Barriers and Facilitators to Commissioning Cost-Effective Services for Promotion of Mental Health and Wellbeing and Prevention of Mental Ill-Health

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Public Health England exists to protect and improve the nation's health and wellbeing, and reduce health inequalities. We do this through world-class science, knowledge and intelligence, advocacy, partnerships and the delivery of specialist public health services. We are an executive agency of the Department of Health, and are a distinct delivery organisation with operational autonomy to advise and support government, local authorities and the NHS in a professionally independent manner.

Acknowledgements

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Plain English summary

Even when there is plenty of evidence that there are actions that help promote better mental health and wellbeing and/or prevent mental ill-health this does not mean that they will be implemented. This report looks at some of the reasons why no action is taken and what can be done to change this. Many different barriers to implementation are discussed.

One concern is that one organisation / sector may be responsible for funding and/or providing services, but most of the benefits are gained by other organisations or sectors. This situation can become even more complex if multiple organisations are responsible for either funding and/or providing services. There may also be less interest in investing in mental health if they are no local champions (supporters) of mental health. Such champions can be skilled communicators, often well known in a community, who can help strengthen the case for investment.

Another challenge is that some of the organisations that will need to support the delivery of mental health interventions may have very little incentive to do this. For example, two of the eight interventions we have modelled in Commissioning Cost-Effective Services for Promotion of Mental Health and Wellbeing and Prevention of Mental Ill-Health (Public Health England, 2017) are delivered in school settings. School head teachers might have control of money that can be used to improve mental health, but they may be much more interested in spending money on activities that they know will help meet their own priority goals, such as better exam results. They may also not be aware of how better mental health might help them achieve their own primary concerns. For example, better mental health can help children do better in their school exams and tests. Both within, but also outside the health system, there may not be enough people working in other sectors who have the skills and training to deliver mental health promoting interventions.

Building partnerships between organisations can also help to meet these challenges. In this way actions can be coordinated, common goals established. In some circumstances it may also be possible for all sectors to commit to providing some funding to help avoid situations where one sector is expected to pay for mental health promotion and/or mental ill-health prevention actions while another sector gets most of the financial and other rewards. Steps might also be taken to improve training opportunities and collect information on the current level of funding that is being allocated to mental health promotion and mental ill-health prevention activities.

It is also important to increase what we know about what works to improve mental health in different settings. The evidence base on promotion and prevention activities, not just for mental health and wellbeing, but also for other health issues, is often less well developed than the evidence base on treatments for health problems. In order to persuade more decision makers that there are things that can be done it is important to keep on strengthening this evidence base. This includes collecting information on economic issues, such as the costs of different

actions and the financial costs and benefits that will be seen if these interventions are made available to their target audience. Measures can be taken to monitor progress towards the achievement of goals. This means collecting information on outcomes and impacts relevant to all sectors that either fund or deliver services and not just the health system. Examples include: educational attainment related outcomes for schools, colleges and universities; crime and justice outcomes for police and community safety; legal and debt related outcomes for welfare and money advice; and work related outcomes for employers. In order to effectively target additional resources to where they are most needed, it is also important to know what already mental health promotion and mental ill-health prevention activities are already being implemented.

Introduction

This report looks at some of the barriers and facilitators to the implementation of actions to promote better mental health and wellbeing and prevent mental ill-health. The findings have been informed by a review of reports and other documents from local government organisations and clinical commissioning groups on mental health promotion and mental ill-health prevention activities, as well as a workshop held at the London School of Economics in May 2016.

Implementation, and its efficacy, will be dependent on many different factors. It will be influenced by the quality of relationships between national, local and neighbouring commissioners of services and interventions, service providers and the wider community. It will be influenced by resource and capacity constraints, as well as perceptions as to the relative importance of different issues within and beyond health policy. There will be differences in financial and other incentives between different sectors that need to be involved in the implementation. The regulatory environment will also play a role in influencing the amount of attention paid to any topic, including mental wellbeing and wider health promotion.

A better understanding of some of these factors, and examples of how barriers have been overcome, can help local and national commissioners and service providers consider ways to better facilitate implementation of plans to promote better mental health and wellbeing across England.

Identifying barriers and facilitators

Table 1 briefly highlights eight barriers to the implementation of mental health promotion and mental ill-health prevention interventions. For each of these barriers one or more potential facilitators have been identified. These are then discussed drawing, where possible, on examples that have been implemented in England.

Table 1: Barriers and facilitators to investment in promotion of mental health and wellbeing and prevention of mental ill-health

Barriers	Facilitators
A. Fragmentation and cross-sectoral responsibility for promoting mental health and wellbeing and preventing mental ill-health	• Actions to build partnerships across sectors, such as co-locating staff in the same premises or local consultation to achieve early multi-sector buy-in. • Development of cross-sectoral actions as part of health & wellbeing strategies. • Ensuring mental health and wellbeing is well covered in Joint Strategic Needs Assessments.

B. Lack of local mental health champions or local community involvement in service development	• Identify potential local champions and relevant local stakeholders that are interested in fostering change and::
	  1. are familiar with the policy making process or could become so.
	  2. could coordinate and discuss potential actions with the community as a whole.

C. Fragmentation and cross-sectoral responsibility for funding mental health and wellbeing and mental ill-health prevention	• Creation of pooled or shared budgets • Dedicated funding streams for mental health promotion and/or mental ill-health prevention
D. Limited incentives in multiple sectors to invest in promotion and mental ill-health prevention	• Make use of and/or collect further evidence on the benefits of better mental health and wellbeing for the funding sector. • Identifying the interests of a sector and collecting information on outcomes and impacts relevant to it eg education related outcomes for schools, crime and justice

	outcomes for police, legal and debt related outcomes re money advices and work related outcomes for employers.
	• For actions funded within health system, identification of benefits for physical as well as mental health.
E. Lack of awareness of value of promoting mental health, wellbeing and mental ill-health prevention	• Investing in measures to make it easier to obtain information on the benefits of mental health, wellbeing and mental ill-health prevention, working in partnership with relevant national and local groups • Consider monitoring and regulatory measures to encourage greater investment in mental health and wellbeing.
F. Limited capacity in some sectors for promotion, wellbeing and preventive actions	• As part of mental health and wellbeing strategies, map the current availability of services and identify any gaps in capacity. • Look for mechanisms to embed development of capacity into routine training where possible, eg within teacher training courses
G. Perception of limited evidence on what works for promotion, wellbeing and preventive actions	• Take further action to strengthen the evidence base on what works by embedding evaluation and routine monitoring of uptake and impacts of funded projects. • Encourage continued dissemination of ways in which mental health and wellbeing schemes have been developed and sustained eg collaboration between Public Health England and the Local Government Association.
H. Limited information on resources invested in promotion of mental health, wellbeing and mental ill-health prevention	• If possible to collect, consider some information on funds allocated for promotion of mental health and wellbeing at national and local levels.

A. Barrier: Fragmented and cross-sectoral responsibility for mental health, wellbeing and mental ill-health prevention

Promoting and protecting mental health necessitates action in many different sectors. One of the major challenges that is frequently identified is difficulty in collaborating and coordinating across sectors. Different sectors may be responsible for funding activities that can promote mental health and wellbeing or help prevent mental ill-health or suicidal behaviour. However, they may not see these goals as being of particular importance when set alongside other responsibilities. Historically, there may have been few links between some sectors, and there may be difficulties in speaking in a common language.

Frequent public sector reform can also create lack of continuity, making it harder for sectors and/or organisations to coordinate actions for better mental health. One example of this concerns the mental health and wellbeing of children and young people, where schools play a critical role in the delivery of services. The education landscape in England is both complex and fluid; it has been noted that engagement with schools on mental health issues has been affected by 'recent changes to the education system, with a reduced role of local authorities and a proliferation of multi-academy trusts, each with different governance structures' (Frith, 2016).

- Facilitator: Development of shared policy and implementation strategies

One key element in overcoming this fragmentation of responsibility at local level is to better align activities towards a shared vision for mental health between different stakeholders within and external to the health system (NHS Scotland, 2016). Historically, mental health had been a low priority in public health strategies (RCPsych, 2010). Collaborative working and leadership between CCGs and public health teams to commission services has helped to expand the availability of mental health and wellbeing services (in particular low-level support) to individuals (Regan, Elliot and Goldie, 2016).

Achieving this collaboration requires a detailed understanding of the local situation. It is very helpful to produce a detailed policy strategy through ongoing dialogue with different service commissioners, providers and other interested stakeholders, taking account of Joint Strategic Health Needs and mental health impact assessments, as well as relevant national sources of data and intelligence, eg the Suicide Prevention Atlas (Box 1), and highlighting the potential benefits from investing in mental health. This can help to clarify and align interests.

Box 1: The Suicide Prevention Atlas (Public Health England, 2017)

The Suicide Prevention Atlas provides information on suicide and self-harm, relevant risk factors (prevalence of depression, number of older people living alone, use of opiates and crack cocaine and unemployment) and service contacts for every local authority in England, giving people important information to help them in their plans to prevent suicide. It also shows which local authorities have suicide prevention plans in place.

One example of this is Warwickshire County Council's Public Mental Health and Wellbeing Strategy. Their approach recognises the importance of a cross-sectoral approach to mental health and sets out the case for action, including drawing on past economic arguments about the return on investment (Gath, Mawson and Taylor, 2014). The approach used in Warwickshire has in turn been helpful and cited in other recent public mental health strategies, eg the approach of Cambridgeshire County Council which also provides both quantitative examples of return on investment alongside qualitative statements about the value to individuals of better mental health and wellbeing (Cambridgeshire County Council, 2015).

- Facilitator: Building and supporting partnerships

The Health and Social Care Act 2012 transferred much of the responsibility for public health to local authorities. Building partnerships between the new local authority public health services and others actors is vital to implementation of public mental health strategies. It will take time to build alliances among local stakeholders for the development of a more integrated approach to these issues. However, it will be possible to begin by building and strengthening existing partnerships and relationships with elected council members, relevant organisations and local strategic groups. Local partnerships are also vital to the success of implementing suicide and self-harm prevention strategies. Many different groups in addition to the health sector potentially could contribute to such local partnerships, for example faith groups, police and crime commissioners, the armed forces, local network rail offices, job centres, schools, colleges and housing associations. A recent resource on local suicide prevention planning states that 'a stakeholder mapping exercise is a useful way of establishing the relevant potential members and the scope of their role' (Public Health England, 2016).

The importance of obtaining 'buy-in' for future priorities and implementation plans will also is helped by involving the wider local population in strategic planning. An example is the wide consultation that took place over a number of months in Kent as part of the process of developing a range of mental wellbeing and health promotion actions (Kent County Council, 2015) (Box 2). This approach can support alignment of common goals and outcomes. It also allows local expression of ideas on the types of activity that might be provided and before matching them with evidence on their effectiveness. At a practical level, opportunities to co-

locate staff from different organisations within the same building can also help enhance relationships and mutual trust between individuals and organisations (McDaid and Park, 2016).

Different approaches to sharing the financial risks and rewards for mental health promotion programmes between sectors can also help with implementation. Regulatory and financial incentives have been used effectively to encourage intersectoral partnership working at local and national level for mental health and other health promotion activities in a number of different countries (McDaid and Park, 2016). This could include the development of pooled sector budgets for mental health activities. NHS England and the Department for Education have provided £3 million to pilot a Mental Health and Schools Link. At least 250 schools have nominated a mental health lead who will work closely with a named point of contact in local CAMHS services and clinical commissioning groups (Department for Education, 2015). An evaluation of the pilot was published in February 2017. Such work shows how collaboration can help in establishing common priorities, a shared language, awareness and understanding between these different sectors.

Box 2: Example of a cross-sectoral programme for mental wellbeing and mental illness prevention in Kent (Hann, Hemming and Hamilton, 2015).

Kent County Council has worked to strengthen partnerships with many sectors in developing their public mental health strategy, putting their emphasis on mental wellbeing promotion and mental illness prevention. They have also worked to identify opportunities to leverage additional funding for programmes.

Mens groups to protect mental health, mental health first aid training, workplace wellbeing programmes, support for parents, measures to tackle social isolation, domestic violence victim support, mental health awareness in primary care and mental wellbeing in school are among the wellbeing promotion and prevention actions funded.

The programme is subject to evaluation, including measurement of outcomes using the Warwick Edinburgh Mental Wellbeing Scale (WEMWEBS).

Actions to develop partnerships across sectors can also be initiated by sectors other than health. For instance, in Northamptonshire the Office of the Police and Crime Commissioner is playing an active role in activities that are concerned with the promotion of mental health, as well as addressing crime (Box 3).

Box 3: Early intervention to support mental health in Northamptonshire

In Northamptonshire the Office of the Police and Crime Commissioner (PCC) has recently created and funded the full time post of Director for Early Intervention. The Director is a key adviser to the PCC on early intervention policy and practice, working on the development and delivery of early intervention strategy and plans, working with partners including the police, local authority directors of public health, schools and the voluntary sector.

This could include work related to early intervention to support mental health, as the director should be involved in '*developing multi-agency approaches to identifying risk factors* (including poor mental health, risk of abuse and behavioural problems*) and indicators to signify early intervention requirements, which are evidence-based, effective and provide consistency*'.

The post holder has a strong background in mental health and wellbeing services within the county '*including support for families, school based challenging behaviour services, perinatal mental health support, GP and hospital based WellFamily assistance and social prescribing services, which leave her ideally placed to deliver the early intervention programme*' (Office of Northamptonshire Police and Crime Commissioner, 2016).

B. Barriers: A lack of local mental health and wellbeing champions

A shortage of active champions or advocates for mental health may mean that awareness of the benefits of investment is not as strong as it could be, especially outside of the health sector. Champions could help further develop partnerships and make the argument across sectors, securing financial and other resource commitments.

- Facilitators: Measures to identify and support mental health champions

One action that may help in at least identifying champions is the current campaign linked to the Mental Health Challenge. This has been created by seven non-governmental organisations to encourage local authorities to ideally have a cabinet member or health and wellbeing board member to champion mental health issues (http://www.mentalhealthchallenge.org.uk/the-challenge/). Members of 89 councils have signed up (as of 27th February 2017) to be champions. They receive information and some support from the Mental Health challenge team. As a further incentive, councils

who do have champions have their details published on the Mental Health Challenge website.

Champions can also focus on specific sectors. In Cambridgeshire, for example, 84 workplace mental health champions were trained to promote mental health campaigns in the workplace and provide information on services and supports that are available (Cambridgeshire County Council, 2015). As part of Brighton and Hove's mental health and wellbeing strategy, a network of mental health champions has been established, drawn from sectors including employers, the police, the arts, leisure and the local council (Brighton and Hove City Council, 2014).

C. Barrier: Fragmentation in responsibility for funding mental health, wellbeing and mental ill-health prevention

One direct consequence of fragmentation in the organisation and responsibility for mental health and wellbeing is a myriad of different potential sources of funding. Many interventions to promote mental health will be financed and delivered outside of the health sector. This raises challenges as the sector that funds the activity may not be the principal beneficiary of any financial return on investment: in essence one sector may pay while another may benefit. One of the most visible examples of this barrier concerns school-based mental health promotion, as schools are primarily responsible for funding mental health promotion-related activities on school premises. In some cases there may also be a time lag with these benefits, so that one sector pays, while another benefits, but not for several years. Linked to this issue is the social rate of time preference – a measure of society's willingness to postpone private consumption now in order to consume later. Too high a rate of time preference means that individuals and public sector decision-makers **implicitly** discount future benefits at too high a rate and so under-value future outcomes and thus under invest in activities such as prevention or promotion in favour of actions that have a more immediate impact.

- Facilitator: Creation of dedicated pooled funds for mental health and wellbeing

One way to overcome these issues is to pool funds across sectors to support activities for which there are common goals. This could involve the development of formal partnership agreements with shared budgets. At a more modest level it could also involve the creation of dedicated funds for mental health promotion that potentially encourage innovation in cross-sectoral activities as seen in Brighton and Hove (Box 4). Another example of this approach is the Public Health and Wellbeing Fund set up by Wiltshire Council which also provides small competitive grants that can promote mental health and wellbeing.

Box 4: Brighton and Hove City Council: establishment of dedicated mental wellbeing innovation

A Mental Wellbeing Innovation Fund has been established by Brighton and Hove City Council and NHS Brighton and Hove, as part of their mental health and wellbeing strategy. This has facilitated initial small-scale funding for a range of projects to which community groups can apply for funding; matched funding has also been raised. Evaluation indicates positive changes in wellbeing levels and qualitative impacts were also recorded by funded schemes which has helped them in making the case to secure other sources of longer term funding (Brighton and Hove City Council, 2016, Brighton and Hove City Council, 2014).

D. Barrier: Limited incentives in multiple sectors to invest in promotion and prevention

Linked to the issues of fragmented funding is the common difficulty in persuading non-health sectors that there is a strong enough case to invest their resources in mental health promotion and mental ill-health prevention. Too little attention has been paid to identifying the costs and benefits to those sectors that would need to fund an action.

- Facilitator: Highlighting sector-specific benefits of better mental health

It is important to highlight the benefits to different sectors of investing in mental health in outcomes that are of relevance to those sectors. One example concerns school-based mental health promotion services that would have to be funded directly by schools in many parts of England. In this case it is helpful to flag up the existing evidence from the UK (Gutman and Vorhaus, 2012, Challen, Machin and Gillham, 2014) as well as internationally (Durlak et al., 2011) on (mainly short-term) improvements in educational outcomes, school engagement and school atmosphere for children in schools who have better emotional health and wellbeing. Highlighting any cross-sectoral short-term gains – benefits that can be realised within relatively short time periods, such as within one or two years – will be helpful in increasing the commitment and willingness of these non-health sectors to invest in mental health measures. In some cases it will be possible to attach a monetary value to these educational sector benefits, for instance on the costs avoided as a result of not having to provide special educational services. There can also be broader benefits to society that in addition may also be valued monetarily, such as the benefits to the economy over adult working life that are associated with achieving higher grades in exams. As Box 5 illustrates, this economic argument can be compelling as the economic costs of poor mental health to schools and parents are substantial.

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Box 5: Highlighting costs of poor mental health to other sectors – the example of education

Data from the British Child and Adolescent Mental Health Survey in 1999 were used to identify a nationally representative sample of children aged 5-15 with diagnosed mental health problems. Three year follow up data were collected on the costs and resource impacts and the adverse impacts to the education sector of poor mental health were quantified.

54% of additional costs were for mainstream education services (including additional teacher time and extra meetings with parents) and 34% of costs were for special education needs services (mainly special school placements) that are usually the responsibility of local authorities (Snell et al., 2013).

Another example of the advantages of taking a cross-sectoral perspective on investment in mental health promotion and prevention can be seen from experience in Canada where it was possible to identify the financial benefits associated with investment in the Better Beginnings, Better Futures (BBBF) project. (Box 6).

Box 6: Estimating some of the immediate economic co-benefits to schools: an example from Canada

The Better Beginnings, Better Futures (BBBF) project targeted primary school children and their families living in three disadvantaged communities in Ontario, Canada (Peters et al., 2010). Evaluation looked at outcomes and costs at one, four and seven years after programme participation in comparison with control school populations. This included costs to several different sectors: education, health and social welfare. In addition to looking at social, emotional and behavioural outcomes for children and their parents, the evaluation also considered a number of outcomes related to school performance. Levels of current academic achievement were measured in terms of each child's relative position in their class and in their performance on a standardised maths test.

The overall economic analysis demonstrated that the programme did not reduce costs to the health system, in fact these increased. However they were more than offset by a reduction in the need to use special educational services, improved wellbeing of teachers and a reduction in the need for social welfare services which led to an overall 2.5:1 return on investment (Peters et al., 2010).

The approach was intended to promote the health and wellbeing of children and their families living in low-income disadvantaged areas of Ontario through activities including parenting support and psychological wellbeing interventions for children. In addition to documenting impacts on the social, emotional and behavioural outcomes for children and their parents over seven years, the interim evaluation also considered a number of outcomes related to education and social welfare budgets

Looking beyond education, another example of the value of highlighting costs and benefits to other sectors can be seen by looking at actions to prevent domestic violence. Early action to support domestic violence victims has benefits for their mental health and self-harm prevention. Economic analysis indicates substantial costs beyond the health sector that can be avoided through action (Box 7). This increases the willingness of other local stakeholders, such as the police, to help fund early intervention actions.
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Box 7: The economic case for action to tackle domestic violence

In Kent, an Independent Domestic Violence Advisors (IDVA) Service is funded through support not only from the county council's public health department but also by the Fire and Rescue, probation and police services. Early action to support domestic violence victims has benefits for mental health and self-harm prevention, but there are also wider positive resource impacts for health and other sectors.

In developing this jointly funded service the council were able to cite economic modelling work commissioned by NICE estimating that for every 100 clients that IDVAs work with, they will avoid £0.9 million in costs to the criminal justice system, £0.3 million to the health system, as well as lost employment costs of £0.4 million (Mallender et al., 2013). These avoided costs more than outweigh the costs of the service.

E. Barrier: Lack of awareness of the importance of promoting mental health and wellbeing and mental ill-health prevention.

More generally, there may be a lack of awareness of the importance of mental health and wellbeing as well as the prevention of mental ill-health. This goes beyond identifying the economic case, reflecting limited knowledge about mental health, which still remains a topic that many individuals are uncomfortable talking about.

- Facilitator: Raising awareness across sectors

One way to counter this is to invest in measures to raise awareness – across all sectors. For instance, although there is an economic case for investing in workplace mental health promotion, not all workplaces may be aware of the potential benefits, or

the best ways in which they can be achieved. This is more likely to be the case in smaller workplaces in the private sector. At a local level, action can be taken to help facilitate investment in workplace health promotion: WorkHealthy Cambridgeshire run by the Public Health Programmes team at Cambridgeshire County Council offers employers one free Mental Health First Aid training course for up to 14 staff to improve awareness and knowledge of mental health issues in the workplace, as well as signposting employers to other potential supports (Workhealthy Cambridgeshire, 2016). There may also be opportunities for building strategic alliances with organisations that may have a different primary focus, which is nonetheless linked to mental health. This One example of this is collaboration between mental health and loneliness focused organisations at national level to raise awareness of both issues to a wider audience, including stakeholders in different sectors (Edwards and Farmer, 2014).

- Facilitator: Monitoring mental health promotion and wellbeing actions

Another way to encourage the development of mental health promotion and prevention activities outside the health sector, where incentives for action and awareness may be low, can be through regulatory measures, alongside incorporation of targets or standards regarding mental health into any routine inspections or assessments that are conducted.

An example of how this has positively influenced mental health promotion is the requirement for schools in England to have a behaviour policy in place that includes measures to prevent all forms of bullying among pupils. From September 2015 the school inspection body OFSTED also introduced a judgement into their inspections on the quality of measures to support personal development, behaviour and welfare of children (OFSTED, 2015) which should give further impetus to school-based mental health promotion activities .

Workplaces could be encouraged to adhere to the UK Health and Safety Executive's Management Standards for work-related stress. In some countries actions are being taken to look at the quality of workplace mental health promotion. For instance in Denmark, a guidance tool has also been developed to help labour inspectors to conduct psychosocial assessments of the working environment (Wynne et al., 2014).

F. Barrier: Limited capacity for promotion, wellbeing and prevention actions

The Five Year Forward View for Mental Health identified capacity gaps within the public health system. It recommended that Health Education England, working with Public Health England, 'develop an action plan so that by 2020/21 validated courses are available in mental health promotion and prevention for the public health workforce (including primary care)' (Mental Health Taskforce, 2016).

- Facilitator: Developing capacity and awareness of mental health issues within health and other sectors

In addition to addressing the recommendation from the Mental Health Taskforce on capacity within public health, it is also vital to raise awareness and develop capacity around mental health promotion in other sectors. For example, looking at child mental health and wellbeing, and given that 50% of long-term mental health conditions start by the age of 14, and one in 10 pupils are expected to have a mental health problem, school-based interventions around mental health literacy will clearly be important.

The Future in Mind report highlighted the need to develop a workforce in schools that is confident in promoting good mental health and identifying problems at an early stage (Department of Health, 2015). The Department for Education has produced advice to help schools identify mental health problems, understand the referral process with Child and Adolescent Mental Health Services (CAMHS), and inform commissioning services (Department for Education, 2016). The information portal of the non-governmental organsation MindEd Consortium (www.minded.co.uk) also aims to support staff working with children and young people.

Schools may need support when commissioning services; they may not have the skills or knowledge to assess the appropriateness or evidence base around planned interventions for mental health promotion. One recent report notes that Oxfordshire County Council is exploring the idea of a 'quality mark' for schools provision so that schools can be assured that their support is of good quality (Frith, 2016).

Again there is the challenge of ensuring sufficient resources and time to train professionals working outside of the health sector to take on limited potential mental health promotion roles. One potential area to explore is to embed these skills within initial professional training programmes, such as initial teacher training (Shepherd et al., 2013).

Future research might look at ways to incorporate mental health promotion skills into all aspects of teaching, and supporting teachers to do this (Fazel et al., 2014). Examples of initiatives include training teachers in Youth Mental Health First Aid (MHFA); this is subject of an evaluation by the University of Bristol. Islington CAMH services are collaborating with schools and offering to train teachers on children's emotional wellbeing (Islington CAMHS, 2016).

G. Barriers: Limited information on what works

A general challenge for public health, and not just public mental health, is the strength of the evidence base on what works. This issue was also highlighted in respect of

wellbeing and mental health promotion by the Chief Medical Officer for England in her 2013 annual report which was focused on public mental health (Davies, Mehta and Murphy, 2014). A lack of appropriate mental health-related data is also a barrier to developing a strong evidence base on interventions that aim to promote mental wellbeing and prevent mental health problems (Regan, Elliot and Goldie, 2016).

- Facilitators: Measures to strengthen the evidence base

Various measures can be taken to strengthen the evidence base. They can include ensuring that there is a requirement from granting bodies to request the routine collection of engagement, continued uptake and outcome data associated with different mental health promotion/prevention actions. These requirements could also ensure that information on resources used, including the time of volunteers, as well as information on cost, is collected. This can help other commissioners in looking at both the potential impacts and costs of interventions.

Ideally such evaluations should compare impacts and outcomes for those who receive any intervention with those who do not; this may not be easy to undertake for population-level universal programmes, but there may be opportunities to compare outcomes for one local area where an action takes place with another where it does not. It is also helpful to make use of common outcome measures, for instance the Warwick Edinburgh Mental Wellbeing Scale (WEMWEBS), to increase the potential for pooling results of small-scale studies of same intervention. WEMWEBS, for instance, is being used as a core outcome measure to evaluate the impact of Kent County Council's Mental Wellbeing Investment Programme.

At a national level, bodies such as the recently established What Works for Wellbeing Centre (https://whatworkswellbeing.org/) and the National Institute for Health Research (as a research-commissioning body) can help strengthen the robustness of the evidence base. These bodies in turn should aim to engage effectively with national and local public mental health commissioners to help communicate information on what works and also the potential return on investment.

Greater levels of evidence on what works can help secure future sources of funding. The Big Lottery, as a matter of routine, embeds a requirement for evaluation in many of the programmes they support. One example is the Big Lottery HeadStart pilot programme to support the mental health and resilience of young people in schools in Kent. Following a favourable evaluation, this is now being expanded by the Big Lottery with a further £10 million of funding over five years. The programme brings together schools, youth clubs, health services, the voluntary sector and family support services to build a community where young people can get the support around them which increases their resilience and emotional wellbeing when faced with adversity. It will now also look to find ways to sustain the programme in the long term (Watkins, 2016).

H. Barriers: Limited information on resources invested in promotion of mental health, wellbeing and prevention of mental ill-health

It remains very difficult to identify the level of resources that are committed to mental health and wellbeing promotion. This is made more difficult because of the multi-sectoral nature of responsibility for funding and delivering services. Without this information it may be more difficult to monitor whether sufficient resources are being allocated to these activities.

- Facilitator: Seek to collect at national and local level information on resources invested in promotion of mental health and wellbeing

Bodies such as Public Health England might consider whether it is possible to collect better data on the levels of resources allocated to promotion activities in different local areas. If it possible in some transparent way to be able to compare resource levels for at least some aspects of public mental health activity between local areas, in the same way as the new NHS Mental Health Dashboard (NHS England, 2016) is beginning to publish information on mental health spend and other core indicators, then this could act as an incentive for local areas to ensure that they are spending sufficient resources in these areas.

Conclusions

This brief report has examined some of the barriers to implementation and ways in which they may be overcome. Any implementation strategy needs to be mindful that many different facilitators will need to be employed. A good starting point is to undertake a situation analysis to fully understand the ways in which local (and national) mental health and public health systems function, including differences in funding streams and other financial incentives. This analysis can also be used to help identify mental health champions to be worked with.

Fundamentally, at its core effective implementation will mean building partnerships between the many organisations that fund and/or deliver mental health promotion, wellbeing and mental ill-health prevention interventions. Economic evidence looking at return on investment to different organisations can play a very crucial role in facilitating such implementation, especially if the key outcomes, resource use and costs that are of interest to different sectors, are calculated.

Finally it is important to learn from the past. This report has highlighted examples of ways in which implementation can be achieved. At an England level, there may be scope for an organisation, such as PHE, to offer an opportunity for examples of implementation to be stored together, for instance on a website, in order to help inform the development of future implementation strategies.

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