



IMPROVING WELLBEING THROUGH HEALTHY LIFE CHOICES

Lessons from a **West Midlands initiative** with
Health Trainers and Psychological Therapy Practitioners

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Executive Summary

New developments in 'Talking Therapies: A four-year plan of action' sets out approaches to training and delivery of psychological therapies broadening the benefits of talking therapies to people with physical long-term conditions or medically unexplained symptoms.

Improving wellbeing through healthy life choices provides some key learning to help Increasing Access to Psychological Therapy (IAPT) services collaborate with, in this case Health Trainer (HT) services, to improve access for clients to make physical and mental healthy life choices. Well-being as a positive outcome in improved physical and/or mental health is of prime concern to both HT and IAPT programmes.

Key messages

Physical Health and Mental Health are inter-related

- Poor physical health is a significant risk factor for poor mental health;
- Positive mental health and well-being protects physical health and improves health outcomes and recovery rates.
- Early intervention and treatment of mental health problems is recommended to improve health outcomes for people with physical illness
- Early provision of advice on promoting physical health for people with mental ill health will help to increase well-being and prevent development of physical health problems.

Health Trainer services were introduced as a new public health workforce from 2004, to work with people from disadvantaged communities, supporting them in considering their health behaviours and lifestyles and deciding about possible changes to make.

IAPT services were introduced in 2008 to offer patients a realistic first-line treatment for depression and anxiety disorders. An additional workforce of 3700 therapists has been trained – and a further 2,400 will be trained over the next few years – to increase access to psychological therapy. IAPT services use a "Stepped Care model" which means matching need to the appropriate intensity of 'psychological' intervention to deliver positive outcomes. These outcomes are based not only on providing therapy that will help the individual, but wider outcomes by helping people to for example, come off sick pay and benefits and stay in, or return to work.

Key findings

Health Trainers are meeting clients with unmet mental health issues

HTs are coming into contact with people who may have mental well-being issues and/or more serious undetected mental health problems, working in the most deprived areas where there are the largest numbers of people, experiencing poorest physical and mental health. HTs can feel uncertain about how, or whether to support someone with more serious mental health issues and where to access appropriate support for them. For some, if the mental health issues are not addressed the HT's interventions may be confounded.

IAPT practitioners are meeting clients with poor lifestyle as well as physical health problems

such as: Heart Disease, Stroke, Diabetes and other long terms conditions and medically unexplained symptoms. IAPT training currently focuses on mental health issues and less on the benefits of physical healthy lifestyle behaviour change in their clients.

Developing a collaborative approach

Providing mental health awareness training for HTs

Mental Health First Aid (MHFA) – a nationally recognised programme can achieve significantly increased levels of knowledge and confidence for HTs, in understanding and responding to mental health issues and problems. MHFA (because of the nature of the course) does not deal with all HT's concerns around role boundaries, levels of responsibility, thresholds for referring to /or detailed knowledge of local IAPT and mental health services. Currently MHFA also does not cover aspects of mental well-being and interventions in greater detail, wider than the predominant illness focus.

Providing additional development time for local HT and IAPT services to develop joint working

Further on-going support and/or development work should be considered to address shortfalls in MHFA training and to encourage better outcomes for clients of both services, in terms of improved health and mental well-being.

Such development work can provide benefits for both services by providing an opportunity to:

- Learn from each other
- Develop an understanding of each other's roles and services
- Explore joint working arrangements and develop pathways across their services
- Integrate the 5 ways to well-being within HT and IAPT practice

Realising the benefits

This report recommends how working together to improve outcomes for clients can best be achieved, HTs and Psychological therapists/well-being practitioners who have many similarities in meeting the needs of the whole community have:

- achieved a shared understanding of each other's services and roles, to deliver the best outcomes for their clients
- developed action to help them create holistic services and referral pathways that can improve outcomes for their clients.
- a better understanding of the access thresholds, allowing protection and championing of each other's services

The report learning focuses on joint working between IAPT and Health Trainer Services but much of the learning presented could apply to other non-mental health front line workers and services that would benefit from engagement and on-going support from, or liaison with local IAPT services.

1. Introduction

This report focuses on a pilot of Mental Health First Aid training as part of a broader development process for Health Trainers and offers some lessons for future joint training initiatives across the country.

The National Health Trainer (HT) programme, which started in 2006, and the Improving Access to Psychological Therapies (IAPT) programme workers, from 2008, are both concerned with people's well-being, with HTs focussed on physical health and IAPT on mental health.

A workshop in August 2009 explored how emotional resilience and mental well-being could be better supported in the economic downturn and established a time limited HT/IAPT Task and Finish Group to encourage regional links between the two programmes and to consider what mental health awareness training HTs should be offered. Four regions chose the Mental Health First Aid (MHFA) package and the West Midlands undertook a detailed pilot of it.

The Health Trainer Service

The 2004 Public Health White Paper *Choosing Health* introduced the Health Trainer Service as a new public health workforce to work with people from disadvantaged communities, supporting them in considering their health behaviours and lifestyles and deciding about possible changes to make.

Many of these people would not normally access this support through existing services. They also find themselves constrained in making recommended changes to improve their health and reduce their risks of ill health, by wider factors such as income, housing and other pressures.

Many of the techniques that Health Trainers use aim to help people become more confident to make decisions and changes in their lives. They equip individuals to assess and evaluate current health choices and to reflect on and prepare for change (O'Hara 2009).

"I think that my empathy and resolve to treat each client with respect has improved."

HT core areas of focus are physical lifestyle behaviour change, including smoking cessation, healthy eating, exercise, and alcohol.

Different models of HT services have developed across the country, with some hosted by healthcare organisations, some by local authorities and some by third sector organisations; they are also based in many different settings, such as communities, prisons, workplaces, primary care (Murfin *et al* 2009).

HT Workforce and Training

HT trainees are recruited from their local communities and provided with training which results in a National City & Guilds Certificate at level 3 in the National Qualifications and Credit Framework.

In some services, in addition to qualified HTs and trainee HTs, there are HT Champions (HTCs), who facilitate the uptake of HT and other health interventions – this is often referred to as 'signposting and improving access to services'. The HTCs have usually undertaken health improvement training through a recognised programme at level 2 of the National Qualifications Framework (e.g. the Royal Society of Public Health Understanding Health Improvement Award at level 2).

Training is based on four National Occupational Standards (competences):

HT1	Make relationships with communities
HT2	Communicate with individuals about promoting their health
HT3	Enable individuals to change their behaviour to improve their own health & well-being
HT4	Manage and organise your own time and activities

These core competences define health in its broadest sense and both health and well-being are included throughout.

Health and well-being – a state of complete physical, social and mental well-being, and not merely the absence of disease or infirmity. Health is a resource for everyday life, not the object of living. It is a positive concept emphasising social and personal resources as well as physical capabilities (Skills for Health 2006)

Mental health and well-being relate specifically to the scope for Competence HT3:

Enable individuals to change their behaviour to improve their own health and well-being

The focus in this competence is on improving health and well-being by changing behaviours relating to physical health for which attending to mental well-being is an important aspect. The challenge therefore is to clarify what this means in practice.

Improving Access to Psychological Therapies

The purpose of the Improving Access to Psychological Therapies (IAPT) programme is to support Primary Care Trusts in implementing National Institute for Health and Clinical Excellence (NICE) guidelines for people suffering from depression and anxiety disorders. To this end, 3,600 additional therapists are being trained, between 2008 and 2011, to increase access to therapy for an additional 900,000 people. A linked aim has been to enable people to remain in or return to work.

IAPT is based on the use of Stepped Care which means matching need to the appropriate intensity of intervention to deliver positive outcomes, thereby reducing the potential for dependency and poor use of resources. Patients are continuously monitored, enabling patients to step up to more intensive treatment as indicated (Steps 3-5), step down to less intensive treatment (Steps 1-2) and step out when an alternative treatment or no treatment become appropriate.

IAPT services are also tasked with embedding employment advice and support within their services as there is strong evidence that work is good for mental health. Good work can provide a number of protective factors for disorders such as depression and anxiety and is integral to delivering a psychological well-being service that is able to support people in their recovery.

“I have learned to be flexible and willing to step back and give the client time.”

Workforce and Training

There are two main types of workers within an IAPT service:

- **High Intensity Therapists** trained in Cognitive Behavioural Therapy for people with moderate and severe depression and anxiety disorders. Training is provided by universities and the qualification is a post graduate diploma. Other Step 3 therapies, recommended by NICE, will be offered for depression from 2010, underpinned by competency frameworks, national curricula and learning materials, as continuing professional development for already experienced therapists
- **Psychological Well-being Practitioners (PWPs)**, trained in cognitive behavioural approaches for people with mild to moderate anxiety and depression. These approaches include guided self help, delivering psycho-educational interventions and sign-posting. Training is run by universities and the qualification is a post graduate certificate, although undergraduate routes are being developed and encouraged to increase access to training from broader sections of the community

Services also have administrative staff, employment advisors, a GP advisor and links with other services such as housing, drugs advice and benefits support.

Additional non recurring financial support was offered through IAPT in 2009 to support people in the economic downturn to:

- Broaden the availability of low intensity-type interventions in non-IAPT areas as a precursor to and enabler of the implementation of a full IAPT service in each PCT area
- Target an improved service offer in localities experiencing the greatest impact of the economic downturn
- Improve sign-posting of service availability for patients/clients with mental health issues and employment concerns between local employment services, community support resources and the NHS
- Enhance the skills of primary care staff to identify people at risk of developing anxiety and depression and to improve the emotional resilience of the wider population

Links between the two Programmes

There is clear, positive and strong synergy between these two programmes in where they are delivered, the clients that they see and the needs they are trying to meet. Well-being as a positive outcome either in improved physical and/or mental health is of prime concern to them both. However, their respective focus on physical health/lifestyle or mental health potentially limits the outcomes they can deliver. We know that poor physical health is a significant risk factor for poor mental health; conversely, positive mental health and well-being protects physical health and improves health outcomes and recovery rates, for e.g. coronary heart disease, cardio vascular disease and diabetes (Friedli & Parsonage 2007).

Early intervention and treatment of mental health problems is recommended to improve health outcomes for people with physical illness, as well as early provision of advice on promoting physical health for people with mental illness to help them increase well-being and prevent development of physical health problems (DH 2010).

HTs are targeted to work in the most deprived areas where there are the largest numbers of people experiencing poorest physical and mental health. So it is not surprising that HTs are coming into contact with people who may have mental well-being issues and/or more serious undetected mental health problems.

This situation can make HTs feel uncertain about how or whether to support someone with more serious mental health issues and where to access appropriate support for them. In some cases, if the mental health issues are not addressed the HT's interventions may be confounded.

This need for mental ill-health and well-being awareness and training has been well recognised by local services. The Health Trainer Workforce Audit in 2009 shows that approximately 78 services across the country have provided additional training on mental health for HTs and HT Champions.

Additionally, IAPT training focuses on mental health issues and practitioners may lack awareness of the benefits of physical health behaviour change in their clients. IAPT services also need to facilitate access to clients with unmet mental health needs/problems, with a focus on depression and anxiety.

“Made more effort to create a calm and relaxed environment and take into consideration any anxieties they may have about speaking to me.”

2. West Midlands Joint Project on Training and Development

Pilot work was initiated by bringing together two IAPT and two HT services in the West Midlands. The learning from this pilot work informed a Mental Health and Health Trainer development package which included Mental Health First Aid training for HTs.

Structure

- 1 Two day **Mental Health First Aid** training programme.
- 2 Two day **Development Programme** bringing together representatives from HT and IAPT/PCMH services in two localities to:
 - Develop proactive ways of working together, with agreed principles, tools and approaches, including using a threshold approach
 - Get to know each other and understand each other's services and expectations
 - Agree and produce an action plan
- 3 One day **Consolidation**, where representatives from second stage come back together, to review progress, share developments and plan next steps. (NB this had not been delivered at the time of report writing) .

Headline Results

Three over-arching issues arose from the pilot work:

- 1 The need for **protection of roles/boundaries** – particularly for Health Trainers, who are working at Band 3 and Psychological Well-being Practitioners working at Band 4 in training and at Band 5 once qualified. *Note: These bandings relate to NHS Pay bands and job weighting across set job evaluation criteria. (The NHS Staff Council 2010).*
- 2 Exploring **thresholds/triggers** which can instigate engagement/referral across the services, including making use of appropriate assessment tools.
- 3 Developing **liaison and joint working approaches**.

Reflections on Use of Mental Health First Aid

Mental Health First Aid (MHFA) is a first aid approach to mental health, as the title suggests. Originally conceived by Betty Kitchener and Professor Tony Jorm in Australia, MHFA has been introduced in a number of countries including Hong Kong, Finland, Singapore, Canada and Scotland and England. Wales and Ireland are currently working on introducing MHFA.

MHFA is the help given to someone experiencing a mental health problem before professional help is obtained. It teaches people how to recognise the symptoms of mental health problems, how to provide initial help and how to guide a person towards appropriate professional help. It does not aim to teach people to become therapists.

The mnemonic **ALGEE** is used throughout the training for each mental health problem explored:

Assess risk of suicide or self-harm
Listen non-judgementally
Give reassurance and information
Encourage the person to get appropriate professional help
Encourage self-help strategies

The following represents feedback relating to the MHFA ALGEE approach across three key questions:

What are we expecting HTs to do?

HTs are protocol driven with usually 45 minutes allocated for initial assessment. For some, the protocol indicates referral back to the GP (for example, if the client was expressing suicidal ideas). Through ALGEE, HTs are provided with guidance on assessing suicide risk, with key questions to ask around suicidal intent and a process to follow that helps them provide support and access to appropriate help. This has further implications for how much time HTs can spend with clients who may have mental health issues. Non-judgemental listening is emphasised as the most important element of ALGEE and helps HTs to carry out more effectively the other basic steps of ALGEE. This means HT's may need to be more flexible and allow more time in their interactions, particularly where there are known mental health issues or when they arise.

“The client cried a little but was reassured that I did not judge them and went on to make successful behaviour changes.”

Mental illness diagnostic categories e.g. for depression and anxiety are used throughout MHFA training. These categories are used in IAPT to identify and refer patients appropriately in the stepped care model, so it is useful for HTs to have some understanding of them although it is stressed in MHFA training that the HTs role is not to diagnose. Participants are encouraged to think in terms of:

- Presence of symptoms
- Duration of symptoms
- How much/whether the issue/symptoms are interfering with everyday life

This approach helps HTs to assess “At what point do mental health issues become a problem?” Exploring thresholds for sign-posting and referral are key to the West Midlands HT and MH Development Sessions and it is beneficial when HTs and IAPT services understand the triggers/thresholds for engaging each other’s services.

MHFA training is primarily illness focused, with little time to address clients’ mental well-being in any depth, or to share tools for promoting and protecting it. The West Midlands HT and MH Development sessions covered these areas, with a particular focus on how the 5 ways to well-being can be integrated throughout the HT intervention. www.neweconomics.org/projects/five-ways-well-being

What level of (mental health/ mental well-being) intervention are we expecting from HTs?

HTs attending MHFA training were concerned about expectations of their level of responsibility to mental health issues, particularly when dealing with someone who was suicidal. They were clear they did not wish to be perceived as a therapist/counsellor.

MHFA training equips HTs to provide ‘first aid’ by using ALGEE: they are not responsible for resolving clients’ mental health problems. The West Midlands HT and MH Development sessions helped participants identify and understand professional relationships, boundaries, and limitations, protecting professional roles in a way that helped both HTs and IAPT services.

MHFA also helped HTs understand the experience of someone who has had, or is experiencing mental health problems and to identify those who may require a mental health service intervention.

How does MHFA training support HTs to put new-found knowledge into practice?

From the West Midlands evaluations, HTs can see how they intend to make use of the learning they have gained through MHFA training.

Key issues arise on:

- Needing support to explore and understand the local Mental Health system, to help navigation
- Developing on-going liaison with and support from local Mental Health services
- Needing to work alongside other professionals

Local mental health services and action planning are covered only briefly in MHFA training, given the time constraints for content delivery. The West Midlands HT and MH Development sessions developed understanding of respective services and systems as well as planning on-going joint working relationships and practice. Local HT and IAPT services will benefit from making time to give each other information about their respective services.

These views were supported in a separate evaluation of MHFA.

NHS Islington concluded that there was a need for “more support to convert learning into action through more practical demonstration of help, more use of role play and case studies and provision of information on local services.” (NHS Islington)

“I have been more aware of how to recognise depression and anxiety and more confident in dealing with clients with mental health issues.”

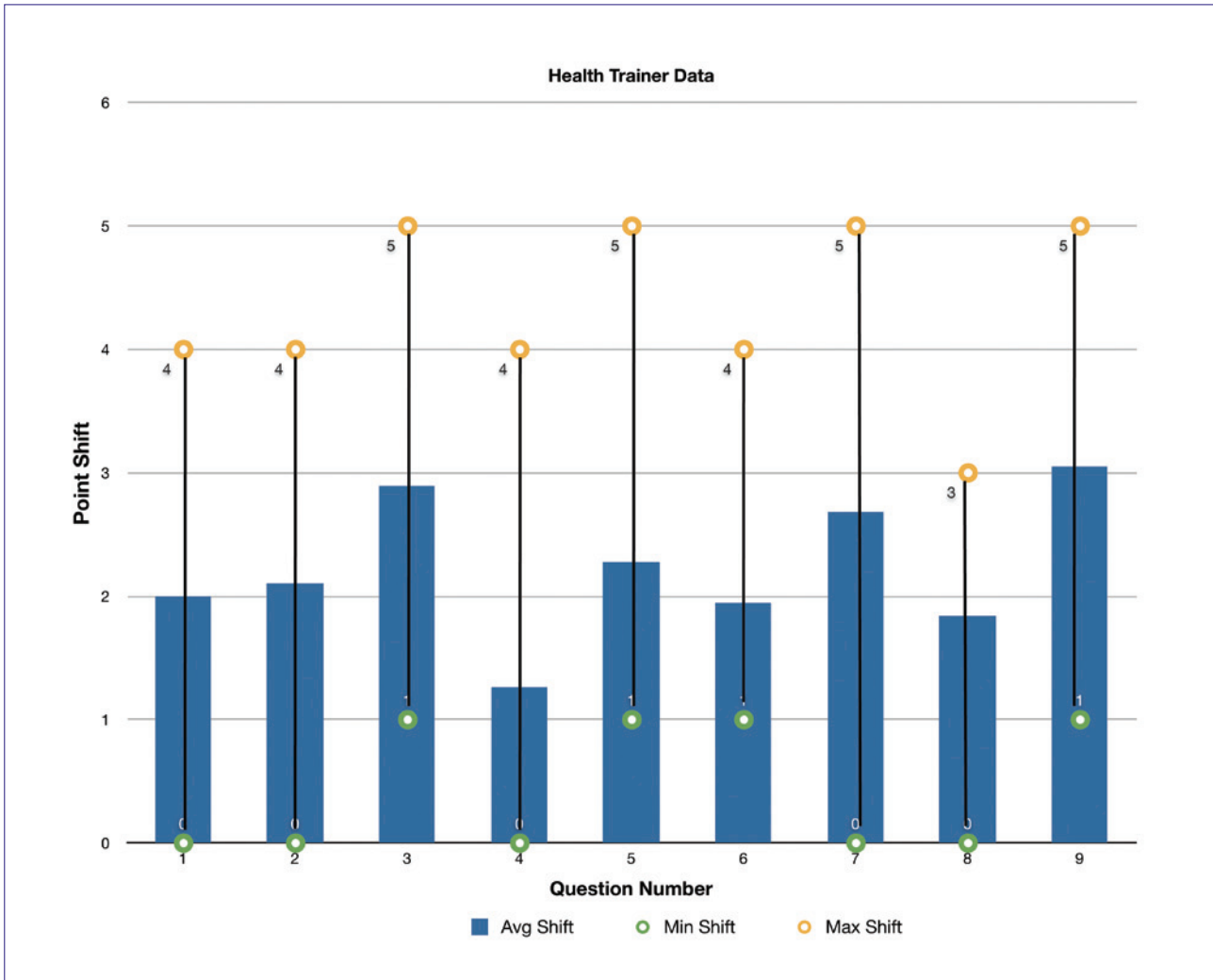
Results of West Midlands Development sessions

The two graphs overleaf show the details of the responses of the attendees at the HT and Mental Health Development sessions. Attendees scored themselves using a simple scale ranging from no knowledge/awareness to expert level knowledge and confidence. This self assessment was conducted before and after the development sessions for 9 key questions in the case of HT's and 7 key questions for IAPT staff (these questions are in the tables below the graphs).

- Min point shift shows the lowest recorded individual attendee change in knowledge and confidence for that question
- Max point shift shows the highest recorded individual attendee change in knowledge and confidence for that question
- Average point shift shows the average recorded change in knowledge and confidence across all attendees for that particular question

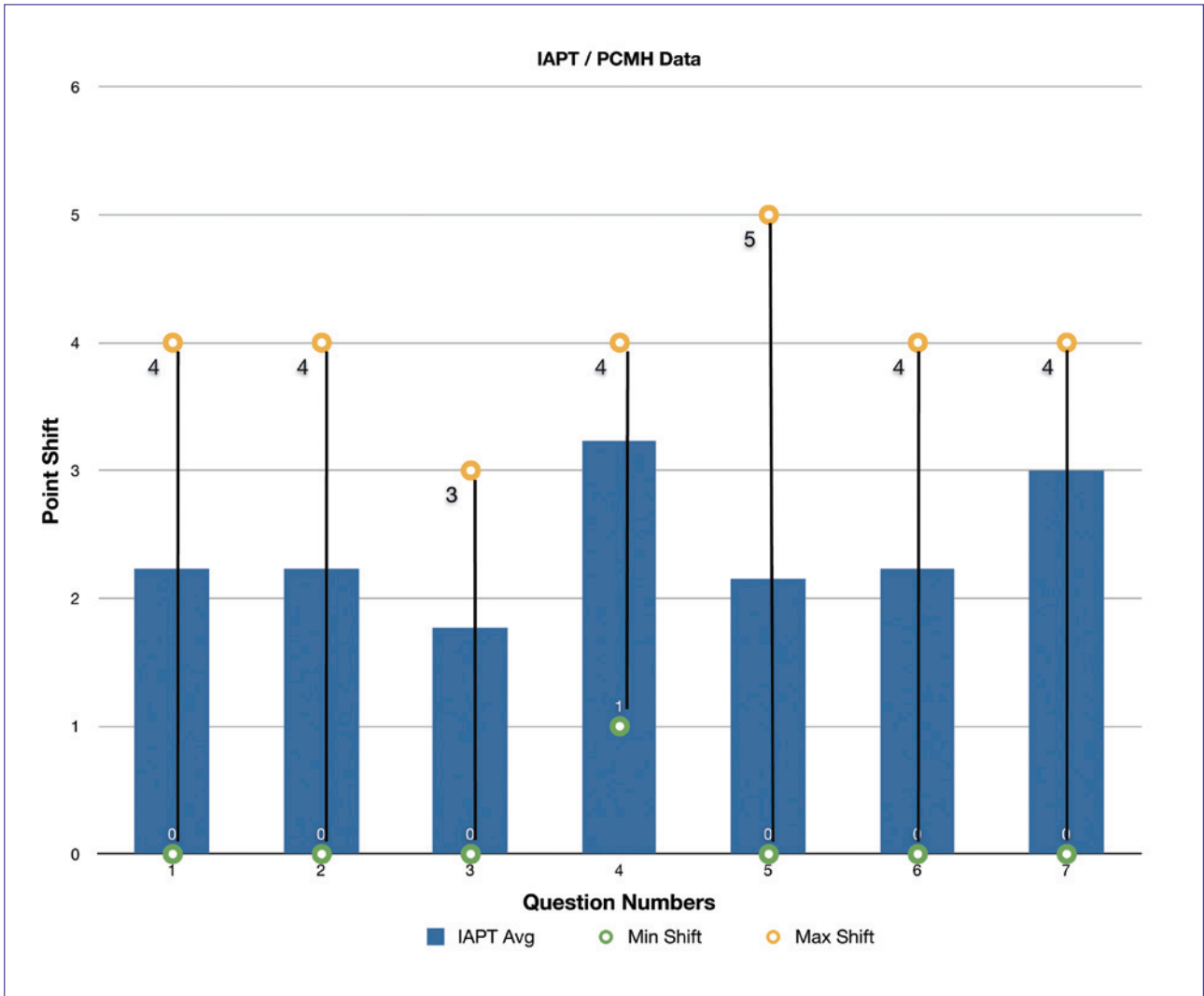
Across most questions for HTs and IAPT staff the average point shift was two points showing a marked increase in both confidence and knowledge about each other's respective services and joint working plans.

Table 1: results for HTs attending two sets of development sessions



Question	HT avg	Min shift	Max shift
Q1 Knowledge of IAPT/PCMH overall principles	2	0	4
Q2 Knowledge of local IAPT/PCMH delivery	2	0	4
Q3 Knowledge of local communication/referral protocols between HT service and IAPT/PCMH	3	1	5
Q4 Confidence to assess mental well-being issues	1	0	4
Q5 Confidence of Who do I refer to IAPT/PCMH or specialist mental health services	2	1	5
Q6 Confidence of When do I refer to IAPT/PCMH or specialist mental health services	2	1	4
Q7 Confidence of Where do I refer to IAPT/PCMH or specialist mental health services	3	0	5
Q8 Knowledge of tools to assist decision making in assessment and referral	2	0	3
Q9 Knowledge of locally agreed plan between HT service and IAPT/PCMH	3	1	5

Table 2: results for IAPT staff attending two sets of development sessions



	Question	IAPT avg	Min shift	Max shift
Q1	Knowledge of Health Trainer overall service principles	2	0	4
Q2	Knowledge of local Health Trainer delivery	2	0	4
Q3	Knowledge of local communication/referral protocols between HT service and IAPT/PCMH	2	0	3
Q4	Knowledge of '5' Ways to Well-being	3	1	4
Q5	Confidence of Who I signpost/refer to local Health Trainer services	2	0	5
Q6	Knowledge of tools to assist decision making in assessment and referral	2	0	4
Q7	Knowledge of locally agreed plan between Health Trainer service and IAPT/PCMH	3	0	4

Results on the use of MHFA

Attendees were asked to score themselves before and after taking part in the course on a scale of 1 = no knowledge and confidence to 10 = maximum knowledge and experience in how best to support others with a mental health problem.

The graph below presents the combined scores for 4 cohorts of participants in MHFA training.

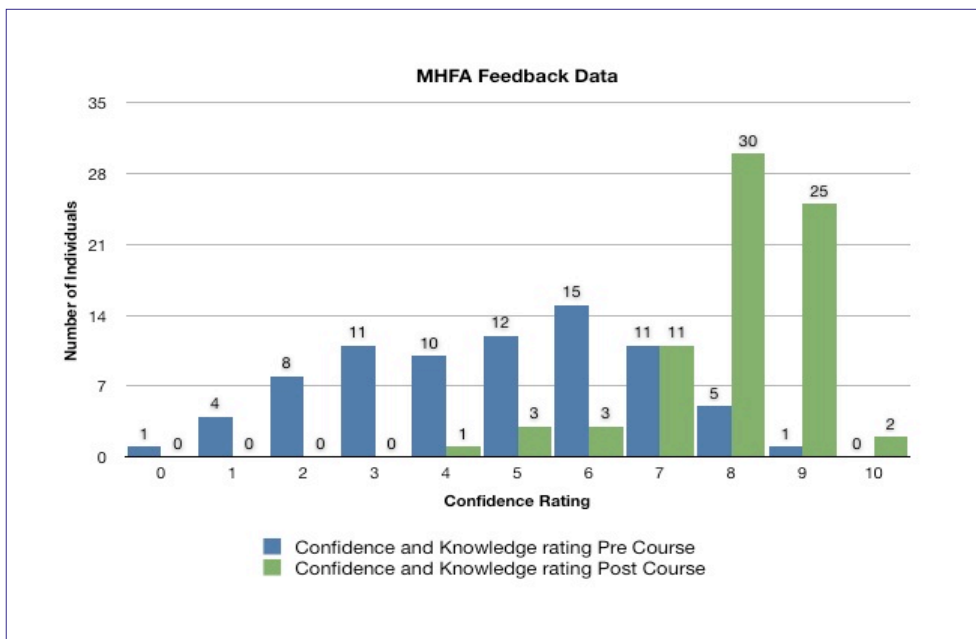
As can be seen the post course scores show a significant move to the right of the graph, demonstrating an increase in knowledge and confidence among the attendees after taking part in the MHFA training.

In addition participant feedback on making use of what HTs learned through MHFA training for the first four cohorts fell into the following themes:

- Integrating learning within their HT role and everyday practice
- Identifying and supporting clients with mental health needs, signs and symptom recognition through increased understanding, knowledge/awareness
- Signposting – both in terms of knowing more about what is available as well as the need to find out more
- Sharing the learning with colleagues and teams
- Additionally using the learning in their personal life
- You can also see comments made by HTs in the West Midlands on the impact of MHFA on their practice and how it has helped them with their clients in Appendix 1 and in the text boxes throughout the report

See Appendix 1 for the learning outcomes for the Mental Health and Health Trainer Development Package together with the West Midlands Development Sessions Programme outline. We have also included indicative costs per learner.

Table 3: MHFA Feedback Data



3. Which Mental Health Awareness training should you choose?

MHFA appears to be the mental health awareness training of choice delivered in:

- East Midlands
- North East/Yorkshire and Humber
- West Midlands
- London

Whatever training is chosen, some fundamental questions have to be addressed as explored in the West Midlands Initiative:

- What are we asking HTs to do?
- What level of (mental health/mental well-being) intervention are we expecting from them?
- How does the training support HTs to put new found knowledge into practice?

A national evaluation of MHFA training showed that course feedback was “overwhelmingly positive and many participants report the training having an immediate impact on their confidence to approach someone in distress and offer advice and support”.

www.mhfaengland.org.uk/silo/files/national-evaluation-summary.pdf

Other organisations who have conducted formal evaluations on MHFA training include NHS Islington (2010), Bath University (2010)

MHFA training was evaluated very positively as increasing knowledge and confidence in both NHS Islington and Bath University,, as well as improving perceptions of mental health issues and increasing use of MHFA in practice.

Anecdotally, Yorkshire and Humber note that feedback from HTs on the MHFA training has been extremely positive and they would recommend it as an extremely useful component of HT training. Results from the first four cohorts of HTs receiving MHFA training in the West Midlands are very favourable.

Summary: Getting the most out of MHFA training for HTs

- 1 MHFA training on its own (or any other MH awareness training which simply seeks to increase knowledge and not take account of where and how this knowledge is put into practice) may leave unresolved issues/dilemmas for participants. Such training should be supported and supplemented with further development work and/or support across local HT and IAPT/MH services.
- 2 MHFA training is a very intense two-day course that gives a lot of information to take in. For some, the training can raise personal issues. Support given by the trainers to participants affected in West Midlands was very good. Some HTs felt “prior warning” is needed about the potential personal impact particularly of Day 1.
3. Although MHFA is a set course it is important to:
 - Get ‘suitable trainers’. Competitive tendering was helpful in gauging previous experience particularly with the target audience. It also ensured the ‘best’ values were instilled leading to the ‘most appropriate’ interpretation and delivery of MHFA for the target audience. This was essential to getting a better balance between an illness and wellness focus
 - Brief trainers to ensure they understand the outcomes you are looking for and set some expectations, for example:
 - The training should take account of the context and likely application of MHFA to the role of the participants
 - Avoid blurring role boundaries : emphasise that MHFA training enables ‘first aid’ and increased confidence to engage and work with people where there are mental health/ well-being issues and does not develop competence in delivering mental health interventions
 - Additional explanations/information/trainer interpretation of the course materials is important for clarity and for reassuring participants, and depends on the experience, knowledge and understanding of the trainers
- 4 In the West Midlands, larger than usual groups (around 20 HTs) were trained so two additional facilitators, who were Mental Health Service User consultants, supported delivery to good effect. They shared their personal perspectives and experience of what is needed from a human perspective, in engaging and supporting people with mental health issues.
- 5 One of the West Midlands Mental Health Development Programme leads attended each MHFA course to provide support, continuity and links into the supplementary development work. Their participation has helped to guide some of the discussions and has been reassuring about how to apply the information in the context of the participant's roles.

Conclusions

From the experience in the West Midlands, MHFA training (because of the nature of the course) cannot deal with all the HTs' concerns around role boundaries, levels of responsibility, thresholds for referring to/or detailed knowledge of local IAPT and mental health services. Also, MHFA training does not cover aspects of mental well-being or interventions in any great detail and has a predominant illness focus.

However, MHFA is a nationally recognised mental health awareness course, providing consistent content. Evaluations of MHFA training show that it can achieve significantly increased levels of knowledge and confidence in understanding and responding to mental health issues and problems. HT and other non-mental health front line services may wish to consider bespoke courses delivered and/or provided locally, or supplement HT mental health awareness, as some areas have done (Appendix 2).

On balance, MHFA would seem to be a fair choice for mental health awareness training for HTs in building their confidence and knowledge of mental health issues and problems. However, to achieve the best outcomes for clients, further on-going support or development work should be considered that addresses the shortfalls in MHFA training and can add value, centred on the practical examples. This Mental Health Development Package can then provide the added benefits of more local joined-up working, as well as improved mental health, well-being and lifestyle outcomes for clients across these two important and valuable services.

For the learning outcomes, development sessions programme outline and costings per learner for the West Midlands Mental Health and Health Trainer Development Package (see Appendix 1).

“My confidence since the course allowed my client to feel secure in sharing his very distressing experiences, knowing that I would respect his feelings at all times.”

Lessons for the future

- 1 This report may help to inform HT legacy arrangements as the national HT support programme ended in September 2010. For IAPT, it may help to inform further guidance on commissioning, particularly around IAPT's engagement and joint working with the wider non-mental health services and its public health partners.
- 2 In the current climate of delivering better outcomes through efficient and evidence-based practice, it is essential to maximise the opportunities for effective joint working across these two services.
- 3 Providing protected development time for IAPT and, in this case, HT services to learn from each other, understand each other's roles and services, explore joint working arrangements and develop pathways across their services brings dividends for both services, as well as better outcomes for their clients, in terms of improved health and mental well-being.
- 4 In selecting mental health awareness training for HTs and other non-mental health front line staff, careful consideration should be given to ensure the 'right' learning outcomes are achieved for the target audience and further liaison and/or support across local services and IAPT/Mental Health services are employed.
- 5 MHFA is a set programme and examined here as a case example. This report should be shared with MHFA England to influence any further development/enhancement of this nationally recognised mental health awareness programme.
- 6 This report has not covered the development of physical well-being skills for the IAPT workforce in any depth and this is an important area for further investigation.

We (the authors) would like to thank all the HTs, IAPT and PCMH staff in the West Midlands who participated in MHFA training and development sessions and informed this report.

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Evaluating Mental Health First Aid Training for Line Managers working in the Public Sector, University of Bath School for Health

Appendix 1

West Midlands

Learning Outcomes for 2 Day Development Programme

- 1 Health Trainers and IAPT/PCMH staff have a good and increased understanding of each other's service (variations and good practice).
- 2 Health Trainers will have knowledge of appropriate referral pathways to PCMH/IAPT/specialist mental health services. (variations and good practice).
- 3 PCMH/IAPT will have knowledge of appropriate signposting/referral pathways to HT Service.
- 4 Health Trainers and IAPT/PCMH will have increased awareness of ways to improve mental well-being.
- 5 Each locality will have an agreed action plan for developing ways of working together within a realistic framework.

In addition to the learning outcomes above it is anticipated that the Health Trainers who have undertaken Mental Health First Aid training and participate in the development sessions will have an opportunity to clarify and reinforce learning within their role and local context.

Learning Outcomes for Consolidation Day

- 1 Health Trainers and IAPT/PCMH staff have agreed ways for working together within a realistic framework.
- 2 Health Trainers feel confident to support clients with mental well-being issues and were necessary to access PCMH/IAPT services, appropriately.
- 3 HT and IAPT/PCMH will have shared knowledge of practice, development and innovation in different localities across the West Midlands.
- 4 HT and IAPT/PCMH staff will have identified and explored regional trends /themes that emerge throughout the development process.
- 5 HT and IAPT/PCMH staff will have reflected upon and refined shared action plans to develop and enhance best practice.

Domains to consider in supporting joint working across HT and IAPT Services

1 Pathways, thresholds and triggers for engaging each other's service

Agree pathways and referral protocols between services including any consent issues and information sharing agreement

Agree on referral criteria between services e.g.

- HT to IAPT: if people's lifestyle behaviour is related to depression/stress/anxiety
- IAPT to HT: for people with specific goals of reducing drink/smoking/weight & increasing activity

Agree on thresholds e.g.

- Level 1 – Health Trainers take on low level mental well-being, utilising e.g. 5 Ways to well-being
 - Level 2 – IAPT/PCMH and HT telephone/email liaison/consultation (no client details) and joint assessments (with clients consent)
 - Level 3 – HT's Referral to IAPT, Specialist Mental Health Services or Vol sector organisations (direct/via GP)
- NB: Issue identified – HTs referring directly to/holding referral forms for IAPT need to be discussed and agreed locally.
- Stepped Care for Mental Health – HTs service engaged as part of Step 2 IAPT/PCMH to hold referral forms for HT service.

Trigger questions for HTs

- How much are the (mental health issues) interfering with their client's everyday life?
- Potential use of 2 screening questions for depression and help requested.

2 Joint working – Communication and Planning

Paying attention to:

- a Understanding professional relationships, boundaries, and limitations
- b Protection of professional roles
- c Capacity within teams

For example:

- Identifying a designated liaison contact staff member within respective services
- Exchanging service directories/web-sites
- Ensuring inclusion of each other's service in local information leaflets/directories
- Provision of:
 - list of HT's and at which GP Practices they are located
 - neighbouring IAPT services for out of area clients
- Attending respective team meetings
- Attending GP meetings jointly
- Joint events – drop in's, coffee mornings, support groups

3. Training – needs and opportunities

For example:

- On-going mental health and well-being awareness training - including assessments so HT's can inform and reassure clients who they signpost/refer to IAPT
- IAPT to deliver e.g.
 - 'How to raise the (mental health/well-being) issue' training
 - Training in stress control groups – HTs could accompany client to support them and learn subject to potentially deliver
- Training around motivational interviewing, Lifestyle – smoking, nutrition etc and Health conditions to IAPT/PCMH
- Attending groups e.g. Long Term conditions
- Shadowing, (may need agreement for HTs to Shadow IAPT/PCMH)
- Coaching
- Development days with other services

4 Working with clients with mental health and well-being/lifestyle issues

To promote person centred approaches that are holistic, motivate and improve confidence of clients

For example:

- Integrating 5 ways within HT practice and provide common language across services
- HT service can offer extended service to IAPT/PCMH clients with lifestyle issues as part of recovery plans
- HT's can help to tackle mental health stigma through client interactions and as champions of mental health and well-being within the community
- HT's to access and use self help mental health material e.g. Northumberland self help leaflets, Living Life to the Full etc

5 Measuring and sharing success

How and when?

For example:

- Investigate if HT system can track referrals to PCMH/IAPT
- IAPT – numbers signposted/referred to HT service
- Use of pre and post well-being score in some HT services
- Capturing narratives/case studies/good news stories. This is an on-going part of HT's practice
- Client evaluations
- Pilot quantitative small sample of evaluation of referrals into HTS/IAPT

6. Getting sign up and support locally for joined up working

For example:

- Senior management agreement to action plans
- Feedback to commissioners on joint working
- Whole team sign up required across IAPT/PCMH and HT services
- Organisational sign off of operational policies, standards and protocols (as required)
- GP and community based mental well-being providers informed of joint working

Programme Design	Benefit
Run over 2 days 9am – 4pm	<p>2 days gives enough time for participants to develop a depth of understanding of each other's services that created a positive environment to maximize opportunities to:</p> <ul style="list-style-type: none"> • Get to know each other and begin to develop working relationships • Build a meaningful action plan together
Two programme manager facilitators with support from a service user consultant. We employed 2 service user consultants and shared the MHFA training and development sessions between them	<p>Both facilitators and service user consultants had attended MHFA training delivered to HTs and so were able to pick up issues that had arisen for HT's in MHFA training. Having 'critical friends' whose experience bridged the services involved helped to secure the right context for individual role reflection.</p> <p>Our service user consultants were extremely good at helping the group find the right 'well being' versus 'mental health' balance. They also added to the positivity and motivation to 'go that extra mile' to make a difference.</p>
Two HT services and their respective IAPT/PCMH service are invited to participate for 2 geographical areas. We invited each HT service to nominate a manager and 4 HT staff and each IAPT/PCMH to nominate a manager and 4 staff which have included mainly PWP practitioners, STR workers and a couple of High Intensity workers	<p>The similarities and variations between both HT and IAPT/PCMH services provide some important learning.</p> <p>Good practice shared across HT and IAPT/PCMH on day 1 and also sharing action plans at the end of day 2 led to creative ideas being taken on by other areas.</p> <p>Having a range of IAPT/PCMH staff really helped to build on the depth of experience and local resource intelligence held within these services.</p>
Programme Facilitators	Service User Consultants
Kate O'Hara and Kevin Heffernan NHS West Midlands	Alan Rowland Jenny Monaghan
For more information contact kate.o'hara@nmhdu.org.uk Promoting Well-being and Public Mental Health Team National Mental Health Development Unit www.nmhdu.org.uk	

Programme Outline	
Day 1: AM Session	Day 2: AM Session
<p>Introduction to the programme and ground rules</p> <p>Individual Practitioner Baseline Self Assessment</p> <p>What do we do?</p> <p>Working in their service groups</p> <p>Group 1 IAPT/PCMH Services</p> <p>Group 2 HTs</p> <p>Group exercise to develop presentation of the main components of their respective services highlighting local variations</p> <p>What are the main components of HT?</p> <ul style="list-style-type: none"> • Presentation/feedback on what the service intends to deliver • Any local variations <p>What are the main components of IAPT/PCMHs?</p> <ul style="list-style-type: none"> • Presentation/feedback on what the service intends to deliver • Any local variations 	<p>Introduction and recap of ground rules</p> <p>Team Building Activity</p> <p>This is time well spent we used the “lost in a blizzard activity”. It is particularly beneficial if you can make connections between the learning points from this activity to the action planning activity later in the day around e.g. gaining consensus and communicating effectively.</p> <p>Introduction to the ‘Ways to Well-being’</p> <ul style="list-style-type: none"> • Presentation on well-being and the Foresight report 5 Ways to well-being • Group activity – the 5 ways are posted around the room with flip chart <p>On post-its</p> <p>HT’s are asked - locate the 5 ways in what you currently do. What more could you do to promote each of the 5 ways through your interventions?</p> <p>IAPT/PCMH are asked – map what you currently do or could do, to support the promotion of each of the 5 ways within the community?</p> <p>Group feedback and discussion</p>
Day 1: PM Session	Day 2: PM Session
<p>What do we expect from each other?</p> <p>In locality groups (HT and IAPT/PCMH services) for the 2 geographical areas have a broad initial discussion exploring:</p> <ul style="list-style-type: none"> • Thresholds • Communication • Joint working/training • Measuring success <p>30 minute feedback with Q&A’s from each group (these flip charts are processed and used as handouts next day when beginning to action plan)</p> <p>If it is felt the previous activity has not elicited all the opportunities and/or issues e.g. protection of role boundaries, impact of working together on respective services e.g. increased referrals etc you can include a 20 min group discussion on the advantages and potential opportunities?</p> <p>Summary</p> <p>Round robin review of the day</p>	<p>Use the 6 domains to build a locality Action Plan</p> <p>Working in locality groups, identify a minimum of 3 action points for each domain, noting who is responsible for each action and by when.</p> <ol style="list-style-type: none"> 1 Pathways, threshold and triggers for engaging each other 2 Joint working (communication/planning) 3 Training (needs/opportunities) 4 Working with clients with mental well-being/lifestyle issues 5 Measuring success 6 Getting sign up and support locally <p>Group feedback on Action Plans</p> <p>Evaluation</p> <p>individual – repeat Individual Practitioner Baseline Self Assessment</p> <p>Group – we devised this based on Edward De Bono’s 6 hats using 6 corresponding questions.</p>

NB. The programme may be delivered in one day by removing the team building activity and integrating the “What do we expect for each other “ within the Action planning session on day 2.

Indicative costings for West Midlands Health Trainer and IAPT/PCMH Mental Health Development programme**Mental Health First Aid Training**

7 (2 day) sessions of 20 participants = 140 trained

2 MHFA instructors and materials = £13,300

Cost per participant = £95

Cost per participant adding venue at £30 a day = £155

Cost per participant adding User Consultant Involvement = £175

Please note that MHFA instructors charge across a range. Also MHFA instructors usually train up to 12 with 1 instructor and up to 16 participants with 2 instructors.

Development Days

Venue cost approx £30 a day = £60 per participant for 2 days

Add User Consultant costs @ £20 = £80 per participant

Please note this does not include the cost for facilitators

Impact of MHFA on HT practice in the West Midlands

Since undertaking MHFA training:

"I have become more aware of the differing forms of mental health problems. I think that my empathy and resolve to treat each client with respect has improved from an already solid foundation." (i)

"Made more effort to create a calm and relaxed environment for my clients and take into consideration any anxieties they may have about speaking to me." (ii)

"I have been more aware of how to recognise depression and anxiety and more confident in dealing with clients with mental health issues. I am also aware of the poor provision of mental health services in my area and a real need for IAPT." (iii)

"I have been involved in a pilot project at a local centre that helps people with severe and enduring mental health diagnosis. We have done initial assessments with them and in some cases signposted to physical activity. We have arranged group walks in a local park, facilitated cook and eat sessions, taken them on trips to local supermarkets, done a relaxation session and being able to provide lots of advice on healthy lifestyle changes as well as supporting them on a weekly basis with changes they have made." (v)

"I have worked closely with a client suffering from schizophrenia who has experienced many of the symptoms covered by the training such as delusions and hallucinations. He shared his experiences with me and told me of the time he was arrested because he thought he was Jesus and tried to make staff in a restaurant take down a picture of his father God. He told me it had taken 5 years for his medication to be effective but now he feels much more able to cope with life but he is still afraid to leave his flat at weekends because of abuse from teenagers in the area." (vi)

"Found that the knowledge and understanding of mental health issues in more depth than before has enabled me to have a greater empathy with my clients and has worked towards being able to build rapport more easily.

It has cleared up many "grey" areas of misunderstanding and misinformation thus enhancing my skills as a health trainer dealing with mental health patients." (vii)

"I have been involved in working with a group of patients from a local centre whose aim is to help and support people with mental health problems. Through the training I have gained a level of understanding of the different illnesses suffered under the umbrella of "mental Health" and how they differ and the affects of the illnesses. With this information I am able to work with patients in my role as a Lifestyle Coach/ Health to encourage healthy eating and Physical Activity to assist in improving their health in all aspects." (viii)

"Gained an understanding of the various support and help that is available for people with different mental health problems. I have gained a thorough understanding of how to approach and deal with someone had depression / anxiety etc. for example being, supportive, non-judgmental, listening, giving reflective feedback and also knowing what support services are in place such as Wolverhampton healthy minds, help lines and resource books." (ix)

"Engaged with Wolverhampton Healthy Minds team and delivered a talk on the Health Trainer service to their 'Stepping Forward' low intensity support group. This has enabled people to make the link between their mental and physical health and access both services appropriate to their needs." (x)

"Gained a greater understanding of being able to empathise with people in situations by giving me the ability to see things from their perspective. I remember the empathy video and think of that whilst people are telling me their situations. Sometimes it's too easy to think you know what people mean when they say "X" but really they mean "Y". I know I used to do this all the time so as a consequence I now ask people what they mean when I don't quite understand what they mean, I ask them what their situation "looks like" to them rather than imagining it myself." (xi)

Impact of MHFA on HT practice in the West Midlands

MHFA helped me with my client by:

“Improving my knowledge of the many different forms of mental health problems and the need to treat each client as an individual. I was recently working with a client who had a host of mental health problems and was finding it very difficult to get the client to set any goals. In the past I would have found this frustrating but due to the training I was able to step back and realise that the client needed time and space. I closed the session and suggested that next meeting we went for a walk, which he agreed was a good idea. Free of the pressure of a one to one session in an enclosed space the client opened up a lot more and progress was made. I have learned to be flexible and willing to step back and give the client time.” (i)

“Allowing me to have a better understanding of depression and anxieties – I was able to recognise they were anxious and give them the space and support they needed. The client cried a little but was reassured that I did not judge them and went on to make successful behaviour changes.” (ii)

“Helping me understand their feeling and anxieties and applying this when addressing lifestyle issues and setting goals.” (iii)

“Being able to confidently look for low level mental health issues and confidently deal with them.” (iv)

“Giving me the confidence to work with clients who have mental health issues by having more knowledge and information both on the subject its self and areas surrounding it” (v)

“Enabling me to listen in a non-judgemental way and I felt that my confidence since the course allowed my client to feel secure in sharing his very distressing experiences knowing that I would respect his feelings at all times. I felt more able to look beyond his illness and try to get to know the person, who just needs to be accepted as he is.” (vi)

“Enabling me to gain an understanding and knowledge of the illnesses, symptoms and effects of mental ill health – using this information I am then able to provide my clients with the best help to suit their needs which will assist on their path to recovery.” (viii)

“Today a client was explaining their eating situation and I asked them what it looked like to them, I then asked them what the difference between now and the time before was and they gave me their own answer rather than me simply making it up in my own head and assuming what she meant.” (xi)

Appendix 2

Mental Health Awareness Training delivered to Health Trainers across the regions

East Midlands	<ul style="list-style-type: none"> NHS Nottingham City - Mental Health leads run ? bespoke training NHS Lincolnshire – all HT's received MHFA 2 day training
North East	<ul style="list-style-type: none"> Gateshead Council – HT team receive MHFA 2 day training provided by MIND Yorkshire and Humber – nearly all HT's have received MHFA 2 day training provided by Community Links a1/3 sector org accredited to deliver and Stress check training NHS Tameside and Glossop – MH Awareness ½ day session organised by NHS Tameside and Glossop Primary Care Mental Health Team (PCMHT). Plans for Senior HT's to complete Beating the Blues training through PCMHT. Also as a service looking at Neuro-Linguistic programming, and counselling skills training to better equip staff. Good relationships with PCMHT and can call for advice when needed
North West	<ul style="list-style-type: none"> NHS Stockport – HT's have received Interventions for Mental Health in Everyday Practice. A training programme to develop the skills of frontline staff (IMHEP)
West Midlands	<ul style="list-style-type: none"> NHS West Midlands – Approx 140 HT's to receive MHFA 2 day training as part of Health Trainer and Mental Health Development Package

Content and Learning Outcomes of MHFA

1 Mental Health First Aid (MHFA)

www.mhfaengland.org.uk/

The 2 day course covers:

- The five steps of Mental Health First Aid
- How to recognise the early stages of depression and anxiety (stress)
- How to recognise the early stages of suicide and self-harm
- How to recognise the early stages of psychosis
- The range of effective interventions and treatments

MHFA training provides:

- Better understanding of mental ill health
- More confidence about mental health problems and how to offer early help to others
- Reduced stigma about mental ill health
- Better awareness of your own and other people's mental health issues (NB as described by MHFA Yorkshire and the Humber)

www.mentalhealthfirstaidyorksandhumber.org

2 MHFA England Instructor Training

www.mentalhealthfirstaid.csip.org.uk/downloads/how-to-apply-.html

Other MH awareness training provided across the country

3 Interventions for Mental Health in Everyday Practice. A training programme to develop the skills of frontline staff (IMHEP) NB this course is only currently available in Manchester and Stockport)

IMHEP is a new two day training course to develop 'psychological awareness' for those working with vulnerable individuals. The course develops practical skills in identifying and responding to distress effectively, using a structured model of care.

Learning Outcomes

Participants will:

- Feel more confident in their judgements about how best to support people with mental health problems/emotional distress
- Be able to deliver their organisation's services more effectively for people with mental health problems/emotional distress
- Be able to use a brief, flexible structured interview to gather key information relevant to a client's mental health problems/emotional distress
- Have an enhanced appreciation of risks for their clients and increased confidence in responding to difficult situations
- Be better able to help clients in becoming clearer about their problems and strengths, decide on their next steps and have an increased awareness of local resources to support them

Contact: douglas.inchbold@manchester.nhs.uk or Elysabeth.Williams@stockport-pct.nhs.uk

IMHEP have scheduled training for HTs in August 2010 on working with people with dementia and their carers.

Bespoke Mental Health Awareness Training

Yorkshire and Humber MH awareness training package

– Aileen Moore

Aim

The relationship between our well-being, what we eat, how we exercise and how we manage emotions is well known and researched. This programme aims to explore how we can better manage those aspects of our lives to maximize our emotional and physical well being. Sessions will be interactive with the food and mood theme running through the programme. There will be practical tips, exercises and tasting sessions of healthy foods. Self help materials will be used and ideas for running sessions in the community will be developed.

Programme – 6 Sessions with HTs in Wakefield/ Barnsley

- Food and Mood
- Keeping Active/ how behaviour affects Mood
- How to combat Low Mood
- How to stop Worrying
- Managing Stress
- Managing Anger

a.m.moore@blueyonder.co.uk

Mental Health Awareness training pack accompanied by a Learners Pack where the candidate answers questions on various scenarios. The handbooks and course content was written in 2008 by a Professor C Brooker Professor of mental health and criminal justice at the University of Lincoln. The course is offender setting focused and has been tested by Leicestershire and Rutland Probation Service.