employers (for example, through a focus on stress management or good line management practices), and encouraging public and private sector employers to sign up to shared principles on this (eg the Working Well programme in Knowsley asks businesses to agree to a series of standards, including in relation to mental health and wellbeing).
- Helping people with mental health problems to remain in employment or to return to the workplace (this was a common priority for CCGs, in particular).
- Reducing levels of unemployment in the local community as an upstream public mental health intervention.



## Mental health awareness and stigma reduction

Most areas had a stated aim to improve the understanding of mental health in the local population and/or to tackle stigma and discrimination (9 of 16 sites in the random sample). The detail provided on how this would be achieved was sometimes limited. In some cases the objective appeared to be to improve understanding/awareness across the whole local population, whereas in others specific target groups were identified (see 'Targeted versus universal approaches' below). For example, in Hertfordshire a county-wide 'year of mental health' was held in 2015/16 involving monthly events to promote mental health and wellbeing across the county's population. In Bristol, targeted mental health awareness campaigns have focused on high-risk communities, such as black, Asian and minority ethnic groups. Frontline staff in public services have also been common targets for awareness-raising work (see section 9).

## Improving personal wellbeing

In most areas, the need to empower local people and communities to look after their own mental health was identified as a priority. More often than not, these discussions were framed around the 'Five ways to wellbeing model', with an intention to promote this model (or similar) among the local population or specific groups within the population.

## Suicide prevention

This was mentioned in most but not all areas. It should be noted that many of the documents included in the stocktake pre-dated recent national policy commitments around suicide prevention, and as such our work is likely to underestimate the true amount of work currently being conducted in developing suicide prevention strategies. We did not review suicide prevention strategies as part of the stocktake as this is being conducted as part of other work supported by Public Health England.

## Wider socio-economic determinants

The mental health impact of wider socio-economic factors (other than those described in the previous sections such as employment) received less consistent coverage. Some local areas indicated that in order to improve population mental health and wellbeing, action would be needed on upstream determinants, such as those listed in the table below:

<b>Table 2: Examples of areas including work on social determinants of mental health in planning documents</b>	
Debt/poverty	Blackburn with Darwen London Borough of Lambeth Warrington Leeds Nottingham West Sussex London Borough of Bromley
Housing	Knowsley London Borough of Tower Hamlets London Borough of Lambeth Warrington West Sussex Leeds
Green spaces/built environment	Nottingham West Sussex London Borough of Tower Hamlets London Borough of Lambeth London Borough of Harrow London Borough of Merton
Domestic violence/abuse/youth violence	Sheffield Bristol Cornwall Hertfordshire London Borough of Haringey London Borough of Lambeth Warrington

However, there tended to be less evidence of specific actions that would be taken in relation to each of these issues. Looking across the local areas included in the stocktake, there was no consistent picture in terms of which of these determinants were identified as priorities, and each determinant was only mentioned sporadically in the documents reviewed.

An important caveat here is that the review focused on actions and interventions which were explicitly linked to mental health (see section 3). It is likely that in many local areas, work on social determinants is underway that could potentially support improvements in population mental health and wellbeing as a secondary benefit, and that this stocktake has not captured the full extent of this work. For example, most local areas are likely to be doing work on debt and poverty reduction, or on housing. However, although this may be the case, based on the documents reviewed it appeared that public mental health does not currently tend to be the principal driver of this work.

## How are priorities identified?

Many of the documents reviewed did not provide detail on how the priorities given were identified. Where this was discussed, a wide range of influences were cited, including:

- National policy priorities and funding (eg perinatal mental health)
- Consultation/engagement exercises with the local population and professionals
- Data on local population health needs from joint strategic needs assessments (JSNAs) and other sources
- Research evidence on the effectiveness of different interventions
- Local political priorities (eg of councillors or elected mayors)
- Availability of funding for specific issues/approaches

The widespread emphasis given to children and young people's mental health and wellbeing (focused particularly on people up to age 18) appears to reflect the combined impact of multiple policy agendas over a sustained period of time which have coalesced around this set of issues (eg the focus over the last 10-20 years on early years, for example through Sure Start or the Troubled Families programme). The high priority given to the start of life is supported by research evidence from the Marmot review and many other sources. Interviewees also suggested that it was seen as a politically attractive area to focus on.

It was evident that certain documents and models have been particularly influential in shaping local areas' choices of priorities. The following were commonly mentioned in the documents reviewed:

- Future in Mind
- The Five Ways to Wellbeing model
- The THRIVE model (Timely, Helpful, Respectful, Innovative, Values-based and Efficient) for children and young people's mental health

## Universal versus targeted approaches

Based on the documents reviewed, most areas reflect a mixture of universal approaches directed at the whole population and targeted approaches focusing on high-risk groups or utilising specific interventions. Quantifying the balance between the two is beyond the remit of this work, however while most areas include universal approaches within their overall vision, many of the specific commitments identified in the document review were targeted on priority population groups. Universal approaches appeared to be used most commonly in relation to areas such as early years and mental health awareness.

In most of the local areas included in the stocktake the documents reviewed demonstrated an explicit commitment to reducing health inequalities. For example, in Knowsley a key principle of the health and wellbeing strategy is to address the “unequal distribution of health and wellbeing” in the area and work towards a “fair distribution of power and resources throughout the population”.

In some areas, we found an explicit connection had been drawn between public mental health and the goal of reducing health inequalities. For example, the 2014 annual report from the Director of Public Health for Bedford states that “In the town of Bedford, areas of low life satisfaction correlate well with areas of high deprivation. Therefore, to address mental wellbeing we must continue to address inequalities”. Similarly, the health and wellbeing strategy for the London Borough of Camden argues that “ensuring good mental health for all” will help to reduce wider health inequalities.

In areas with a strong health inequalities focus, the provision of targeted preventative interventions to individuals/populations at heightened risk of developing mental health problems was framed as being part of this strategic commitment. High-risk groups commonly mentioned included people living with long-term physical health conditions, carers, and members of minority/marginalised groups in the population such as black, Asian and minority ethnic groups; lesbian, gay, bisexual and transgender communities; looked after children; offenders; homeless people; and people with autism or a learning disability.

## Life course approaches

Life course approaches are increasingly used in strategic and planning documents as a conceptual framework for structuring interventions and priorities. These are far from the only approaches it is possible for local areas to use – other approaches include inequalities-based approaches and rights-based approaches (focusing on political and socio-economic empowerment of marginalized groups and individuals).

Most of the areas included in the stocktake plan to provide interventions aimed at children and young people, working age adults, and older people. In some areas particular emphasis appeared to be placed on the two ends of the spectrum, with a focus on children and young people and on social isolation among older people.

Several of the areas reviewed described their approach as being a life course one and/or structured their planning documents and priorities according to 3 stages of life – using terminology such as ‘starting well’, ‘living well’ and ‘ageing well’ (9 of 16 sites in the random sample). Often a life course approach within epidemiology is associated with placing a particular emphasis on early years and key transition points, and as reported above this was certainly present in planning documents reviewed in relation to early years. We found limited evidence of other components of a life course approach, for example a focus on key transitions in life, critical/sensitive periods or accumulation of risk factors.

## Creating the right conditions for change

As well as outlining specific interventions and approaches to be used, the planning documents reviewed also discussed broader actions which would create enabling conditions in which work on mental health promotion and prevention of mental health problems could be taken forwards. These included:

- Workforce training
- Awareness-raising campaigns
- Identifying mental health champions
- Mental health impact assessments
- Co-producing change with service users and carers
- Integrated commissioning

It is worth noting that these can be considered important strategies in themselves – for example, mental health impact assessment is a public health intervention in its own right. This highlights that planning arrangements for public mental health may need to include proposals for action at this level as well as specific service interventions.

Workforce training was the most commonly identified mechanism being used to enable change. This included training in mental health awareness, mental health first-aid, self-harm, suicide, bereavement, and more specific skills such as delivering brief psychosocial interventions, or training maternity professionals on childhood attachment. In some areas, this was framed in terms of the ambition to enable staff to 'make every contact count' (eg Warwick, Richmond, Southampton, Haringey).

Training is being targeted at a wide range of groups including:

- GPs and other primary care staff
- Social care practitioners
- Frontline staff in third sector organisations
- School staff including teachers and school nurses
- Staff in universal services such as children's centres, midwives, health visitors
- Youth offending team practitioners
- Parents and carers

In-line with the priorities described in section 5, there is a particular emphasis in many areas on training staff working with infants, children and young people in child development, emotional wellbeing and mental health. Some areas (eg Bristol) are using joint training to bring together professionals from different sectors (eg mental health leads in schools with CAMHS staff) to improve collaboration, shared learning and integrated working.

Some of the supplementary qualitative interview participants stressed the importance of system leadership for public mental health, including gaining political support from elected members in local government and/or an elected Mayor (eg in Bristol, Leeds). The development of mental health champion roles in local authorities, schools and elsewhere also featured as a key mechanism through which objectives around public mental health will be achieved. Examples such as the Lancashire Children and Young People's resilience, emotional wellbeing and mental health transformation plan and Bristol CCG's operational plan illustrate how these roles are being conceived as ways of supporting the delivery of interventions within individual sites, and as a means of ensuring appropriate leadership and governance for public mental health commitments. In part this may reflect the impact of national programmes such as the local authority mental health challenge.

The use of mental health impact assessment was seen as a potentially useful tool to encourage a focus on prevention and promotion. In a few areas (eg Lambeth, Merton, Blackburn with Darwen), planning documents recommend carrying out routine mental wellbeing impact assessments across key local authority activities such as housing, planning, regeneration and community safety. For example, in Lambeth the intention is to integrate this with equality impact assessments (which are mandatory) to ensure that assessment of mental health impacts becomes fully embedded. In other areas such as Sefton and Southampton mapping of provision is flagged as key mechanism for identifying priorities, highlighting gaps, and in exploring how the delivery of different services and approaches could be optimised to support public health objectives.

The involvement of service users, carers and members of the public in planning processes is another factor that could play an important enabling role, but evidence of this in the planning documents reviewed was variable. Plans show reference to consultation (asking 'are these the right priorities?') through to co-production ('what priorities should we be focusing on?').

Planning documents in sites such as Lambeth and Blackburn with Darwen are notable in their use of co-production both with members of the public and with local stakeholder organisations in both the development of plans and the delivery of change.

A final notable mechanism identified from plans for enabling delivery of public mental health objectives is an integrated approach to commissioning. The Knowsley Children and Young People's Mental Health Transformation Plan for example recognises the increasing role of academies and colleges as commissioners of mental health support as a key enabler for delivering mental health promotion and wellbeing.

## Governance and accountability arrangements

The sophistication and maturity of the governance structures supporting work on public mental health appears to be variable, although we should stress that the methodology used for the stocktake was not designed to support a formal assessment or comparison of governance structures in different areas. In some areas, governance appears to be primarily the role of the lead organisation with ownership over the plan. For example, accountability for public mental health within the West Norfolk CCG operational plan lies with the CCG board, and in Haringey, the Health and Wellbeing board is identified as the having overall governance and accountability for delivery of the public mental health commitments in their Health and Wellbeing Strategy.

In other places such as Southampton (Southampton City Strategy) and Wigan (CAMHS Transformation Plan), the delivery of public mental health has been incorporated into established boards and structures developed through previous programmes of work and which in turn are tasked with the role of providing governance and accountability for this work.

Some areas have established new governance structures to oversee specific programmes of work on public mental health. The Children and Young People's resilience, emotional wellbeing and mental health transformation plan in Lancashire is one example where a new governance structure is outlined to allow delegated authority for delivery. Relationships between this board and existing boards overseeing Transformation and Primary Care Transformation respectively provide an overall system of governance.

## Financial resources

In most cases the documents reviewed did not identify specific funding to support the objectives and interventions described. Where resources were outlined, this was largely associated with specific nationally-funded programmes. For example, national funding has been made available to increase investment in perinatal mental health and to support the implementation of local transformation plans for children and young people's mental health. Some of the areas had also received grants from other sources to support specific programmes eg the Big Lottery-funded Headstart program in schools. However, the total amount of funding available locally to support promotion of mental health or prevention of mental health problems in the round was not given in the documents reviewed.

To support the stocktake, we analysed financial data returns sent by local authorities to the Department for Communities and Local Government (DCLG)<sup>10</sup>. This dataset was made available for the first time in 2016 and includes planned spending on public mental health. The use of this dataset should be heavily caveated. In particular, in apportioning spending to different programme lines, it is not clear how local authorities have decided what counts as 'public mental health' spending. In the absence of clear guidance on this, it is highly unlikely that all local authorities have used a consistent approach.

Accepting these caveats, our analysis of DCLG data returns found that local authorities across England report spending an average of 1.6% of their total public health budget on public mental health. There is wide variation behind this average, with individual responses ranging from 0% to 28%. This is likely to reflect in part the inconsistency in interpretation discussed above.

There is inevitably a degree of arbitrariness in terms of what is included and what is not included within the fold of 'public mental health'. There are other spending lines in the dataset that are not classified as 'public mental health' but which would nonetheless have a clear impact on public mental health and wellbeing, and which could contribute towards local action on public mental health. Relevant categories include:

- Health at work
- Substance misuse - Preventing and reducing harm from drug misuse in adults
- Substance misuse - Preventing and reducing harm from alcohol misuse in adults
- Substance misuse - Specialist drug and alcohol misuse services for children and young people

If spending on these is included, then activities closely linked to public mental health accounts on average for 6.5% of the total public health budget.

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<sup>10</sup> Local authority revenue expenditure and financing England:2016-2017 budget individual local authority data <https://www.gov.uk/government/statistics/local-authority-revenue-expenditure-and-financing-england-2016-to-2017-budget-individual-local-authority-data>



It is also worth noting that part of local authorities' expenditure on social care may also contribute towards public mental health. For example, in the DCLG data spending on the following accounts for 9.9% of total social care budgets:

- Social support: Social Isolation
- Information and early intervention
- Social support: Substance misuse support
- Mental health support - adults (18–64)
- Mental health support - older people (65+)

Similar data is not available on CCG expenditure on public mental health.

## Emerging questions and challenges

In previous sections we have focused predominately on the content of plans and the approaches being taken to deliver those plans. Having reviewed a wide range of planning documents across 35 local area, we identified four overarching challenges associated with public mental health planning. Several of these were also independently identified by interviewees in the course of the stocktake.

### Strength of partnership working

As discussed in earlier, local areas vary in terms of the maturity of partnership arrangements, for example in relation to whether there is an established partnership board overseeing local work on mental health. In some cases, partnership working reflects areas in which there has been ongoing work on public mental health or where public mental health is being considered within other established programmes of work. There is also variation in terms of the extent to which there are established mechanisms for co-production with service users, carers and the public.

### Alignment across local systems

We saw distinct differences between areas in the degree to which plans are aligned. In some cases, we found there appears to be clear alignment between different documents/strategies across a local system from cross-referencing of priorities, to areas where public mental health is part of an overarching strategy which is reflected through the plans of different stakeholders. However, this degree of alignment is not immediately apparent in all areas. For example, priorities identified in the health and wellbeing strategy in relation to public mental health are not always embedded elsewhere.

### Translating strategy into deliverable commitments

Our observation was that there is often a sizeable list of aspirations in relation to public mental health at the strategic level, but in many areas, it appeared that as yet there have been fewer specific commitments and deliverables included in operational/action plans (and that the majority of these are not measurable targets). In some cases, this may reflect a deliberate

tactical choice to include a wide range of interventions in strategic plans, with an understanding that not all will be implemented immediately, but it raises questions about the relationship between planning and delivery and the extent to which planning processes are effective in identifying clear priorities.

## Outcomes measurement

The documents reviewed demonstrated a general lack of clarity about how best to measure outcomes in relation to public mental health, a finding confirmed by interviewees. In addition, we found that the outcomes currently being measured are not always well aligned with a system's strategic priorities – the priorities may be framed in a broad, upstream terms, but clinical and health systems outcomes are often still dominant. This may reflect the availability of data from national outcomes frameworks, and the expectation that public mental health interventions should deliver outcomes that serve other policy agendas (for example, reducing A&E attendances). A further challenge is the disparity between measuring the immediate impact of individual interventions and the overall population effect over time, with a number of plans reflecting broader outcomes such as educational attainment, or outcomes in which there would likely be little measurable change for many years.

## Conclusion

The aim of this document was to provide a high-level summary of how local areas are currently incorporating mental health promotion and prevention of mental health problems in their planning processes. In conducting the stocktake we were encouraged to find that these issues were being addressed at some level in every part of the country we examined. However, there appears to be wide variation within and between local areas in terms of the level of priority being given to this agenda, the approaches being taken towards it, and the extent to which specific plans have been agreed and put into action.

Part of the rationale for conducting the stocktake was to inform the design of local prevention planning guidance and the wider Prevention Concordat for Better Mental Health programme. The challenges described in the previous section are particularly pertinent to this. We would highlight the following implications:

- Prevention planning in relation to mental health is highly variable across England. While the content of prevention planning should always be flexible and responsive to local circumstances (for example in terms of the specific interventions prioritised), there is scope for national support in relation to the processes used to develop and implement plans and the conceptual frameworks deployed in doing so.
- It is not clear that the key stakeholders in a given local area are always fully aligned in terms of the approaches being taken towards prevention planning. Public Health England and other national partners in the Prevention Concordat for Better Mental Health programme should explore actions to support closer partnership working at the local level.

- Outcomes measurement is an area where there appears to be particular uncertainty, and an appetite for support from national organisations.
- Guidance should also cover practical questions about how to translate high-level strategy into deliverable commitments, and how to develop appropriate leadership and governance arrangements around these commitments. We found evidence that this has been challenging to do in practice.

These findings were used to inform the design of the accompanying practice resource document, 'Together for better mental health: Preventing mental problems and promoting good mental health'.

As part of the Prevention Concordat for Better Mental Health programme, a number of other resources are being made available which will support local areas in building on the progress already made. These include:

- **Mental health and prevention: taking local action for better mental health**
- **Better Mental Health for All: A public health approach to mental health improvement**
- Together for better mental health: Preventing mental health problems and promoting good mental health A practice resource for local areas
- Mental Health and Wellbeing Joint Strategic Needs Assessment Toolkit: Profile and Knowledge Guide
- Commissioning Cost-Effective Services for Promotion of Mental Health and Wellbeing and Prevention of Mental Ill Health
- Psychosocial Pathways and Health Outcomes: Informing action on health inequalities
- Prevention Concordat for Better Mental Health Consensus Statement

By way of conclusion, the results of the stocktake and wider engagement work indicate that the Prevention Concordat for Better Mental Health programme comes at an opportune time – one where momentum is building, but where there is still much to be done.

## Annex A: Further details on methodology

### Random sample

To ensure that the stocktake included a wide cross-section of different areas and populations, we used the following steps in selecting sites to include in the random sample:

- We included 4 sites from each of the 4 regions of Public Health England (London; North of England; Midlands and East of England; and South of England)
- Within each region, we stratified local areas by deprivation and selected one area randomly from each deprivation quartile. Stratification was done by ranking local authorities in terms of the proportion of lower layer super output areas (LSOAs) having high levels of deprivation, measured using the index of multiple deprivation (IMD). This approach gave us a place-based measure of deprivation which took into account the geographical clustering of deprivation.
- When neighbouring areas were sampled, we sampled again to maximize the diversity between sites include in our final sample.
- We examined key characteristics of the sites included in the random sample to check that the sample included a mixture of different local authority types (unitary/county/metropolitan/borough) and to ensure the balance of urban/rural sites was broadly comparable to that seen across the country as a whole.

The following areas were included in the random sample:

- Bedford
- Bristol
- London Borough of Bromley
- Bury
- Cornwall
- Knowsley
- London Borough of Lambeth
- Norfolk
- North Yorkshire
- Nottingham
- Poole
- London Borough of Richmond upon Thames
- South Tyneside
- Staffordshire
- London Borough of Tower Hamlets
- West Sussex

## Purposive sample

The 19 areas included in the purposive sample were identified through a variety of routes:

- Suggestions from Public Health England Centre leads/the national Public Health England public mental health team (6 sites)
- Analysis of data from the local government association (LGA) and DCLG (6 sites). We selected sites where reported spending on public mental health per capita was high AND where mental health and wellbeing was identified as a priority in the LGA health and wellbeing boards priority database.
- Intelligence gathered from other sources eg relevant awards programmes/media coverage (7 sites)

The following areas were included in the purposive sample:

- Blackburn with Darwen
- Bracknell Forest
- London Borough of Camden
- Greater Manchester devolution area
- London Borough of Hackney
- London Borough of Haringey
- London Borough of Harrow
- Hertfordshire
- Leeds
- London Borough of Merton
- North Tyneside
- Oxfordshire
- Sefton
- Sheffield
- Southampton
- Wakefield
- Warrington
- Warwickshire
- Wigan

## Map of all areas included in the stocktake

