RSPH
ROYAL SOCIETY FOR PUBLIC HEALTH
VISION, VOICE AND PRACTICE

NHS England

MECC FOR MENTAL HEALTH

North East and Yorkshire Phase 2: 2023-2024

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Acknowledgements and appreciations

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Our thanks go to the team who was involved in the design, delivery and evaluation of the MECC for Mental Health project. This includes: Nelly Araujo (Project Manager, RSPH), Samantha King (Training Lead, RSPH), Laura Smyth (Assistant Project Manager, RSPH), Rachel O'Riordan (Recruitment and Grant Coordinator, RSPH), Chloe Allen (Training Coordinator, RSPH), Dawn Mitchell and Karan Thomas (Lead Training Developers), Mike Lewis (Regional Programmes Manager, Mental Health, North East and Yorkshire, NHSE WT&E), Nicola Davies (Regional Programmes Manager, Mental Health, North East and Yorkshire, NHSE WT&E), Louise Harlanderson (Trainer of Lead Trainers and Senior Stakeholder) and Jason Feavers (Trainer of Lead Trainers and Senior Stakeholder) .

We would like to especially thank the Lead Trainers for delivering the sessions that upskilled 54 North East and Yorkshire Trainers who in turn, were able to cascade the training to a total of 362 end-users.

We would also like to thank the trainers and learners who took the time to complete the evaluation questionnaires and attend evaluation interviews.

Lead Trainers

Lead Trainer	Role	Organisation	ICS
Caroline Lucas	Specialist Trainer	Changing Lives	North Cumbria and the North East
Clare Grey	Senior Workforce Development Officer	Durham County Council	North Cumbria and the North East
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EXECUTIVE SUMMARY

This report encompasses a delivery report and independent evaluation of the Making Every Contact Count (MECC) for Mental Health programme (phase two in the North East of England and Yorkshire 2023/2024) undertaken by Royal Society for Public Health, in partnership with NHS England, Workforce, Training and Education Directorate. Developed in 2020, the training programme aimed to equip frontline professionals across multiple sectors in the North of England to integrate mental health and wellbeing conversations into routine practice by developing and delivering training through a cascade model. The main project activities, outputs and outcomes outlined in this report are as follows:

- In total, 12 Lead Trainers and 60 Local Trainers were recruited from 46 organisations. Between Spring 2023 and Autumn 2024, 9 Lead Trainers and 54 Local Trainers included in the project delivered MECC for Mental Health training to 362 end-users.
- An independent evaluation of the training was conducted using data from over 400 participants collected through questionnaires, interviews, focus groups and observations of training sessions.
- Behavioural expectations of having conversations and of referring for support changed significantly from before to immediately after the course.
- Participants reported that training addressed psychological safety and normalised mental health conversations, reducing stigma and raising awareness. These were described as enabling key conversations and referral behaviours.
- The percentage of people with whom participants were having conversations about mental health increased from pre-course to follow-up.
- On average, each participant reported seeing 91 patients or service users per fortnight who would benefit from talking about their mental health and wellbeing. Therefore, the MECC for Mental Health training programme could have an influence on over 38,500 interactions every 2 weeks.
- Participants also reported that the training facilitated better referrals and conversations through increased awareness of external services and resources available.
- At follow-up, the most common MECC for mental health behaviours that participants had continued including were listening reflectively, using open questions, responding empathetically, and using language that was not stigmatising.

The evaluators observed a high level of fidelity in the delivery of the training. The most frequently used fidelity markers were: trainers encouraging participants to contribute to the session, prompting them to reflect on their own understanding of key concepts, and responding positively to questions.

Overall, participants had positive feedback whether they took part in the training and/or delivered the training, finding it engaging, enjoyable, comprehensive and informative.

The evaluators explored how the training influenced key factors involved in behaviour/ practice change relating to mental health conversations using the COM-B model:

- **Capability** (feeling that you know how to have mental health conversations (psychological capability) and have the necessary skills (physical capability) increased from pre-course to post-course. Both of these changes were sustained at follow-up.
- **Opportunity** (feeling that you have the resources (physical opportunity) and that important people think you should have mental health conversations (social opportunity)) changed from pre-course to post-course. The improvement in physical opportunity was maintained at follow-up. However, although 66% of participants agreed or strongly agreed that they had social opportunity, the statistical test indicated no significant difference in social opportunity between pre-course and follow-up.
- **Motivation** (having the desire (reflective motivation) to engage in mental health conversations and doing so automatically (automatic motivation)) improved from pre-course to post-course. At follow-up, the increase in reflective motivation observed from pre- to post-course was not sustained, though 86% of participants still agreed or strongly agreed that they had reflective motivation. The increase in automatic motivation reported post-course was maintained at follow-up.

Conclusions and recommendations

- The evaluators concluded that training was very well received and appreciated. Training was rated very highly particularly around materials, encouragement and interaction. They recommended that future training packages continue to be experiential, and trainers trained to the same high standard.
- Furthermore, whilst the training was successful at influencing key behavioural influences (through capabilities and motivations), the evaluators recommended that consideration is given during training on how to address social opportunity barriers – for example, how attendees are able to advocate for MECC in their workplace and gain the support of those they work with to implement this. Also, that future evaluations seek to understand the experiences of people who change and do not change, to understand more about the impact of training on individuals and sub-groups.
- From a delivery perspective, RSPH concluded that the MECC for Mental Health programme successfully expanded beyond health and community care, providing essential skills for brief mental health conversations in a variety of settings. Pressures such as funding and time affected recruitment and training delivery within project timescales.
- RSPH's recommendations include expanding training to other sectors, securing leadership buy-in for funding and support, and ensuring participant engagement throughout evaluations. Quality assurance should involve trainers and stakeholders to maintain high standards. With national leadership and local investment, the programme could greatly benefit frontline workers across the UK, aligning with the government's prevention-first approach to health.

INTRODUCTION

This delivery and evaluation report provides a comprehensive overview of the progress made on the Making Every Contact Count for Mental Health in the North East and Yorkshire from Spring 2023 to Autumn 2024. The report highlights the key project outputs achieved and an independent evaluation.

Following a successful development phase, this project focused on embedding sustainability with the development of a second cohort of Lead and Local Trainers and the development of communities of practice.

Background

Making Every Contact Count

Making Every Contact Count (MECC) is an approach that enables opportunistic and person-centred delivery of consistent and concise healthy lifestyle information through brief conversations.

MECC is included in the service conditions of the 2024/25 NHS Standard Contract[1] (service conditions 8.6), which highlights that providers must develop or maintain an organisational plan to ensure that staff use every contact that they have with service users and the public as an opportunity to maintain or improve health and wellbeing, in accordance with the principles and using the tools comprised in MECC guidance. The MECC approach also features in the NICE Public Health Guidance for individual approaches to behaviour change (PH49) recommendation 9 [2].

The MECC approach has been successfully used to support behaviour change in the areas of smoking, alcohol, weight management, and physical activity. By contrast, efforts to implement MECC to improve mental health and wellbeing were not progressing so quickly or with a high degree of coordination. Therefore, in 2020 Royal Society for Public Health (RSPH), in partnership with NHSE Workforce, Training and Education Directorate (NHSE WTE) North developed MECC for Mental Health and began to introduce the training across the North of England.

Mental health

In 2024, the King's Speech committed to a legislative update of the Mental Health Act[3], which would address inequalities in the way mental health crises are addressed. Whilst this programme does not deal with crisis, MECC for Mental Health can be seen as part of the work to prevent crisis through mental health promotion and early intervention strategies.

The NHS Long Term Plan[4], published in 2019, includes a pledge to invest in protecting

1 https://www.england.nhs.uk/nhs-standard-contract/24-25/
2 https://www.nice.org.uk/guidance/ph49
3 https://commonslibrary.parliament.uk/research-briefings/cbp-9132/
4 https://www.longtermplan.nhs.uk/wp-content/uploads/2019/08/nhs-long-term-plan-version-1.2.pdf

and promoting mental health early in the life course and at the first signs of distress to help prevent ill health. To fulfil this ambition, it follows that there is a need for the core and wider public health workforce to understand how to promote mental wellbeing and support those experiencing mental health problems.

Workforce development

The Office for Health Improvement and Disparities developed 'All Our Health', a resource which helps health professionals to prevent ill health and promote wellbeing as part of their everyday practice. Within this resource, there is a guide to help frontline health and care professionals to use their trusted relationships with patients, families, and communities to improve their health and wellbeing. To this end, 'All Our Health' is a useful resource for upskilling frontline professionals to have brief conversations with people about making positive changes to improve their health. 'All Our Health' is a useful tool to sit alongside the MECC approach as an accessible way for practitioners to learn about a variety of health and wellbeing topics to which they can apply MECC-based conversation skills.

Following the first phase of the MECC for Mental Health project, feedback was given that recommended reaching further than primary and community care; in this phase, Voluntary and Community Sector (VCS) organisations and local authorities were also invited to take part. This follows the work done by the University of Northumbria on the reach and scope of the MECC approach. They note the lack of evidence around the impact of MECC for VCS organisations, and they recommend further research to be done to understand the possibilities beyond the traditional audience[5 6].

Using MECC within sectors other than the healthcare sector could be one application of the potential impact of the wider public health workforce. The RSPH's report on the potential reach and impact of the wider public health workforce[7] highlights the opportunity to reach beyond traditional health, care and public health roles. This would bring together a large and varied workforce with the ability to tackle substantial health and wellbeing issues from a variety of angles and perspectives. Reaching beyond the usual audience of MECC brings a new perspective and opportunity.

New Government Priorities

In July 2024, a new government was elected. Their plan for the future of the health sector includes a focus on prevention of ill health and greater support for mental health[8]. The MECC approach to mental health aligns with these goals and provides a sustainable asset for workforce and service development for public health. With the government's new priority and focus on prevention, the upskilling of the core and wider public health workforce will work to enable this.

5 Harrison D, Wilson R, Graham A, Brown K, Hesselgreaves H, Ciesielska M. Making every contact count with seldom-heard groups? A qualitative evaluation of voluntary and community sector (VCS) implementation of a public health behaviour change programme in England. Health and Social Care in the Community. 2022 Feb 26. doi: 10.1111/hsc.13764. Epub ahead of print. PMID: 35218264.

6 Nichol B, Rodrigues A, Wilson R, Haighton C. 2023. A Systematic Review of the Effectiveness of Brief Health Behaviour Change Interventions on Service Users Accessing the Third and Social Economy Sector, Health and Social Care in the Community

7 https://www.rsph.org.uk/our-work/policy/wider-public-health-workforce/unusual-suspects-unlocking-potential-wider-public-health-workforce-report.html

8 https://labour.org.uk/change/build-an-nhs-fit-for-the-future/

Overall, MECC for Mental Health addresses key needs within primary and community care, VCSOs, and local authorities for training on mental health with a health promotion approach. The Making Every Contact Count approach to health-based training is well established and the MECC for Mental Health programme aligns with the new government's focus on prevention of ill health, including the promotion of mental health and wellbeing.

MECC for Mental Health Model

RSPH was commissioned by NHSE WTE in 2020 to design and pilot a mental health promotion training programme for primary and community care. The core training was designed and tested between March 2020 and June 2021 with the support of an expert reference group comprised of representatives from regional and national organisations and experts by experience.

For the training to be sustainably delivered and become embedded in local systems, RSPH designed a cascade model that recruited trainers from local primary and community care organisations. Lead Trainers received training from RSPH's programme design partners, and then went on to deliver to the Local Trainers. Local Trainers recruited participants from their organisations and local networks to receive the training. The project was independently evaluated and found to have a positive impact on those who received the training.

Alison Duffell, Training and Development Officer at Aspire Learning, Support and Wellbeing, describes her experience of delivering the MECC for Mental Health training to her teams and volunteers:

"Mental health is everyone's business, and the importance of parity between physical and mental health is vital."

Alison found that the training helps "improve the mental health of everyone, learn about building resilience, and know where to turn for support when needed… and links to the Mental Health Transformation Plan and locally to the County Durham Mental Health Alliance."

Alison works for Aspire, an organisation that "provides support and learning opportunities within the local community, with service users often referred to us from social prescribing and GP services… and is lucky enough to have a lot of volunteers helping to run the service. They were all keen to take part in the training as well as other paid staff members."

"They were all keen to take part in the training. The learners now have a better understanding of MECC and the Ask, Assist, Act approach. They have gained more knowledge about both good and poor mental health and are now able to share the message about the benefits of good mental health or signpost others to further support if needed." Learners also gained "more understanding, confidence and knowledge in talking about mental health and supporting those in their community."

The project was designed to recruit based on their competencies to deliver the training effectively and with fidelity. Trainers were trained over 2-day training sessions which included sampling the end-user programme as well as practical delivery advice and experience.

The training for end-users was designed to consist of 3 x 3-hour sessions or one 7-hours session. The content was organised as follows:

Module 1:	Introduction to MECC for Mental Health
Module 2:	Knowledge and Skills – having a MECC for Mental Health Conversation
Module 3:	Signposting and Pathways

RSPH developed a full set of training materials including: a slide deck with tutor notes, 3 x 30-minute online learning programmes (1 per module), and learner workbooks. For accessibility, RSPH created a digital hub within **NHS Futures Collaboration Platform** to host these materials and enable all trainers to interact with each other and share learnings.

Assuring the quality of the training

Quality assurance featured throughout the development of the training programme and has been built into the processes and training for trainers. The quality assurance process was designed to be:

- Evidence-based – drawing on well-established frameworks, such as MECC and the 3As (ask, assist, act); pedagogic approaches (e.g., Chunk and Check); and theories of behaviour change (namely the COM-B model). Using fidelity markers to ensure the trainers uphold the quality of the training (see appendix 1) is also a well-established method of quality assurance.
- Supportive – offering the resources and assets which Lead and Local Trainers needed to deliver high-quality training. This included: training grants in recognition of the costs of their time to them and their employer; guidance and support from peers and the project team; and technological support for online delivery.
- Collaborative – we involved stakeholders in the development, delivery, and assurance of training.

Susan Gill, Director of Operations at First Contact Clinical describes her experience of using the MECC for Mental Health to train local trainers and teams within her teams and local network:

"It is pitched at a level that volunteers and staff can utilise, both for themselves. It challenges you to think about language, about the resources we use and if accessible to all. It provides a framework on which you can have a discussion. It prepares people with a range of assets with which they can link people to based on their needs. The feedback has been extremely positive."

"A lot of work has gone into the project, this is obvious. The materials are excellent. The content is appropriate, it is accessible to many and complimentary of the health and social care system. I have thoroughly enjoyed being involved and will continue to deliver beyond the project."

"Delivering the Train the Trainer course was enjoyable. The people who attended were passionate about the subject area and were interactive. While I had prepared beforehand to ensure I was familiar with the resources, it helped cement the content. I felt very confident with the product. I have then delivered several versions of the training locally as part of our workforce development programme. I particularly like that RSPH give permission to flex the training to be ensure it is accessible for the different audiences."

A variety of mechanisms have been built into the programme to quality assure the training delivery and these include:

- 1:1 sessions – to make sure Lead and Local Trainers were confident with the materials and had an effective training plan, before their first training session, Lead Trainers were required to meet with a lead developer, and Local Trainers to meet with their regional Lead Trainer. At these meetings, any adaptations or tailoring of the training sessions were discussed.
- Joint delivery – through its Train-the-Trainer programme, the project encouraged Local Trainers to deliver in pairs, at least for the first training session. As such, most trainers (65%) delivered their end-user training with another MECC for Mental Health Local Trainer.
- Further learning sessions, which took the form of 1-hour webinars designed to complement the core training and to enhance existing skills. Following suggestions from Local Trainers, RSPH offered 2 refresher sessions part way through the delivery window. These sessions provided a point of engagement with some of the original developers of the training and allowed the Local Trainers to ask questions.
- The MECC for Mental Health Trainer Hub was designed in the previous project to make sure all trainers had access to the latest version of the materials and a wide range of relevant resources and information. This was hosted by the NHS Futures platform which is a widely available tool for the health system, and was made available to those coming from other sectors. This platform also provided a forum to interact with others within the MECC for Mental Health Network.
- RSPH membership was offered to all trainers to support professional development in public health. This gave them access to a wider programme of events and webinars, peer-reviewed publications, curated public health news, and a wide range of training opportunities.
- Monitoring and feedback – through direct communications, monitoring surveys, and case studies, RSPH routinely collected information on progress and feedback from all trainers.

Ian Noonan, Consultant Nurse for Mental Health at Calderdale & Huddersfield NHS Foundation Trust reflects on his experience as a MECC for Mental Health Lead Trainer:

"I have many fabulous colleagues at work who are committed to integrating mental health into their physical health, medical, surgical, diagnostic, therapies, and community services. Some have expressed caution about asking the "wrong" question, or not knowing what to do with the answer. It is a joy to see the confidence they express when adding MECC for MH to their toolkit as it is a clear and easily accessible model for person centred very brief interventions that support both the practitioner and the patient to have essential conversations about mental health."

"…Participants were already committed to mental health promotion, but described feeling confident to support colleagues to appreciate and practise that mental health is everyone's business; not to fear asking; to be able to hear and acknowledge what someone says; and to support them to access the right service to help with this."

"As a group of trainers, we also shared training techniques and tips and learned from the teaching practice and from observing others, so I hope that the train the trainer sessions will also have helped participants to enrich their facilitation repertoire."

"I have delivered the training online and in person. Both work, and for a large geographical area such as Yorkshire & the Humber, online has its practical advantages, but there is also a real joy in getting teams together in person and to see that live commitment to promoting the mental health of people in their care."

"… It [MECC for Mental Health] felt like a real collaboration. It was warming and motivating to meet and work with a like-minded group of colleagues from different disciplines and organisations across the region, to explore each other's approaches to mental health promotion and to recognise that mental health is everyone's business."

We've now trained over 150 healthcare professionals, and the MECC for Mental Health is now firmly embedded in our work in the acute trust."

DELIVERY REPORT FOR 2023/2024

The MECC for Mental Health project was originally designed to equip frontline primary and community healthcare staff to integrate mental health and wellbeing messages into routine clinical consultations. The aim was to upskill those who were not specialists in mental health to deliver short conversations as interventions to enable individuals to access the support they need. The training project has been developed further over the 4 years of delivery, and has been expanded to include extra modules, further training, and is now offered to sectors within the wider public health workforce including local authorities, VCSOs, and education settings. This report covers the second phase of the project in the North East of England and Yorkshire.

The MECC for Mental Health project team had 6 specific objectives for this new phase of the training programme which included:

- To continue developing a mental health promotion training programme which responds to the needs and expectations of the non-specialist health and care workforce in the NHS and NHS-commissioned primary and community care settings (expanding to the wider workforce including local authority, VCSOs and education settings).
- To recruit 12 Lead and 56 Local Trainers to cascade the training across the region.
- To provide logistical, technical, and professional support for the delivery of the cascade training process.
- To ensure the cascade training is delivered with fidelity and consistency in relation to content and methodology.
- To evaluate the effectiveness of the training programme.
- To ensure the project is embedded in existing local structures and continues to be delivered by the system in a sustainable way.

Recruitment of Trainers

For delivery of the second phase of the project in the North East and Yorkshire, the aim was to recruit approximately 2 Lead and 12-14 Local Trainers in each of the 4 Integrated Care System (ICS) areas. Following on from the recruitment strategy of the first phases, a competency-based role description was used to clarify the skills needed for the training roles. An expression of interest was disseminated across the region via local contacts, targeted advertisement, and trainers from the previous phase of the project. To encourage recruitment, RSPH offered a year of membership to Local Trainers (Associate level) and Lead Trainers (Member level). To help cover the time of host organisations and freelancers, a training grant of £1000 was offered for Lead Trainers and £400 for Local Trainers.

In total, 12 Lead Trainers and 60 Local Trainers were recruited from 46 organisations. Of these, 3 Lead Trainers and 6 Local Trainers dropped out for various reasons, all relating to work pressures or personal circumstances.

Louise Harlanderson, Programme Lead at Gateshead Public Health, shares her experience of being involved in the MECC for Mental Health project:

Louise originally joined the MECC for Mental Health training in the first phase in 2020. As this was during the Covid-19 pandemic, Louise received all of her training online, but felt supported by the trainers giving plenty of time for ice breakers and discussion.

"I appreciate how much time was given to checking in on people and their mental health and wellbeing during the course. This is something that I have prioritised in my courses."

At the time, Louise felt she learnt a lot:

"Some of the content at the time of training was brand new to me such as health literacy and personalised care approach and trauma informed. I spent time learning more about these so I could comfortably include them in my training delivery."

Louise went on to provide training and support for other trainers. She set up a community of practice in the North East which is still running and invites all mental health trainers to join. She has been instrumental in the success of the project in the North East.

"Training was a part of my role so being able to run the training modules with our MECC champions assisted us in getting it right to work for some of the most marginalised and vulnerable community members such as refugees and asylum seekers, adults with learning disabilities and local workplaces.

They helped us tweak some of the language away from using patient and primary or secondary care and instead use community members, people with lived experience and customers as alternative approaches. I was able to tweak the modules so they could be delivered over the course of one day as well as delivering over 3 consecutive weeks. I also was able to break it down into one-hour sessions to enable people with a learning disability or who had English as a second language to participate in the training but at a much slower pace over a longer period of time.

The adaptability of the course materials has made a difference to the people who I trained as they can make it bespoke for their membership so they feel it works for them."

"I love delivering MECC for MH as I know how much it enables local people to have conversations around mental health and wellbeing."

Louise came back for the second phase of the project in the North East and Yorkshire to train the new cohort of Lead Trainers.

Quality assurance beyond the project

Following the earlier phases of the project, quality assurance was discussed with the trainers to ensure they had the resources needed to continue delivering the training after the closure of the project in a quality assured manner.

The project team ran a number of workshops with current and previous trainers to gain an understanding of their experience of the quality assurance mechanisms built into the programme from the original version. Once feedback had been received, the team reviewed the tools and procedures with a view to update and make them more accessible for trainers to use independently. As the trainers may be running their own quality assurance in the future, including collecting feedback, the team were attentive to the requests of the trainers. Before publishing the guidance and tools, another workshop was held for trainers to review the work done.

At each stage of this work, trainers working independently of the RSPH project team were considered. Following the closure of the RSPH funded project, the materials will still be available on the FutureNHS Collaboration Platform, for trainers to freely access. Furthermore, RSPH will be offering certification and central administration through an optional low cost scheme. This provides sustainability to the quality assurance embedded within the MECC for Mental Health training programme and materials.

Communities of Practice

In previous phases of the project, communities of practice have been developed in parallel with training delivery. This time, however due to capacity constrains there was little interest in forming new groups. Instead, trainers asked for drop-in Lunch and Learn sessions to meet, discuss the training, and hear from the project team as well as other speakers regarding useful topics, such as mental health and referral pathways. In the North East there was an established group organised by a Lead Trainer from the earlier phase of the project which was open to new members.

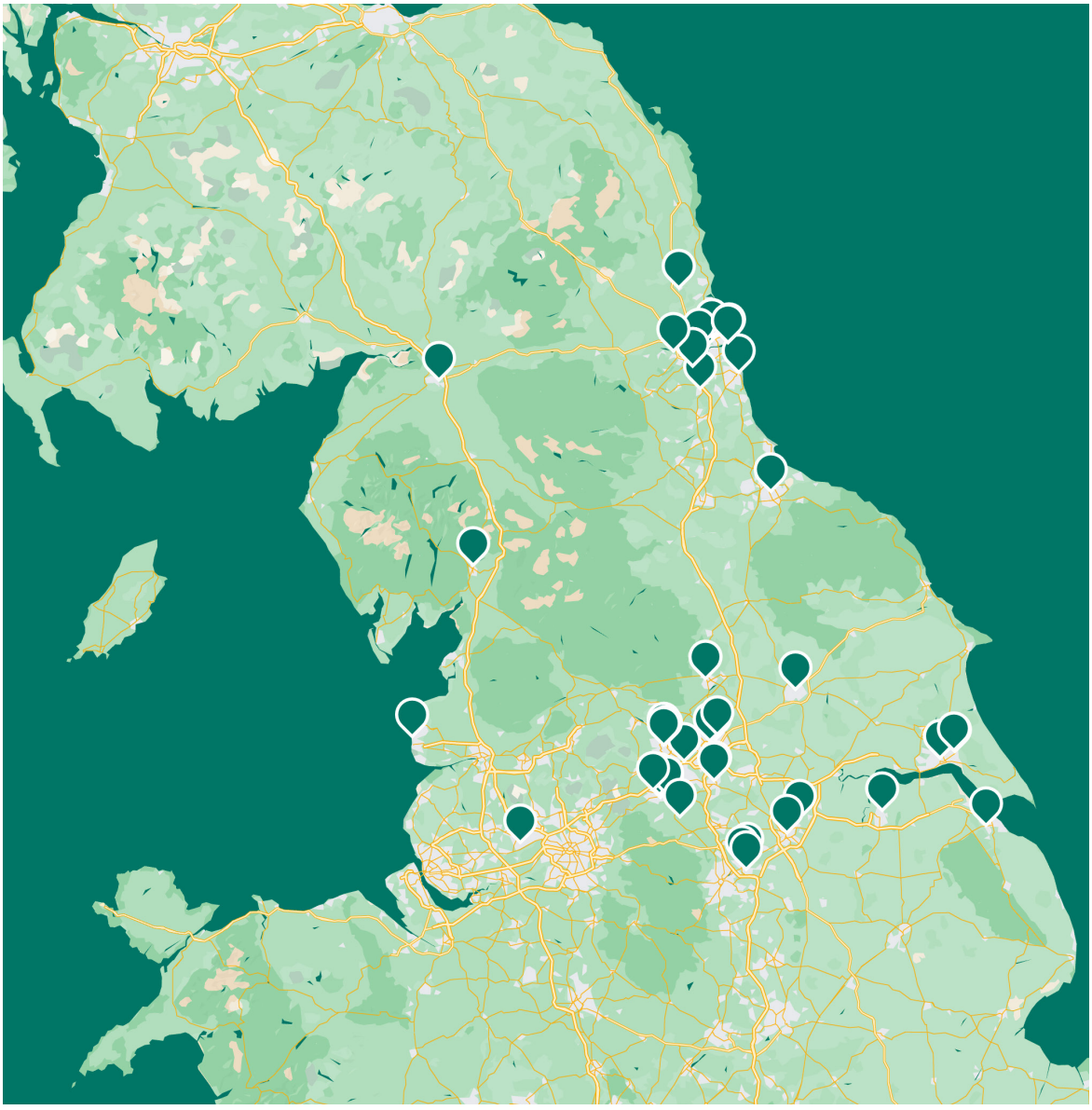
Reach of Training

North East and North Cumbria	17
Humber and North Yorkshire	10
West Yorkshire	5
South Yorkshire	20
Work covers multiple areas and out of area	8

The delivery of training to end-users began in Autumn 2023. The ongoing pressures within the health and social care sector, local authorities and other organisations meant the uptake of training was slower than anticipated. However, many Local Trainers were able to deliver by the end of the project. Many Local and Lead Trainers also went on to deliver further sessions than the suggested. Some of the extra cohorts were not reported, due to the large numbers of attendees (i.e. at university courses) or due to the context where the training was provided (i.e. when combined with other training for induction or to form part of a training offer). The training sessions that were reported covered 362 end-users.

Areas Covered

Trainers were recruited from across the region of the North East and Yorkshire. The North East and North Cumbria and South Yorkshire had the highest uptake of the training. The recruitment of trainers from some areas was challenging due to capacity pressures particularly inhealth system. table 1shows the trainers to area, and Figure 1 shows the geographical spread of trainers on a map of the area.



Trainer job roles and host organisations

In earlier phases of MECC for Mental Health, recruitment of all trainers was restricted to primary and community care organisations. As can be seen below, the 23/24 cohort was opened up to a wide range of organisations adjacent to primary and community care. These organisations include local authorities, social care, social prescribing, education, and a wide range of voluntary and charity sector organisations. The trainers also held a variety of roles within those organisations, ranging from nursing and public health to executive and business development as well as training and education. (See Figures 2 and 3. For full list of organisations and trainer job roles see Appendices 2 and 3)

Trainers by job category

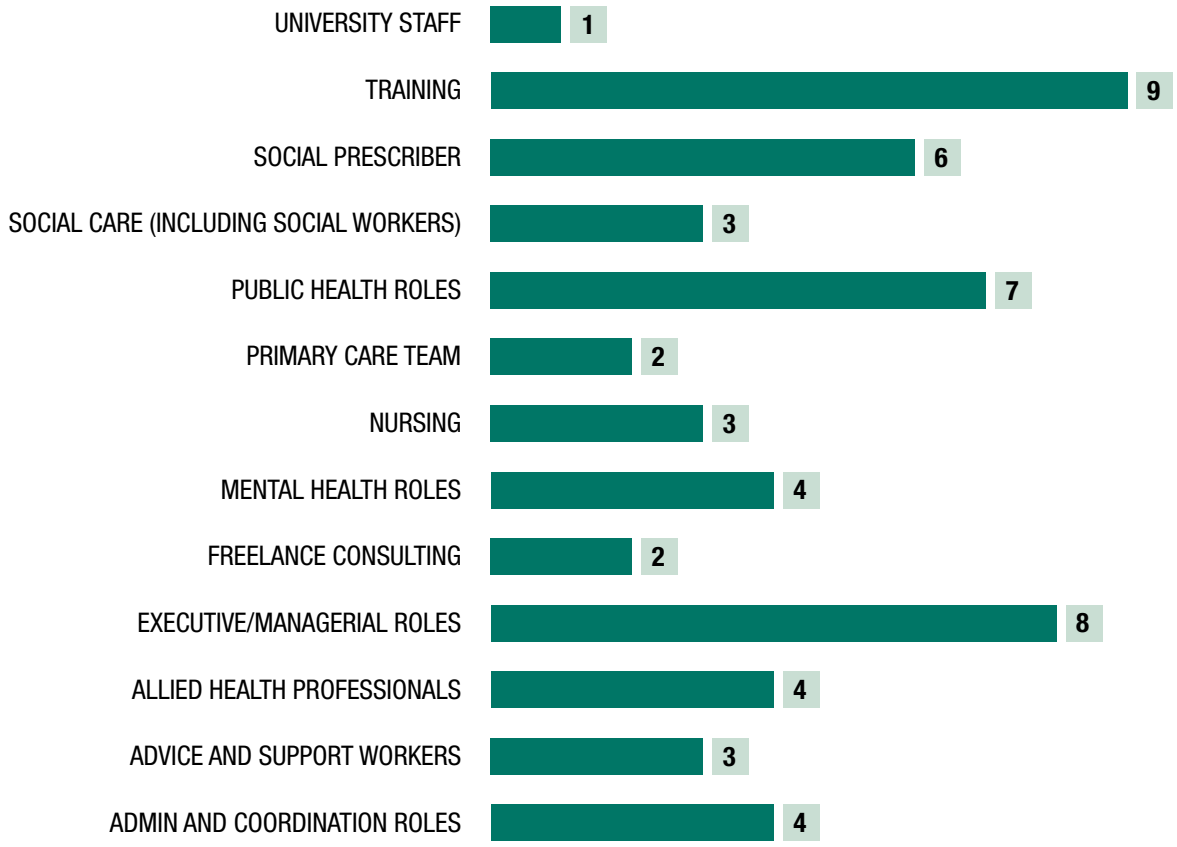


Figure 2 Trainer Job Roles

Trainers by organisation category

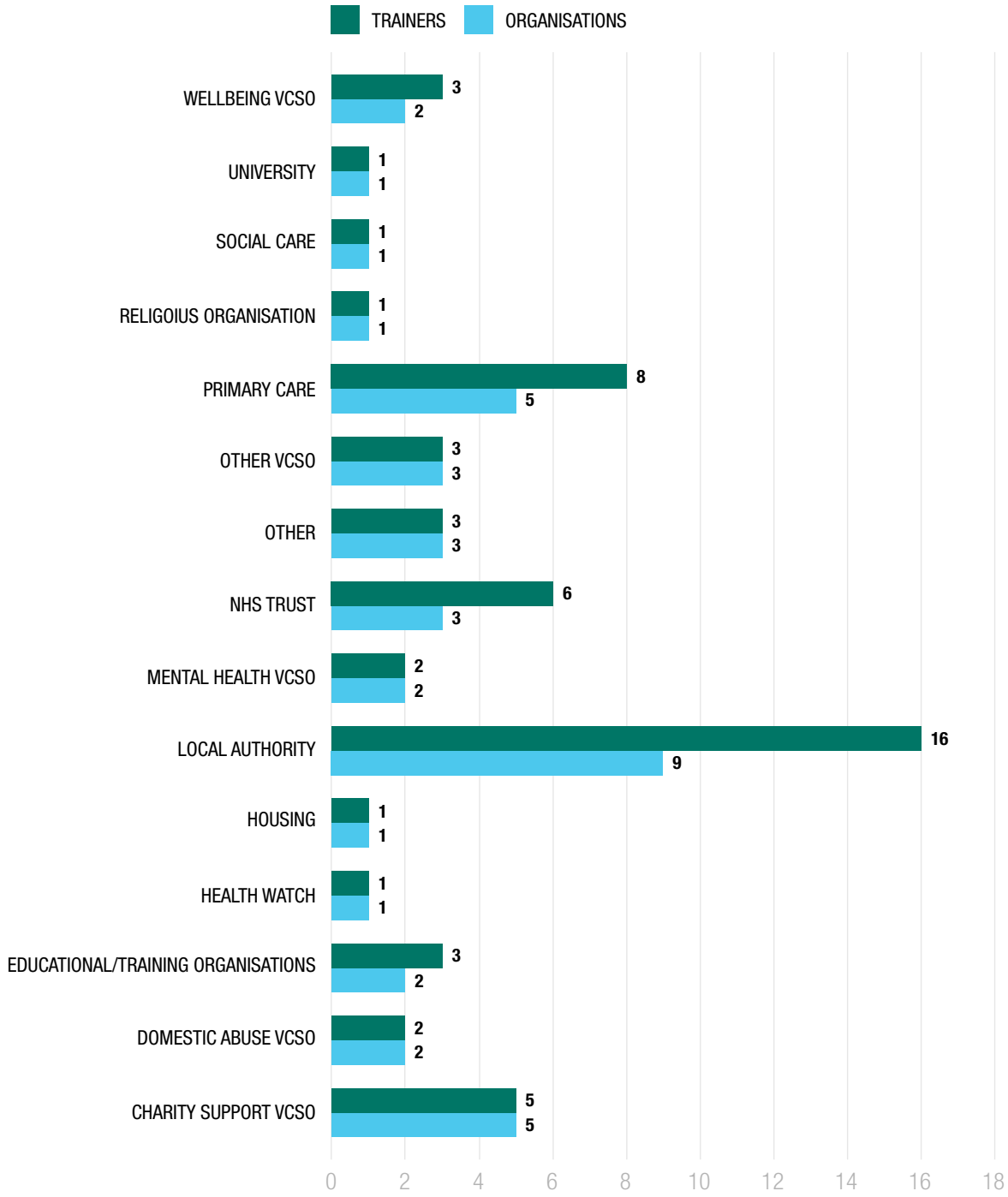


Figure 3 End-users by job category

End-user job roles and organisations

End-users were recruited by Lead and Local trainers from their organisations and local networks. Unlike the trainers, end-users were not selected through a competency-based assessment process and were welcome to participate if they felt the training would be useful for their role. As shown in the graph below, end-users held a wide variety of job roles across many different organisations. However, a significant number of end-users did not report their job roles, and some did not provide information about their organisations either.

End-users by job category

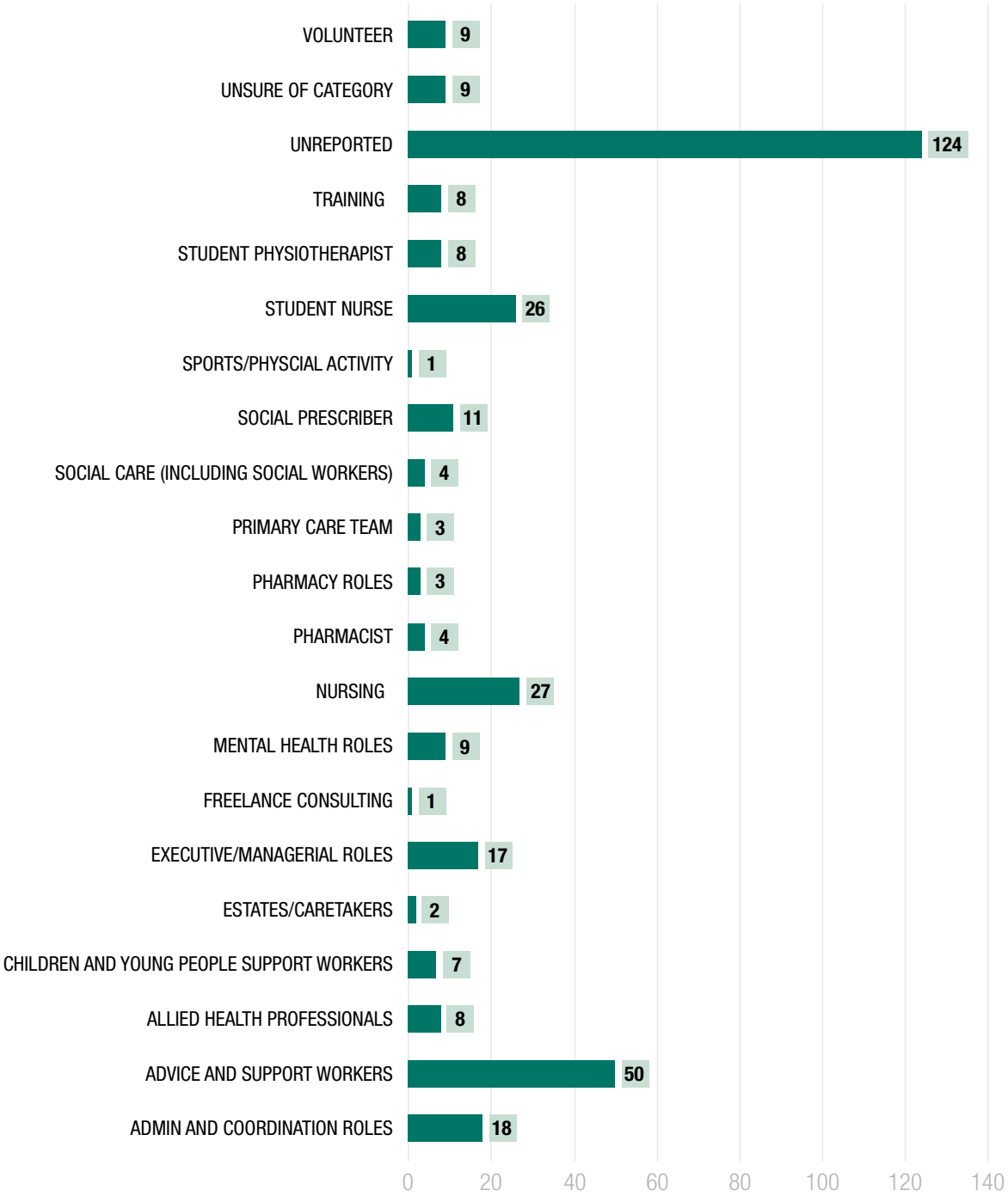


Figure 4 Number of end-user organisations by category

Number of end user organisations by category

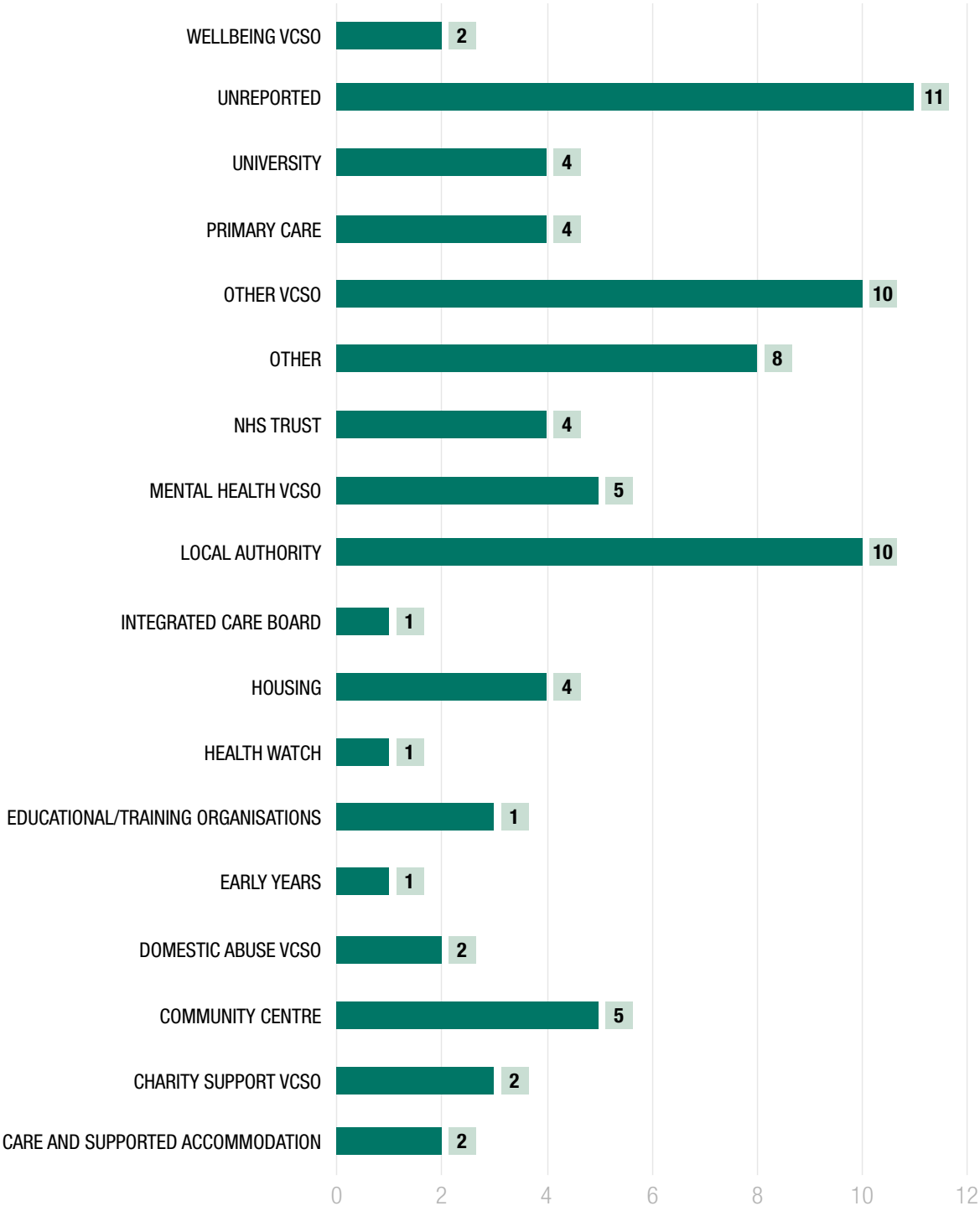


Figure 5 Trainers by organisation category

Natalie Finch, Assistant Professor Mental Health Nursing at the University of Bradford describes her experience of providing MECC for Mental Health training to first year student nurses:

"I am so passionate about a public health approach to mental health and wellbeing. As an educator, I strongly feel that all nurses should be able to take a holistic approach to the care they deliver, yet often find that adult and children's nurses feel anxious about doing so, and do not feel they have the skillset to competently talk about wellbeing. MECC is a tool kit which not only normalises mental health conversations but gives practitioners a framework on how to do so."

"Students are actively and enthusiastically participating in the training and making clear links to other parts of their nurse training programme. Students report really enjoying the training, and finding the framework a useful way to think about building very brief interventions in to their everyday practice."

"I believe that by embedding MECC very early into the nurse training programme, we have a wonderful opportunity to normalise and promote mental health and wellbeing promotion as being a core part of the role of every nurse, not just mental health specialists. MECC allows us to balance our offer to students, moving away from a very physical health centric curriculum in year one. This has potential to take us closer to the idea of parity of esteem for mental health, a crucial goal for everyone in improving the health and wellbeing of the populations we serve."

Conclusions and recommendations on the delivery of MECC for Mental Health from RSPH

Expanding the training beyond health and community care was a success.[9] [10]

Recommendation: Future training should include sectors outside of health and community care. Further to the University of Northumbria's work, it should be closely studied to consider the impacts that it might have

There are pressures across most systems, especially within health and social care, local authorities, and VCSOs. The pressures are related to funding and time, both of which caused delays to the recruitment process and training delivery and limited the development of communities of practice.

Recommendation: Regional and national buy in at the leadership level could prioritise MECC programmes, including this one, and provide both time and money for staff to engage with health promotion. As mentioned at the start of the report, the new government has highlighted a prevention first approach to health, and health promotion is part of that application.

Quality assurance is a vital part of the training programme. Engaging trainers and other stakeholders in the quality assurance process, either through direct input or by making them aware of the mechanisms, helps ensure fidelity to the course and highquality delivery.

Recommendation: Continue involving trainers and stakeholders in the development and implementation of quality assurance and evaluation processes.

Even though the training materials will be freely accessible through the FutureNHS Collaboration platform, the lack of central funding and ongoing support beyond the project presents a barrier to the continued rollout of the training. In discussions with the trainers about their future plans, we found that most were concerned about the potential costs of sustaining the rollout. This is linked to the earlier reflection on leadership.

Recommendation: Regional and local leaders could prioritise MECC within trainers' job roles and allocate the necessary budget for the training.

Through co-production with trainers and external evaluators, the evaluation tools and quality assurance measures were developed. However, while we achieved a high rate of participation in most evaluation activities, some, such as the follow-up questionnaires, had lower engagement. This limited our ability to effectively measure impact.

Recommendation: The project team could work more closely with trainers and end users to ensure higher participation in follow-up evaluation activities.

Following the general election in July 2024, the government has renewed its focus on prevention within healthcare and reaffirmed its commitment to mental health initiatives.

9 Harrison D, Wilson R, Graham A, Brown K, Hesselgreaves H, Ciesielska M. Making every contact count with seldom-heard groups? A qualitative evaluation of voluntary and community sector (VCS) implementation of a public health behaviour change programme in England. Health and Social Care in the Community. 2022 Feb 26. doi: 10.1111/hsc.13764. Epub ahead of print. PMID: 35218264.

10 Nichol B, Rodrigues A, Wilson R, Haighton C. 2023. A Systematic Review of the Effectiveness of Brief Health Behaviour Change Interventions on Service Users Accessing the Third and Social Economy Sector, Health and Social Care in the Community

MECC for Mental Health offers an opportunity to make a lasting impact by aligning with this new agenda.

Recommendation: The RSPH and other national, regional, and local stakeholders should continue advocating for MECC as a valuable public health asset within prevention strategies.

Overall, the MECC for Mental Health programme provides individuals across sectors with the support and skills they need to engage in brief mental health conversations with colleagues, those they support, and the general public. With national and regional leadership and local investment, it could add significant value to the roles of thousands of frontline workers across the UK.

MISC INDEPENDENT EVALUATION

The effectiveness of MECC for mental health will depend on the extent to which people attending training change what they do. Therefore, we have based this evaluation on the COM-B Framework, which helps to understand what influences people's behaviours.

The influences on behaviour can be summarised under the umbrella terms of capability, opportunity and motivation.

Capability: Knowing about, how and what to do and having the 'head space' to do the behaviour.

Opportunity: Both physical opportunity (like time and equipment) and social opportunity (believing that other people accept or support the behaviour).

Motivation: Both reflective and automatic. Reflective motivation is having the want or desire to do the behaviour and automatic motivation is doing something without really thinking about it – because you do it automatically.

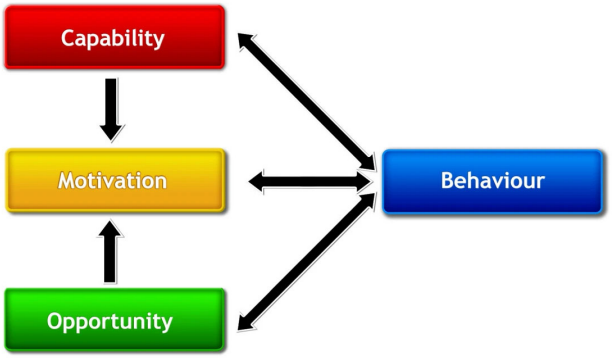
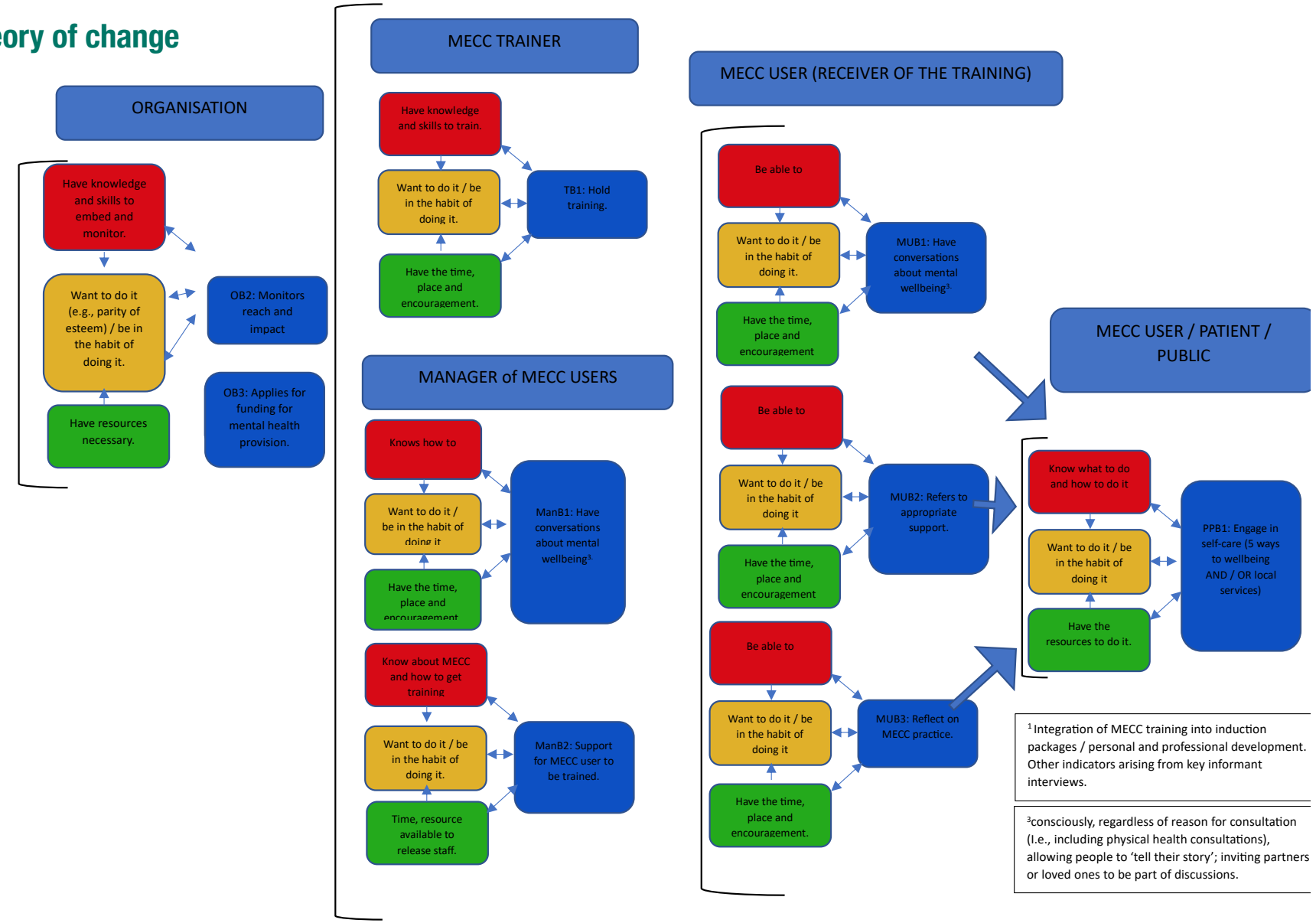


Figure 6 The COM-B Framework

Theory of change



Evaluation methods

We gathered data through 2 methods: interviews / focus groups and online questionnaires.

Over 400 people participated in the evaluation of MECC for mental health.

We based the evaluation on the theory of change we have developed with the RSPH team for MECC (see previous page) for mental health that proposed 2 key behaviours that the MECC users should be doing after the training:

1. Having conversations with people about their mental wellbeing
2. Referring people for more support for their mental wellbeing

In the questionnaires, to understand usual practice and any changes after the MECC for mental health training, we asked MECC users about their expectations that they would conduct these behaviours, before and after the course and at follow-up. We also asked them to estimate before the course and at follow-up, how many times they did these behaviours compared to the numbers of patients or service users they saw. In keeping with the COM-B Framework, we went further to see if we could understand the capability, opportunity and motivation of the MECC users to do these behaviours and whether these also changed after the training course.

In the interviews and focus groups, we asked people about their experiences of both putting the behaviours into practice and, for people who were responsible for training the trainers and delivering training in MECC, their experiences of running training and of the sustainability of the programme. We analysed these data both inductively and using the COM-B framework to identify barriers and enablers to continued MECC for mental health training.

Data limitations

Mixed methods evaluation is an ideal way to capture and triangulate the impact and influence of a training programme and package such as MECC for Mental Health. Because of this mixed methods, multi-faceted approach; we can be reasonably confident in our conclusions – there was consistency in findings across the different methods of data collection; and for the qualitative methods, that similar themes were coming out towards the end of data collection – we had captured the range of views.

It is important to be clear about the limitations, however. The response rates to the questionnaires varied and, in particular, we did not get many people completing the follow-up questionnaire (when they were back at work). This meant we were only able to match a proportion of the data, and that responses at follow-up were particularly lower.

WHAT DID PEOPLE THINK AND FEEL BEFORE THE COURSE BEGAN?

Levels of conversations and referrals for mental health support before training

284/401 (71%) of participants identified between 1 and 100 people who could have benefitted from a conversation about mental health and wellbeing in the last 2 weeks. 36/401 (9%) identified between 101 and 200 people, 26 (6%) identified between 201 and 300, 15 (4% identified between 301 and 400, and 25 (6%) identified between 401 and 500 people. 15 (4%) reported that they saw no people who would benefit from a conversation. The mean number of people (including patients, people using the services, the public, and colleagues) that could have benefitted from a conversation about their mental wellbeing was 91. In total across the region, approximately 38,500 people could have benefitted from a conversation.

We were interested in how many times participants estimated that they had a conversation with the people who could have benefitted. We found that most (273/367, 74%) had 'some' conversations (removing any who had not answered this question rationally[11]). Where participants identified that they had conversations with 'some' of those who could benefit, the mean percentage was 55% (standard deviation = 23.9%).

Table 2. The number and percentage of people who could have benefitted from a conversation who had a conversation

	Number	Percentage
Had no conversations with identified people	41/367	11%
Had some conversations with identified people Note – some is everyone who had any conversations (i.e not all, and not none)	273/367	74%
Had conversations with all identified people	53/367	14%
Had conversations with more people than they identified (excluded from percentage)	19	-

Note: in this table and elsewhere, where % add up to slightly lower or higher than 100%, this is due to rounding down or up

We were also interested in how many times participants estimated that they referred people for further support with the people who could have benefitted from referral. We found that

11 If people said they would have the conversation with more people than they had identified i.e., the percentage of people exceeded 100, we removed the data,

a large minority (45%) did not refer any people who they thought would benefit from referral, whilst 52% reported that they would refer some (again, removing those with percentages of over 100). The mean percentage of those who indicated they would refer some, was 38% (standard deviation = 25%).

Table 3. The number and percentage of people who could have benefitted from a referral for further support who had a referral

	Number	Percentage
Did not refer any identified people	162/363	45%
Referred some identified people	190/363	52%
Referred all identified people	11/363	3%
Referred more people than they identified (excluded from percentage)	23	-

Influences on behaviours before training

At the start of each training session, we asked some questions about trainees' capability, opportunity and motivation to have mental health conversations and to refer people to appropriate support. Appendix 3 shows that reflective motivation was high i.e., that people wanted to have mental health conversations (80% agreed or strongly agreed) and to refer people for appropriate support (80% agreed or strongly agreed). 64% of people said that discussing mental health was something they did automatically but referring to appropriate support was automatic for 53%. Around half of the people agreed or strongly agreed that they had the physical and psychological capability and the physical and social opportunity to have mental health conversations or to refer to appropriate support. Together, this shows that whilst motivation is high, only half of those attending training felt they had the capability and opportunity to conduct either behaviour.

SUPPORT FROM MANAGERS

Management support is a form of social opportunity and is an important behavioural influence. We wanted to understand how supported the trainees felt by their managers, when they were trying to put the MECC for mental health training into practice. We asked this before training and at follow- up.

We asked to what extent the trainees agreed that their manager supported them in having conversations about mental wellbeing and being trained in MECC for mental health. Prior to training, 72% agreed or strongly agreed that their manager supported them in having conversations about mental health. This was 80% at follow-up. 76% agreed or strongly agreed pre-course that their manager supported them being trained in MECC for mental health, 83% agreed at follow-up.

Since role modelling is an important way that people learn in work organisations, we also asked to what extent the manager themselves talks to other people about their mental health. 71% of trainees pre-training and 76% at follow-up agreed/strongly agreed that their manager has conversations with colleagues about their mental wellbeing. These are small shifts in how people perceive their managers, but it is interesting that they seem to all have a trend towards increasing at follow-up.

Table 4 and 5: Tables to show support from attendees' managers

Pre-course: My manager…

	Strongly disagree		Disagree		Neither		Agree		Strongly agree	
Supports conversations	8	2%	14	4%	85	22%	140	37%	132	35%
Supports training	8	2%	16	4%	66	17%	134	35%	156	41%
Has conversations	11	3%	21	6%	77	20%	153	40%	117	31%

Follow-up: My manager…

	Strongly disagree		Disagree		Neither		Agree		Strongly agree	
Supports conversations	6	6%	3	3%	12	12%	26	25%	57	55%
Supports training	6	6%	3	3%	9	9%	26	25%	60	58%
Has conversations	8	8%	2	2%	15	14%	31	30%	48	46%

(pre n=379 / follow n=104) My manager supports me having conversations about mental wellbeing

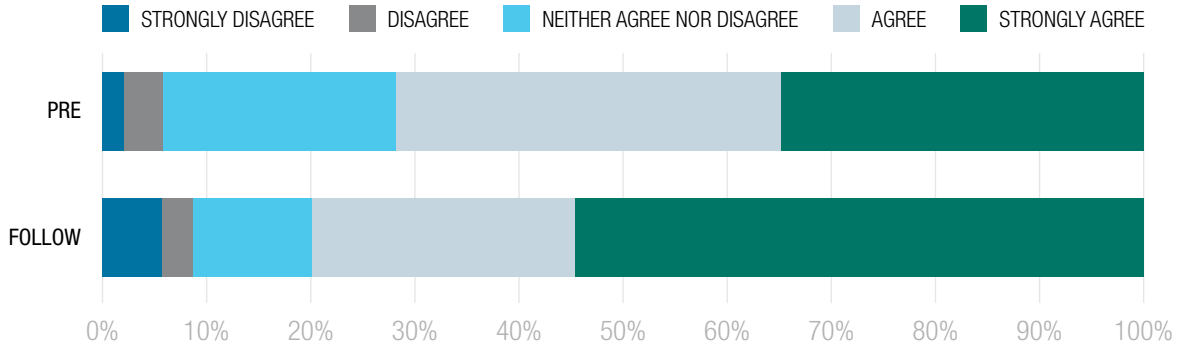


Figure 7 My manager supports me having conversations about mental wellbeing pre-course and follow-up

(pre n=380 / follow n=104) My manager supports me being trained to have conversations about mental wellbeing

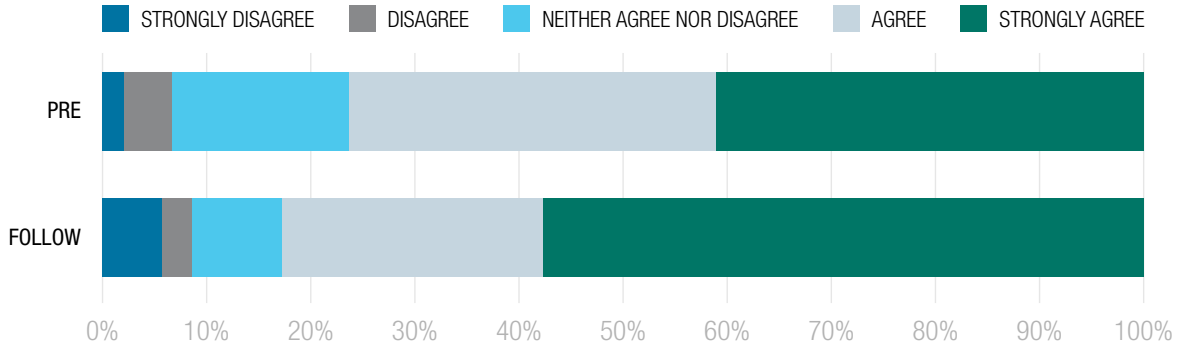


Figure 8 My manager supports me being trained to have conversations about mental wellbeing pre-course and follow-up

(pre n=379 / follow n=104) My manager has conversations about mental wellbeing with me and other colleagues

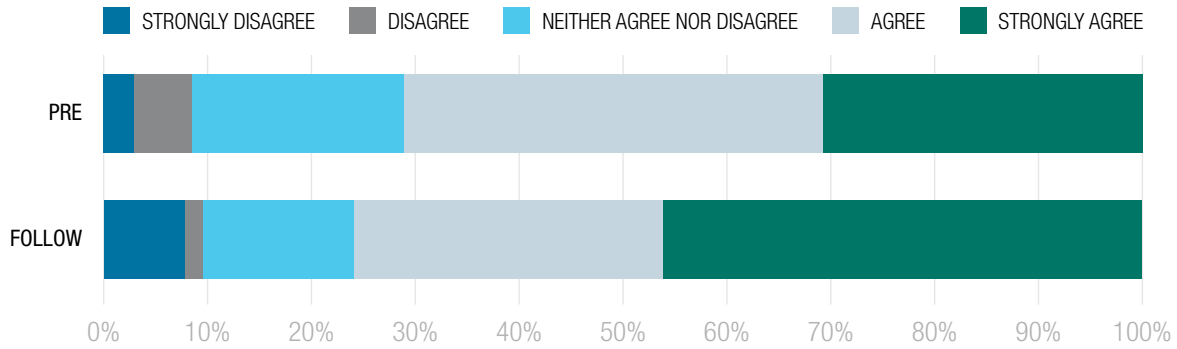


Figure 9 My manager has conversations about mental wellbeing with me and other colleagues pre-course and follow-up

DELIVERY: FIDELITY TO COURSE

We were also interested in the fidelity of the MECC trainers. The MECC for mental health course is an experiential course, where trainees are encouraged to really transform. We asked trainees to state (following training) whether their trainers used the key behaviours of transformational educators. This goes beyond traditional measures of fidelity and satisfaction to focus more on what the trainers were doing which was likely to change the practice of those they were training.

The fidelity markers are 11 selected from a set of 55 published behaviours of transformational educators1. These were chosen at the start of the project in discussion between RSPH and MISC, to ensure consistency of training delivery across the cascade of training process[12] and to best assess the effectiveness of the interactive courses which were being designed; for example, encouraging reflection, discussion and contributions through the session.

As can be seen from Appendix 4, the trainers were very highly rated by attendees. Across the 11 indicators, 86% - 93% agreed or strongly agreed with the statement. Those that were rated highest were the trainers that encouraged participants to feed into the session; encouraged participants to reflect on their own knowledge of key session concepts; and responded positively to being asked questions.

12 Burns D, Tyler N, Chesters S, et al. Identifying the 55 behaviours of transformational educators by evidence-synthesis and Delphi study with UK higher education experts. PsyArXiv; 2022. DOI: 10.31234/osf.io/pc84f.
The cascade process involved the upskilling of local Lead Trainers who then trained Trainers within beneficiary organisations to cascade the programme with colleagues and others.

WHAT CHANGED FROM BEFORE TO AFTER THE COURSE?

Changes in behaviours

The percentage of people with whom the attendees were having conversations about mental health increased from a median pre-course percentage of 40% to a median follow-up percentage of 44%. For referring to appropriate support, the median was 20% at pre-course and follow-up.

Other behaviours at follow-up

We asked trainees (N=102) at follow-up which of the MECC for mental health behaviours they were doing. The most common was listening reflectively (91%), with over 80% of those responding at follow-up reporting that they were also using open questions, responding empathetically and using language that was not stigmatising. The least common was discussing 5 ways to wellbeing with only 36% of trainees reporting using it at follow-up.

Table 6: Attendees' reports of behaviours they are using at follow-up[13]

Behaviour	N (%) reporting using the behaviour at follow-up (total n=102)
Listening reflectively	93 (91%)
Using open questions	91 (89%)
Responding empathetically	89 (87%)
Using language that was not stigmatising	86 (84%)
CHECK/CHUNK*	81 (79%)
Signposting	79 (77%)
Asking twice	72 (71%)
3 A's*	60 (59%)
Discussing 5 ways to wellbeing	37 (36%)

13 Note for table 5: "CHECK/CHUNK*" combines behaviours "Using communication appropriate to the health literacy of the person", "CHECK", "CHUNK", "Using the communication technique: CHECK", "Using the communication technique: Teach Back" "3 A's*" combines the behaviours "Ask", "Assist" and "Act".

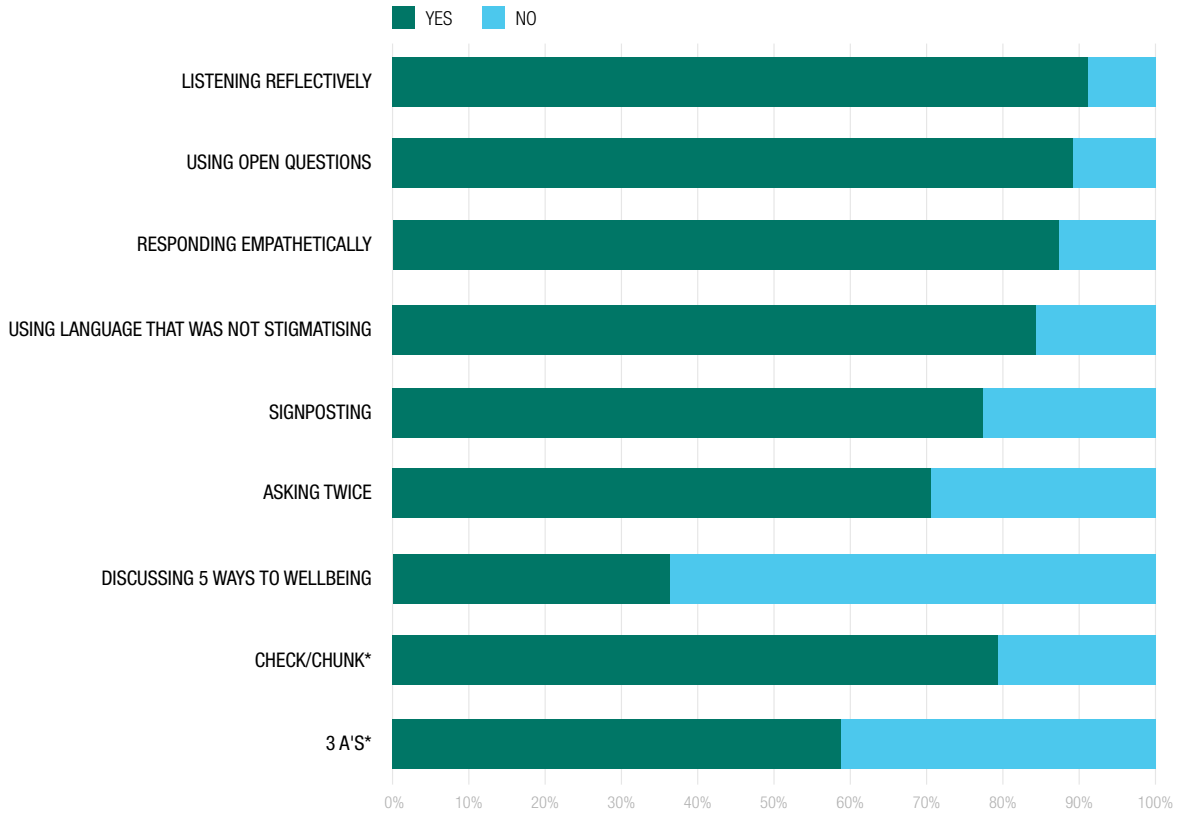


Figure 10 Behaviours at follow-up that those trained are doing[14]

Changes in behavioural expectations

Behavioural expectations of having conversations changed significantly from pre- to post-course, from a median of 5 (interquartile range of 2 to 8) to median of 7 (interquartile range of 5 to 10). Wilcoxon Signed Ranks Test indicated that this change was statistically significant ($z=-5.563$, $p<0.001$).

At follow-up, behavioural expectations were no different than at pre-course, with a median of 4.5 (interquartile range of 3 to 8). Wilcoxon Signed Ranks Test indicating that we should accept the null hypothesis, of no difference in central tendency between pre-course and follow-up expectations ($z= -0.087$, $p>0.05$).

Behavioural expectations of referring for support changed significantly from pre- to post-course, from a median of 3 (interquartile range of 1 to 5) to median of 5 (interquartile range of 3 to 7). Wilcoxon Signed Ranks Test indicated that this change was statistically significant ($z=-5.155$, $p<0.001$).

14 Note for figure 10: "CHECK/CHUNK*" combines behaviours "Using communication appropriate to the health literacy of the person", "CHECK", "CHUNK", "Using the communication technique: CHECK", "Using the communication technique: Teach Back"
"3 A's*" combines the behaviours "Ask", "Assist" and "Act".

At follow-up, behavioural expectations were no different than at pre-course, with a median of 2 (interquartile range of 1 to 4). Wilcoxon Signed Ranks Test indicated that we should accept the null hypothesis, of no difference in central tendency between pre-course and follow-up expectations (z= -1.683, p>0.05).

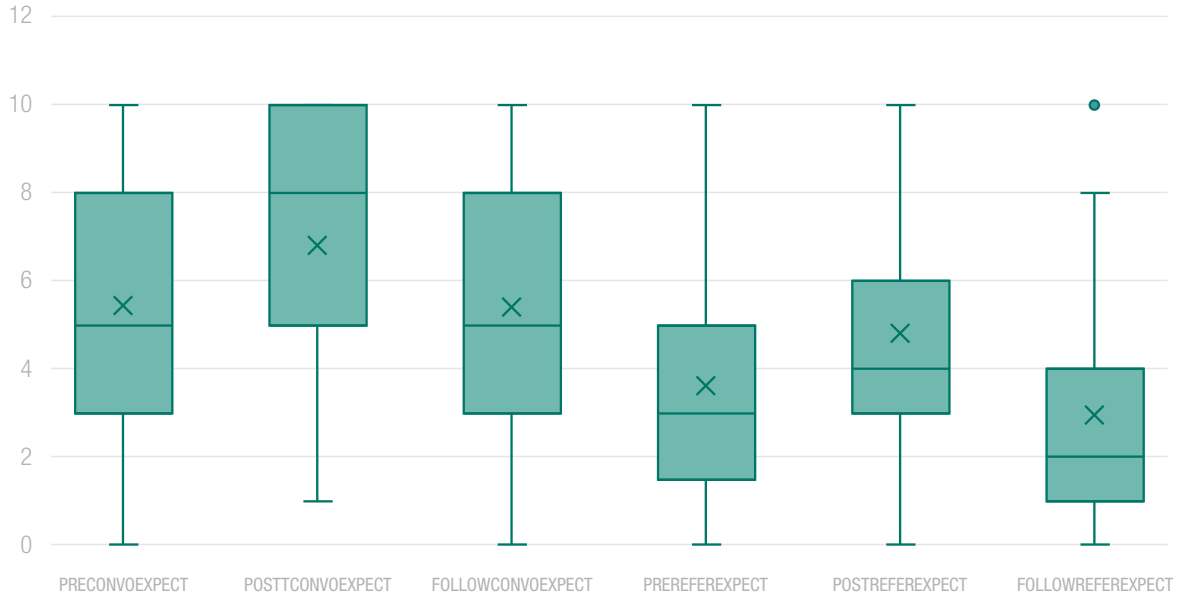


Figure 11 Box plot to show changes in behavioural expectations (for 2 behaviours having conversations, referring for support) at pre-, post- and follow-up

Changes in behavioural influences

We asked about the capability, opportunity and motivation of the course attendees to have mental health conversation and to refer people for appropriate mental health support before the course, immediately after the course (before they had returned to work) and at around 3 months later. We asked people the extent of their agreement with a series of statements, on a scale of 1 to 5, with 1 indicating strongly disagree and 5 strongly agree.

Having mental health conversations[15]

Capability (feeling that you know how (psychological capability) and have the skills (physical capability) to have mental health conversations) changed from pre-course to post-course. Pre-course, 208/401 (52%) of people agreed or strongly agreed that they had the physical capability, rising to 275/300 (92%), whilst 207/397 (52%) agreed or strongly agreed that they had the psychological capability, rising to 272/300 (91%) post-course. Both of these changes were sustained at follow-up, with 85/105 (81%) agreeing or strongly agreeing that they had physical capability and 84/105 (80%) that they had psychological capability to have mental health conversations.

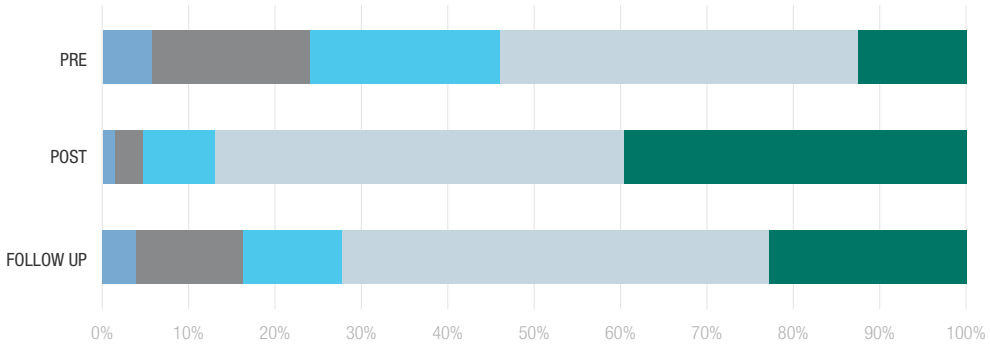
Opportunity (feeling that you have the resources (physical opportunity) and that important people think you should (social opportunity) have mental health conversations) changed from pre-course to post-course. Pre-course, 216/400 people (54%) agreed or strongly agreed that they had the physical opportunity, rising to 261/300 (87%) post-course, whilst 227/400 (57%) agreed or strongly agreed that they had the social opportunity, rising to 245/300 (82%) post-course. The difference in physical opportunity was maintained at follow-up, with 76/105 (76%) still agreeing or strongly agreeing. However, although 69/105 (66%) of people agreed or strongly agreed that they had social opportunity, the statistical test indicated that there was no difference between social opportunity at follow-up and pre-course. The change in social opportunity from pre- to post-course, therefore, was not maintained at follow-up.

Motivation (having the want and desire (reflective motivation) to have mental health conversations and having mental health conversations automatically (automatic motivation)) changed from pre-course to post-course. Pre-course, 320/398 (80%) agreed or strongly agreed that they had the reflective motivation, rising to 283/300 (94%), whilst 259/399 (65%) agreed or strongly agreed that they had automatic motivation, rising to 250/300 (83%) post-course. At follow-up, the increase from pre- to post-course in reflective motivation was lost, but those agreeing / strongly agreeing that they had reflective motivation was still high at 90/105 (86%). The increase in automatic motivation reported was maintained at follow-up with 79/105 (75%) of people agreeing or strongly agreeing that they had automatic motivation to have mental health conversations.

Refer to Appendices 6, 7, and 8 for tables relating to the above.

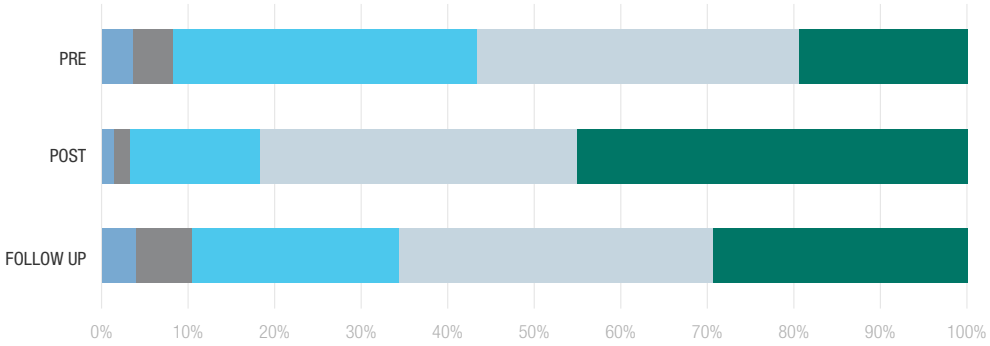
15 Mann-Whitney U test range from -6.837 to -13.026, all $p<0.001$ for changes from pre-to post-course, rejecting the null hypothesis that there is no difference (in terms of central tendency) between the two groups (pre and post the course).
From pre-course to follow up, Mann-Whitney U test ranged from -2.878 to -6.342, all $p<0.004$ for psychological and physical capability, physical opportunity and automatic motivation. For reflective motivation and social opportunity the range was from -1.868 to -1.955 $p>0.05$, accepting the null hypothesis that there is no difference (in terms of central tendency) between the two groups (pre-course and follow up).

Comparison of pre-, post-, and follow-up



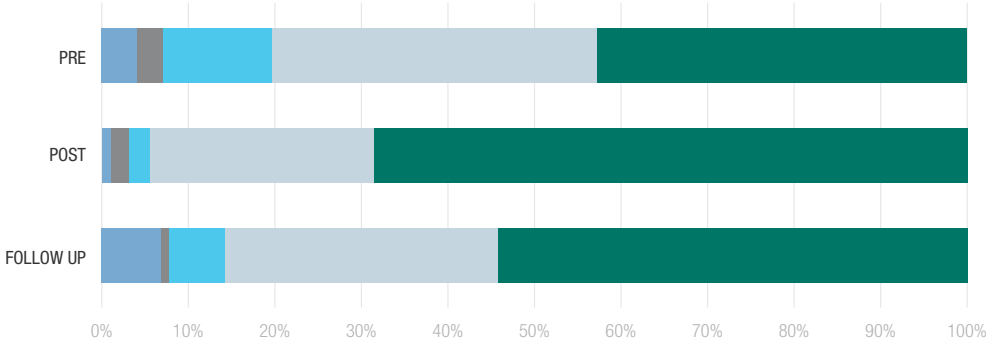
N pre: 400 | post: 300 | follow-up: 105
Median pre: 4 | post: 4 | follow-up: 4

Figure 12 I have the time, space, and materials necessary to have MH conversations with people: pre-, post- and follow up



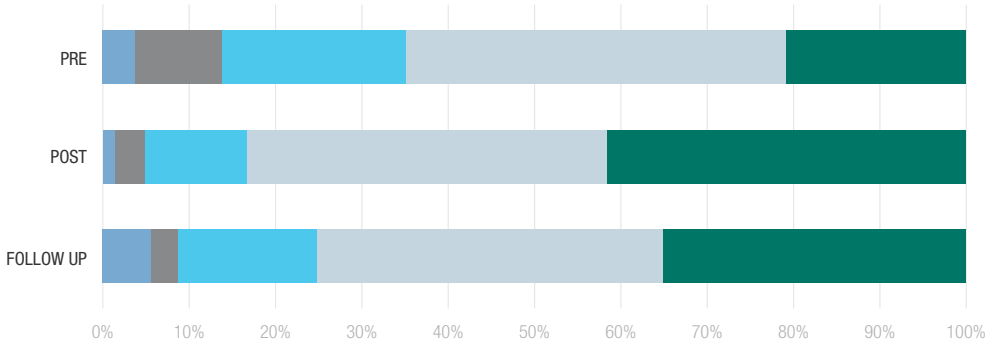
N pre: 400 | post: 300 | follow-up: 105
Median pre: 4 | post: 4 | follow-up: 4

Figure 13 People who are important to me think I should have MH conversations with people: pre-, post- and follow up



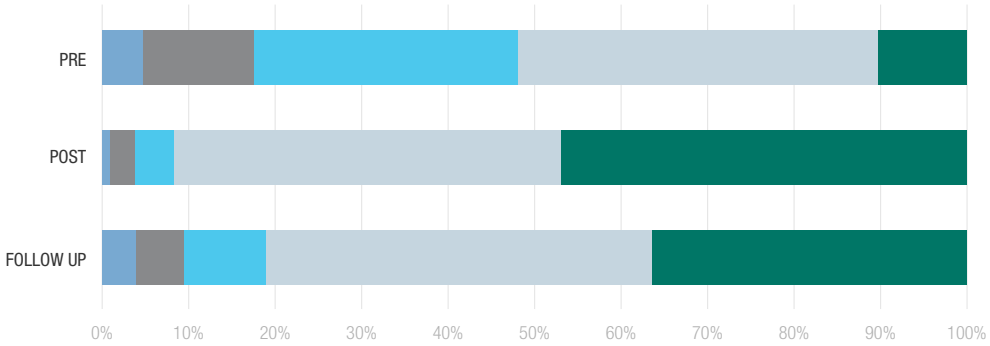
N pre: 398 | post: 300 | follow-up: 105
Median pre: 4 | post: 5 | follow-up: 5

Figure 14 I am motivated to have MH conversations with people: pre-, post- and follow-up



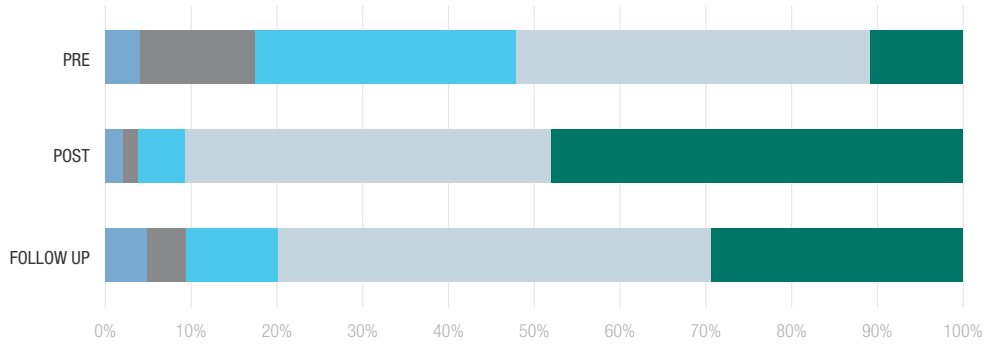
N pre: 400 | post: 300 | follow-up: 105
Median pre: 4 | post: 4 | follow-up: 4

Figure 15 Having MH conversations with people is something that I do automatically: pre-, post- and follow-up



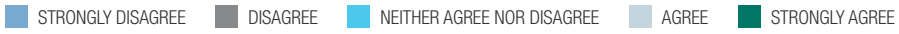
N pre: 399 | post: 300 | follow-up: 105
Median pre: 4 | post: 4 | follow-up: 4

Figure 16 I have the skills necessary to have MH conversations with people: pre-, post- and follow-up



N pre: 397 | post: 300 | follow up: 105
Median pre: 4 | post: 4 | follow up: 4

Figure 17 I know how and have the 'head space' to have MH conversations with people: pre-, post- and follow-up



Referring people for appropriate mental health support[16]

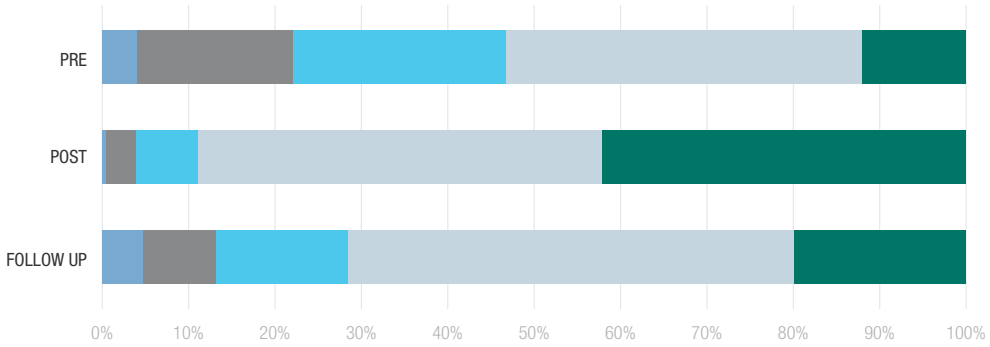
Capability (feeling that you know how (psychological capability) and have the skills (physical capability) to have mental health conversations) changed from pre-course to post-course. Pre-course, 200/388 (52%) of people agreed or strongly agreed that they had the physical capability, rising to 271/292 (93%), whilst 210/389 (54%) agreed or strongly agreed that they had the psychological capability, rising to 270/292 (92%) post-course. Both of these changes were sustained at follow-up, with 79/105 (75%) agreeing or strongly agreeing that they had physical capability and 80/105 (76%) that they had psychological capability to have mental health conversations.

Opportunity (feeling that you have the resources (physical opportunity) and that important people think you should (social opportunity) have mental health conversations) changed from pre-course to post-course. Pre-course, 207/389 people (53%) agreed or strongly agreed that they had the physical opportunity, rising to 259/292 (89%) post-course, whilst 199/388 (51%) agreed or strongly agreed that they had the social opportunity, rising to 239/292 (82%) post-course. The difference in physical opportunity was maintained at follow-up, with 76/105 (71%) still agreeing or strongly agreeing. However, although 68/105 (65%) of people agreed or strongly agreed that they had social opportunity, the statistical test indicated that there was no difference between social opportunity at follow-up and pre-course. The change in social opportunity from pre- to post-course, therefore, was not maintained at follow-up.

Motivation (having the want and desire (reflective motivation) to have mental health conversations and having mental health conversations automatically (automatic motivation) changed from pre-course to post-course. Pre-course, 311/389 (80%) agreed or strongly agreed that they had the reflective motivation, rising to 277/292 (95%), whilst 206/389 (53%) agreed or strongly agreed that they had automatic motivation, rising to 236/292 (81%) post-course. At follow-up, the increase from pre- to post-course in reflective motivation was lost, but the number of those agreeing / strongly agreeing that they had reflective motivation was still high at 90/105 (86%). The increase in automatic motivation reported from pre- topost-course was not maintained at follow-up with only 66/105 (63%) of people agreeing or strongly agreeing that they had automatic motivation to have mental health conversations.

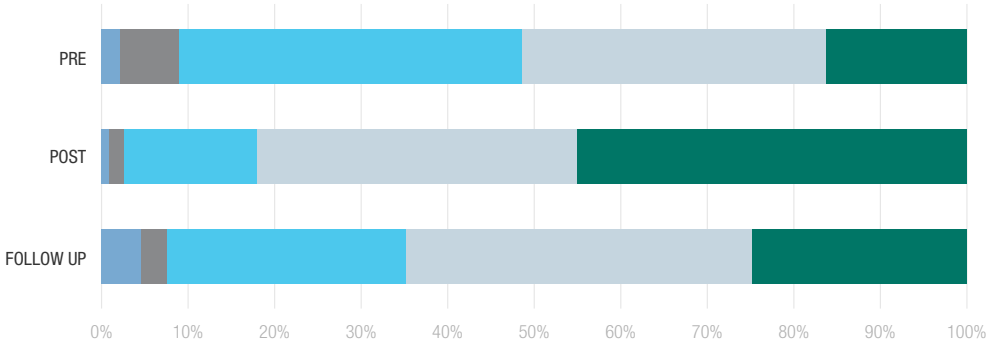
16 Mann-Whitney U test range from -6.837 to -13.026, all $p<0.001$ for changes from pre- to post-course, rejecting the null hypothesis that there is no difference (in terms of central tendency) between the two groups (pre and post the course).
From pre-course to follow-up, Mann-Whitney U test ranged from -2.462 to -5.245, all $p<0.004$ for psychological and physical capability and physical opportunity. For reflective motivation, automatic motivation and social opportunity the range was from -1.685 to -2.472 $p>0.05$, accepting the null hypothesis that there is no difference (in terms of central tendency) between the two groups (pre-course and follow-up).

Comparison of pre-, post-, and follow-up



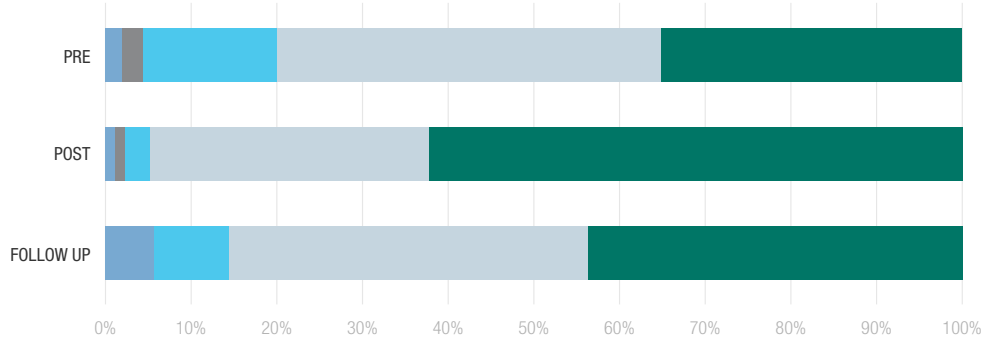
N pre: 389 | post: 292 | follow-up: 105
Median pre: 4 | post: 4 | follow-up: 4

Figure 18 I have the time, space and materials necessary to refer people for appropriate support for their mental wellbeing: pre-, post- and follow-up



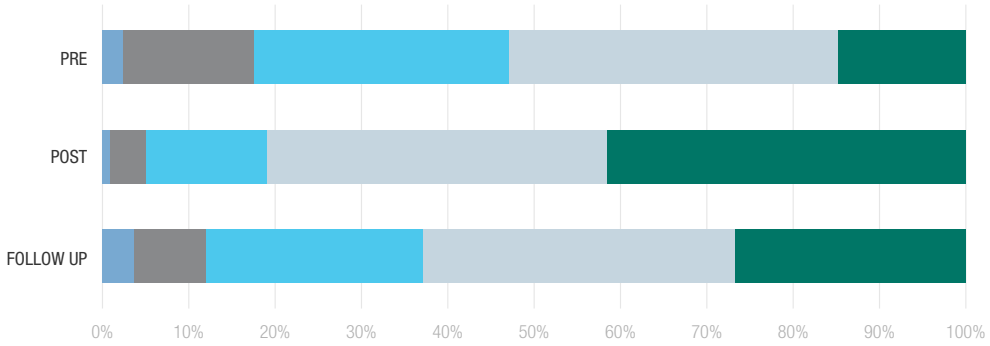
N pre: 388 | post: 292 | follow-up: 105
Median pre: 4 | post: 4 | follow-up: 4

Figure 19 People who are important to me think I should refer people for appropriate support for their mental wellbeing: pre-, post- and follow-up



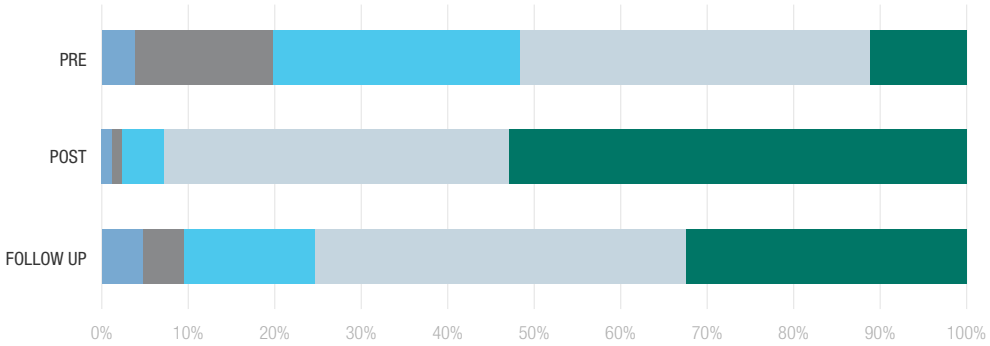
N pre: 389 | post: 292 | follow-up: 105
Median pre: 4 | post: 5 | follow-up: 4

Figure 20 I am motivated to refer people for appropriate support for their mental wellbeing: pre-, post- and follow-up



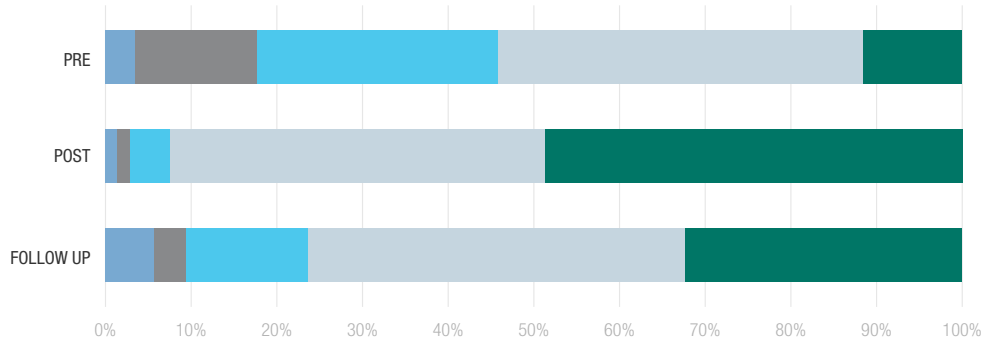
N pre: 389 | post: 292 | follow-up: 105
Median pre: 4 | post: 4 | follow-up: 4

Figure 21 Referring people for appropriate support for their mental wellbeing is something that I do automatically: pre-, post- and follow-up



N pre: 388 | post: 292 | follow-up: 105
Median pre: 4 | post: 5 | follow-up: 4

Figure 22 I have the skills necessary to refer people for appropriate support for their mental wellbeing: pre-, post- and follow-up



N pre: 389 | post: 292 | follow-up: 105
Median pre: 4 | post: 4 | follow-up: 4

Figure 23 I know how and have the 'head space' to refer people for appropriate support for their mental wellbeing: pre-, post- and follow-up

Time to have conversations and refer for support

The time it takes to engage in MECC behaviours is often something that people identify as a potential barrier. In order to explore the perception of time, we asked questions about how long MECC took and whether this added time to their appointments or interactions. 53/105 (50%) of people thought that it did add time whilst 52/105 (50%) thought that it did not.

We asked, "Thinking about any mental health conversations you have had the last 2 weeks: On average, how many minutes do you estimate these conversations last within a routine appointment/interaction?" The results were as follows and the mode at pre-course and follow-up was 6-10 mins.

Table 7: Estimated number of additional minutes spent on mental health conversations at pre-course and follow-up

Estimated number of additional minutes	Pre-course	Follow-up
0-5 mins	56/350 (16%)	15/100 (15%)
6-10 mins	111/350 (32%)	44/100 (44%)
11-15 mins	60/350 (17%)	18/100 (18%)
16-20 mins	50/350 (14%)	13/100 (13%)
21+ mins	73/350 (21%)	10/100 (10%)

A THEMATIC ANALYSIS OF INTERVIEWS

We conducted:

- 19 interviews (11 baseline interviews with stakeholders and trainers (intended to be before training) and 8 end-users who had attended training. Interviewees were randomly selected and put into contact with MISC if they then agreed to participate. Interviews were carried out by a psychologist from the MISC team.
- 2 focus groups: the first with a single trainer (others did not attend) and the second with stakeholders and trainers, who were all identified by RSPH as playing an important role in implementing the MECC for Mental Health train the trainer programme.

At baseline, we asked about previous experience of having mental health conversations within their organisations, team dynamics and expectations. Before the interviews began, 4 baseline participants identified that they had already completed a MECC training course. Therefore, like the end-user participants, these participants were asked 4 additional questions, specifically about their experience with MECC training.

The interviews were audio recorded, transcribed and checked to ensure transcripts were accurate. Each transcript was then coded, and all codes were added to an excel document to identify themes.

We conducted a framework analysis to analyse the interviews and focus groups and identified themes within the 6 behavioural influences from COM-B Framework. As with the rest of the evaluation, we focused on the below 2 key behaviours:

- Having mental health conversations
- Referring people for appropriate support for mental wellbeing.

Having mental health conversations

Physical Capability

Participants reported that without MECC people 'probably feel quite apprehensive and there's a lot of stigma around talking about mental health still' (End-user P13). They reported that they had learned how to have conversations about mental health through training, i.e., they had developed physical capability. For example, learning how to structure the conversations:

" the MECC training helps give a framework to how we can better ask and assist and assess whatever then ask assess assist… so gives a more structure former about how to have that one minute of intervention..."

(Baseline P2).

'it's just really helps me to have almost like a bit of a toolkit and a bit of a script to be able to give to over to other colleagues professionals about look like this, you're not going to make anything worse by asking the question are you OK?'

(Baseline P13)

And having better conversations with their staff:

'it's made it almost a bit easier to start those conversations when we eventually get to the bit about why they're off sick and particularly around their mental wellness, it's really helped with that a lot."

(Baseline P7)

And

'active listing or consciousness listening… I think that's one of the things I got from the courses'

(End-user P19)

Other skills they reported learning included using open-ended questions:

"…what works well is sort of really getting to know the patient, and using a lot of open-ended questions like motivational interviewing questions'

(Baseline P11)

and giving people a way of visualising what's happening:

'… and it was just asking him about his coping mechanisms and when his stress bucket is full or what he does in that circumstance. So, I sort of used some of the phrases and… you've been able to speak to people and give them a way to visualise what's happening and where our limits are, and what makes it overflow and things like that.'

(Baseline P6)

Another skill was *'just asking twice… so when someone has, you know, how are you? I'm fine you know when it's not a very convincing fine, and they come on and say 'actually my dad's ill at the moment', and we've talked a little bit about that and how we can like manage their kind of case load at work'* (Baseline P8)

Indeed, some participants emphasised they would like to have 'a bit more education session around conversations about mental health and where staff can go for tailored support and stuff.' (Baseline – P4)

Psychological Capability

Understanding

Understanding more about mental health has supported good conversations and earlier recognition of potential problems:

'… generally if I open up a conversation about mental health, people seem to me to be a little bit almost dismissive of it and say kind of like, 'oh, I'm fine' and all that kind of thing. But that says I have had certain a few members of staff, that have benefitted significantly. I think for me having some, some understanding of mental health…we have a member of staff who has a lot of sort of anxiety. And now I can see when that started so I can pick it up earlier, put things in place sooner for her…'

(End-user – P19)

Confidence

People reported *'having the confidence to sort of bring things up and ask open questions'* (End-user P18), stemming from increased capability, after the course:

' I feel more confident, to be, sort of putting myself out there…to be able to chat to people… and ask them questions, you know, open questions... since doing the course.'

(End-user P16)

Physical Opportunity

Systems

Participants discussed having specific systems in place to ensure staff felt comfortable and ready to engage in a healthy conversation with a patient.

"We also have… it's not an official system but if a patient rings up and asks for a member of staff if that we always check that that member of staff is ready to take that call or we will say that we will get them to ring them back…because if they're not in a comfortable space and they're not feeling too good that it might be that just need a little bit of time to get they're head space back and probably get them to ring patient back"

(Baseline P1)

Another system regularly brings staff members together, giving them the opportunity to have discussions with each other.

"Urm in our team was very much because we do it with the patients with try and do it with each other as well. So we'll do what we call reflective practice sessions every month… and we'll reflect on any like difficult cases or any learning events that we've had.'

(Baseline P4)

Resources

Participants discussed that *'giving me the resources to be able to say, well, actually, look, I've just been on this training, this is what you can be doing, this is how I can support you'*

(End-user P13) facilitates having conversations about mental health. Not having resources was seen as a barrier:

'maybe having a bit more tailored to where staff can go and how to have conversations… because sometimes with staff like it can become a bit of a competition or you don't feel as comfortable to share with them'

(Baseline P4)

Participants made efforts to '*remind people of different wellbeing stuff for staff'* (Focus group 1 P1)

Money was seen as an important resource to *'up skill people…* (Baseline P9)

Workload and time

Many people discussed how having allocated time for conversations about mental health is very important and appreciated.

'my manager always encourages us at the start of our meeting each week there is an opportunity for us to well actually there is no opportunity she makes us do this [laughs]. But, there's time aside for our own well-being because we deal with a lot of cases that can be quite upsetting that can be quite difficult. And I think I really appreciate that and having that time to be able to talk about how we actually are feeling... And I feel quite confident and happy to speak to my colleagues in that space at that time.'

(Baseline P7)

Not having time was a barrier:

'…having the time to talk because, as I say, everyone's really busy and I think sometimes you sort of think I don't want to engage in that conversation 'cos once start it have I got the time to continue?'

(Baseline P6)

People having *'a workload that's quite heavy'*, however, could overcome by *'realising the value and the difference it can make for somebody'* (Baseline P6)

Leadership and social support

Some participants discussed that *'it really starts with those in leadership positions. To really buy into this whole around, you know, having courageous conversations around, you know mental health.'* (Baseline P3) and that *'to really embed it into the organisation as part of its values…how it functions and making sure it's in policies and in procedures and having regular conversations with staff checking in to see how people are, you know, what do they need.'* (Baseline P3)

Leadership also included *'…managers really need to change that way in which they approach a healthy conversation with the staff…some that avoid it because I think*

sometimes, they don't wanna know or they don't know how to deal with it if it suddenly snowballs and somebody pours out everything that's going on… so I think consistency is key…and a holistic approach to people's mental wellbeing.' (Baseline P7), indicating that role modelling was important as well as policies.

Managing the team to take into account individuals' feelings helped:

'… ability to take people off certain types of work…if they are struggling with their mental health … we can rearrange case load'

(Baseline P1)

A sense of team meant that all honest conversations were easier:

'…we all sit together so even though I manage a team I still sit with team so we've got that constant peer support…it's quite a stressful job it's not people aren't always ringing up with happy stories…'

(Baseline P1)

More support was identified as an important facilitator:

'…I would like to see more support amongst teams…So across our council particularly we've got teams that do it really well and they're really supportive and have conversations about mental health about mental wellbeing and then there's teams that really don't get it right, and that don't really care, to be honest… I would like teams to be a bit more holistic in how they approach staff in terms that everybody is different, everybody's mental wellness is different.'

(Baseline P7)

Social environment

Participants reported trying to create 'a supportive environment and again are supposed to do I think we did psychological safety didn't we, so it touches on that, creating, so that comes into it, creating that sort of psychologically safe place' (End-user P19). Not having this was seen as a barrier:

'if someone wants to have a conversation, that they don't necessarily want to have it in the open office, it's trying to find a space, so if we knew there was a designated space where you could go, I think that would definitely help.'

(Baseline – P6)

The environment promoting wellbeing through posters in the workplace was seen as encouraging of mental health conversations:

'As an organisation, we have got wellbeing boards, can you see them [points to board behind] we've got promoting, people having conversations…looking at what is, what are people's comforters. So we've got pets and things like that. Pictures of our pets on the walls, so that you know so you've got another line of conversation with someone as an opener I suppose…'

(End-user P18)

The general environment and it *'becoming a more normal thing to talk about socially.'* (End-user P17) was a facilitator and participants indicated that *'…there is a shift in that people are more aware and are wanting to be supportive and you know, so I do feel like the culture is going in the right direction of like feeling safe, taking people's perspectives onboard, taking mental health serious and that it is a thing and it does needs to be addressed.'* (End-user P12).

Motivation

People's emotions seemed to prompt them to start or not start mental health conversations: both in terms of automatically stopping them and making them decide not to have or have conversations. For example, where there was still a stigma and feeling of embarrassment about mental health, this was a barrier:

'…There still that that thing that holds them back…I think people find it hard to get past that because there's still that, you know, they're still internalised that embarrassment and shame.'

(Baseline P3)

This seemed to be lessened with MECC training:

'I'd say without having, if they've not done any MECC, or if they've not had some sort of coaching around it, I think they probably feel quite apprehensive and there's a lot of stigma around talking about mental health still…'

(End-user P13)

This seemed to be overcome by MECC bringing the idea of mental health to mind:

'…I suppose just being more mindful, it just brings it all to the forefront how it doesn't always have to be lengthy conversation, you know.'

(Baseline P11)

Some people mentioned that *'…I'm required to have that type of conversation as part of my role'* (End-user P13) and where this was not expected it was a barrier:

'…I've been in health visiting before so I've come even though I'm an acute nurse I'm community background, so I've always had that sort of

preventative sort of head If you like...It's difficult getting that message across to acute nurses, they're not sorta don't have prevention embedded as part of the training…then I think they also have difficultly having them lengthy conversations at wards level because they're out doing all clinical things.'

(Baseline P1)

When they felt it was part of their role, the training helped in feeling more comfortable doing so:

'…naturally, our role is to chat about this sort of stuff, but it's made me more comfortable to talk about it with people… I've definitely had that in, you know, in the last six months since doing this training.'

(Focus group 1 P1)

Identities

Interestingly, some individual characteristics helped or hindered having conversations including gender:

'…I think men especially struggle to talk about feelings and emotions.' (End-user P13) and places with women were facilitative to conversations:

'…we have quite conversations about mental health anyway, we're all quite open at work within the team of women, so obviously feelings aren't as difficult to explain are they.'

(End-user P17)

Age was another factor with 'a lot of the older members of staff *'…still that worry that they're afraid to open up and have those conversations.'* (Baseline P7).

These differences in wanting to talk about mental health were also viewed as just individual differences:

'… I think I'm quite aware we're all a bit different. I think there's one or two colleagues I'm quite open and vocal and but there's one or two I've noticed you know there a bit more withdrawn.'

(Baseline P9).

Referring someone for support

The second behaviour that was analysed using the COM-B was *'Referring someone for support'.*

Capability

Participants discussed having more knowledge and/or available resources for referring people for extra support. People needed to know what was available and how to signpost people:

'…that's a little bit about my role so upskilling people knowledge and understanding about mental health so that they can start conversation and then signpost people to the services within the community as well as some off like services that's available nationally as well.'

(Baseline P10).

Physical Opportunity

Existing connections were seen as important and beneficial:

'… it was then trying to encourage them to get some support to help them with that as well, because we realised that actually once they've got from the not acknowledging stage to realise that they are a victim, that's when we realise that they need that more intensive handling support as well. And so we just facilitated those connections to local organisations that could provide them intense support that they needed.'

(Baseline P5)

Sharing resources was seen as important to help others make appropriate referrals:

'…I've created a webpage with loads of different resources that anybody who's trained with me with me can access. It's all about signposting, so if I've tried to keep a bit of, 'you're not just done the training then you're on your own'.'

(Focus group 2 P1)

Having external services to refer to was important:

'… we looked at an agency that can offer help, so I gave them an explanation of who this agency are, support they offer, how long for, how I can refer her, what will happen next, and she was quite happy for me to do that'

(Baseline P11)

However, referral outside of the organisation might not be as beneficial as inside:

'…I suppose we could signpost people on, but I think it would it could do with somebody more professional to be in the workplace. To be able to sort of take over quite quickly rather than lose that person, you know, in the referral process sort of thing.'

(End-user P16)

Social Opportunity

As with having conversations, job roles facilitated them in referring people for more support:

"… because I was a nurse as well. So I didn't just talk to patients from a medical perspective, but you just wanted to get a bit more information about them and just sign post them to places where they could get help'

(Baseline P3)

'… I work as an occupational health technician in health care… quite regularly as we work with people that are on long term sick looking at how we can get them back into the workplace… a lot of cases that come through are discussing mental wellbeing and trying to signpost people to the right support.'

(Baseline P7)

Participants noted when their organisation is supportive of referring people for additional support:

'… the manager can do referrals to like employee assistant programme for example or signpost to other supports too.'

(Baseline P10)

Motivation

People's individual situations were important when referring for more support:

'…when I suggested it I'd said oh well there is this organisation that I think might be might be helpful, but I sort of first clarified what kind of support she wants, because I think what I'm mindful as a social prescriber to do is not to just come in and say I know what will fix your problem, because by doing so you're not really helping anybody.'

(Baseline P11)

Highlights and recommendations

Before the baseline and end-user interviews began, participants were asked if they had completed any of the MECC training. If they had, participants were asked 4 additional questions about their experience with the training. For example, 'Anything else you'd like to tell us about your experiences of the training and putting it into practice?' and 'What do you think the training will contribute to any changes in the future?'. Additionally, the MECC training was discussed in both focus groups.

Overall, participants had positive feedback whether they took part in the training and/or delivered the training. For example, participants found the training:

Engaging - *"The training was great, like it, I really enjoyed it and the ladies that ran the training we're fab like really engaging…",*

Enjoyable - *"Aw it's been great it's very enriching, I really enjoy it and really appreciated the opportunity to be to for my work to put me on it as well as the experience of learning those new skills of of how to deliver it, urm and its worth the skills within it as well…you know loved it.",*

Comprehensive - *"It seemed pretty comprehensive for, you know, the short space of time that we had...No just appreciate the course the trainers and the follow-up, well appreciated."*, and

Informative - *"No urm, apart from the training was really good, it was really informative. Urm, and I really enjoyed doing it.".*

Particularly participants discussed enjoying specific content, such as:

The 3 A's *"So I agree with everything that [personal name] said there basically just reiterating that, so the three A's model, it is easy to remember, and it's more about the conversation and being with a person, which you can't really forget, ah so it is more about being, then knowing. Which I think really, really helps people.",*

The **stress bucket and five ways of wellbeing**, *"Urm say if we felt the stress book, it was great part or the five ways of well-being. So, we did do you know, shared the video. I added a stress bucket video actually, that was my added bit as well as urm explaining it. Like the five ways of wellbeing you have the video, urm but it was quite good just to add the like the stress bucket version as well."*

Although overall feedback from participants was positive, certain barriers were discussed in relation to the training and implementation. For example, one end-user participant commented that the information was **outdated** and had issues with some of the **phrasing**, *"Like I said though, we went into individual groups to work on some of the activities and you've got that issue of outdated ways of phrasing things and making it quite difficult to understand if you don't already have that knowledge… So I would, I would really think about re phrasing things, and I don't want to say, dumbing it down, cause that's not the right word, but making it more accessible to people that don't have any knowledge of it at all."*

The focus groups noted several barriers when delivering and implementing the training for instance:

Technology - *"That was a nightmare for people, the QR code but once they were in it a lot of people trying to do it on the phones on the course, and then the sliding scale things won't work and they'd knock it slightly it went from 1 to 700, and was like ah...You know, they were trying to bring it down and it was an absolute mare.",*

Funding - *"Urm just thinking about some of the barriers, one of the huge things now is the cost, because there I got a little bit of money to subsidise delivery urm I think it was about £400 we got and then we got free certification.",*

No national steering - *"So yeah, I suppose I'm a bit of a gardener, but you're right, the seed, the seed is good, the actual training is good, the soil I think it depends where you are nationally there is no kind of direct national steerage on MECC training, nothing from CQC. You know, it's just if you wanna do the best that you can, then you become part of it."*

Time and capacity - *"Urm the course itself went well, I think feedback wise for myself and participants and similar to what others on the call have said is a lot is a big time commitment particularly for smaller grassroots third sector organisations and those working in community based settings or actually just across health really, were tight and were squeezed. So you've got to really be able to justify why giving a person full day or two day's worth of time to attend a training course."*

From the baseline and end-user interviews, a few trainees and trainers made specific recommendations.

- Some participants discussed the relevance of the content. For example, one participant mentioned that they would have not included labelling and putting things into boxes, and another participant explained the content needs to cover talking to parents specifically.
- One participant discussed that they would have preferred face-to-face training.
- Additionally, the same participant commented that it would have been ideal to deliver the training straight after the course. However, due to personal circumstances they were not able to.
- One participant mentioned that a refresher session would be beneficial.
- One participant expressed that the training needed to be more accessible to everyone in terms of the language and phrasing used.
- One participant believed that leadership need to make this training available on top of mandatory training.

From the focus groups sessions, the trainers and stakeholders made the following recommendations:

- The main topic suggested was the idea of a regular forum, to create a sense of community for trainers and trainees.
- Participants mentioned the need for future planning and sustainability of the training. They agreed that the training had been successful so far, however there is limited direction and no national steering on the maintenance of this programme. For instance, there is limited thinking into long term strategic plans of the training.
- Participants identified funding as a barrier to implementation and therefore, the need to figure out a better costing strategy.
- One participant mentioned that as trainers, they want more responsibilities, such being responsible for distributing the certificates if given an official template. In doing so, this would save additional costs.

Likelihood of recommending the course

People were asked to rate (from 0-10) how likely they were to recommend the course to friends / colleagues. The vast majority indicated between 7-10 (89/103, 87%). The remaining people indicated a score of between 4 and 6.

CONCLUSIONS AND RECOMMENDATIONS FROM THE INDEPENDENT EVALUATORS

In conclusion, the course was very well received, and we could see how much the hard work of the trainers and RSPH was appreciated. Training was rated very highly particularly around encouragement and interaction. Resources and support were popular with attendees and trainers.

Recommendation: that future training packages continue to be experiential, and trainers trained to the same high standard.

There was a mixed picture from the quantitative and qualitative data about the impact of the course on key behavioural influences. In the quantitative data, reflective motivation was high initially for training and stayed high, capability increased post-training and stayed high (showing that the course had improved knowledge and skills for attendees) and social opportunity did increase as a result of training but this was not maintained at follow-up. Managers were perceived as supportive and had conversations about mental health with colleagues themselves. The qualitative data told a slightly more positive story; that training facilitated better referrals and conversations through increased awareness of external services and resources available (physical opportunities). Participants reported that training addressed psychological safety and normalised these sorts of conversations, reducing stigma and raising awareness. These were described as enabling of the key conversation and referral behaviours. It is likely that we are seeing a masking of change in the quantitative data, because we are looking at scores from the whole group (and some will be changing and some not) whilst the qualitative data allows us to understand the impact on each individual.

Recommendations: That consideration is given during training on how to address social opportunity barriers – for example, how attendees are able to advocate for MECC in their workplace and gain the support of those they work with to implement this. Also that future evaluations seek to understand the experiences of people who change and do not change, to understand more about the impact of training on individuals and sub-groups.

Behavioural expectations to conduct the key behaviours increased following training, but were more similar to pre-course levels at follow-up. However, most attendees reported using the behaviours they had learnt in training in their workplace, particularly those in listening, open questions and responding with empathy, and high levels of using the communication techniques they had learnt in training. They felt that these conversations added on 6-10 mins per conversation.

Recommendation: Future packages could consider how to encourage attendees longer term so that all of them are able to use behaviours in their workplaces, and discussing the time needed to do this.

Some of those interviewed considered how national steering and funding support would facilitate future MECC training.

Recommendation: Training is important and has impact; national buy in and leadership for long term MECC support and sustainable funding packages would support this work and enable an embedded approach.

APPENDICES

Appendix 1: Fidelity markers

In order to ensure that the training sessions delivered were faithful to the original design, project stakeholders (including Local Trainers and Lead Trainers) identified evidence-based fidelity markers which would indicate whether the core aspects of the Theory of Change behind MECC for Mental Health were being realised. These markers were:

1. Description of the context of the session (i.e., how the session fits with other courses, related concepts, theories, practices)
2. Asking participants what is expected from the session
3. Use of stories, anecdotes or real-life examples
4. Continuously monitoring participants' engagement and progress (i.e., observing during activities, discussions etc.)
5. Discussion of learning materials amongst participants (e.g., learner led debates, group and pair discussions)
6. Drawing upon the participants' own experiential knowledge
7. Encouraging participants to feed into the session
8. Encouraging participants to reflect on their own knowledge of key session concepts
9. Responding positively to being asked questions
10. Using language to praise, support, and show positive regard (including identifying areas of strength)
11. Using non-verbal and verbal communication which indicates that the participants are important and being listened to

Appendix 2: Table of host organisations for trainers

Amistad para Refugiados de El Salvador	North East Ambulance Service
Age Concern Tyneside South	North Lincolnshire Council
Aspire Learning, Support and Wellbeing	North Tyneside VODA
Bevan Healthcare (GP Practice)	Northern Care Alliance NHS Trust
Blackpool Coastal Housing	Northumberland County Council
Bradford District Care NHS Trust	Nova Wakefield District
Calderdale & Huddersfield NHS Trust	Rotherham Metropolitan Borough Council
Changing Lives	Sharing Voices Bradford
City Health Care Partnership	South Tees NHS Pain Clinic
City of York Council	South Tyneside Health Collaboration
Creating Positive Opportunity	The Rotherham NHS Foundation Trust
Cumbria Health on Call	Touchstone
Diocese of Durham	Tyne Coast College
Doncaster City Council	Tyneside and Northumberland Mind
Doncaster Mind	University of Bradford
Durham County Council	Voluntary Action North Lincolnshire
First Contact Clinical	Voluntary Action Rotherham
Freelance	Wakefield Metropolitan District Council
Healthwatch Rotherham	Wellbeing for Life
Hull Community and Voluntary Services	Westmorland And Furness Council
I.M.P.A.C.T North East	
Kirklees Metropolitan Borough Council	
Leeds Community Healthcare NHS Trust	
New Beginnings Peer Support	
Newcastle City Council	

Appendix 3: Table of job roles of trainers

1	Advanced Practice Lead, Principal Social Work Team	3	Occupational Health Technician
1	Business Development manager	1	Operations Manager
3	Clinical Educator	1	Practising therapist
1	Clinical Lead Admiral Nurse	1	Preceptorship Education Lead
1	Community Health Champions Programme Manager	1	Public Health Assistant
1	Community Health Service Manager	1	Public Health Improvement Officer
6	Community Link Worker / Social Prescriber	1	Public Health Officer
1	Consultant Nurse for Mental Health	1	Registered Social Worker
1	Deputy Chief Officer	1	Resilience/ Regeneration Officer
1	Director of Operations	1	Senior Public Health Practitioner
1	Early Support Consultant	1	Senior Tutor
1	Family Support Worker – Kirklees Parenting Team	1	Senior Workforce Development Officer
1	Funding, Grants & Training Officer	1	Service Manager
1	Head of Training	1	Specialist Physiotherapist in Pain Management
1	Health and Wellbeing Officer	1	Specialist Quality Lead
1	Health Improvement Practitioner	1	Specialist Trainer
1	Health Improvement Specialist	1	Staff Nurse
1	Hub Coordinator	1	Team Lead
1	Inclusion Health Practitioner	1	Trainer
1	Lead Alcohol Nurse	1	Training and Development Officer
1	Lead Mental Health Community Builder	1	Training Coordinator
1	Lead Trainer / Consultant	1	Training Facilitator & Support Worker
1	Learning and Development Manager	1	Trauma Informed Care Workforce Development Lead
1	Mental Health Alliance Worker	1	Trauma Informed Coach and Consultant
1	Mental Health and Wellbeing Trainer	1	Volunteering and Group Support Manager
1	Mental Health Lead	2	Wellbeing Advisor
1	Mental Health Nursing lecturer (assistant professor)	1	Workforce Development Lead & Mental Health Coordinator
1	Mental Health Services Manager		

Appendix 4: Pre-course capability, opportunity and motivation of attendees to have conversations with people about their mental health or to refer people for further support for their mental health

	Strongly disagree		Disagree		Neither agree nor disagree		Agree		strongly agree		Agree or strongly agree	
Physical Opportunity: I have the time, space and materials necessary to have MH conversations with people	23	6%	73	18%	88	22%	166	42%	50	13%	216	54%
Social Opportunity: People who are important to me think I should have MH conversations with people	14	4%	19	5%	140	35%	149	37%	78	20%	227	57%
Reflective motivation: I am motivated (have the desire and feel I want) to have MH conversations with people	16	4%	12	3%	50	13%	149	37%	171	43%	320	80%
Automatic motivation: Having MH conversations with people is something that I do automatically	14	4%	41	10%	85	21%	175	44%	84	21%	259	65%

	Strongly disagree		Disagree		Neither agree nor disagree		Agree		strongly agree		Agree or strongly agree	
Physical Capability: I have the skills necessary to have MH conversations with people	19	5%	52	13%	122	30%	167	42%	41	10%	208	52%
Psychological capability: I know how (I know what I am doing and why) and have the 'head space' to have MH conversations with people	16	4%	53	13%	121	30%	163	41%	44	11%	207	52%
Physical opportunity: I have the time, space and materials necessary to refer people to appropriate support for their mental wellbeing	17	4%	70	18%	95	24%	160	41%	47	12%	207	53%
Social opportunity: People who are important to me think I should refer people to appropriate support for their mental wellbeing	9	2%	26	7%	154	40%	136	35%	63	16%	199	51%

	Strongly disagree		Disagree		Neither agree nor disagree		Agree		strongly agree		Agree or strongly agree	
Reflective motivation: I am motivated (have the desire and feel I want) to refer people to appropriate support for their mental wellbeing	7	2%	10	3%	61	16%	174	45%	137	35%	311	80%
Automatic motivation: Referring people to appropriate support for their mental wellbeing is something that I do automatically	10	3%	58	15%	115	30%	148	38%	58	15%	206	53%
Physical capability: I have the skills necessary to refer people to appropriate support for their mental wellbeing	15	4%	62	16%	111	29%	157	40%	43	11%	200	52%
Psychological capability: I know how to (I know what I am doing and why) and have the 'head space' to refer people to appropriate support for their mental wellbeing	14	4%	55	14%	110	28%	165	42%	45	12%	210	54%

Appendix 5: Course attendee perceptions of their trainers

	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree	Agree or Strongly Agree
n=315						
Trainer described the context of the session	16	5	7	56	231	287
	5%	2%	2%	18%	73%	91%
Trainer asked participants what they expected from the session	9	8	28	86	184	270
	3%	3%	9%	27%	58%	86%
Trainer told stories, anecdotes or real-life examples	16	6	8	55	230	285
	5%	2%	3%	17%	73%	90%
Trainer continuously monitored, checked our engagement and progress (i.e., observing during activities, discussions etc.)	13	6	9	49	238	287
	4%	2%	3%	16%	76%	92%
Trainer encouraged participants to discuss learning materials amongst themselves (e.g., learner led debates, group and pair discussions)	15	2	11	40	247	287
	5%	1%	3%	13%	78%	91%
Trainer encouraged us to draw upon participants own experiential knowledge	15	4	10	44	242	286

	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree	Agree or Strongly Agree
	5%	1%	3%	14%	77%	91%
Trainer encouraged participants to feed into the session	13	2	6	37	257	294
	4%	1%	2%	12%	82%	93%
Trainer encouraged participants to reflect on their own knowledge of key session concepts	14	2	7	51	241	292
	4%	1%	2%	16%	77%	93%
Trainer responded positively to being asked questions	12	3	7	31	262	293
	4%	1%	2%	10%	83%	93%
Trainer used language to praise, support, and show positive regard (including identifying areas of strength)	12	4	10	41	248	289
	4%	1%	3%	13%	79%	92%
Trainer used non-verbal and verbal communication which indicates that we were important and being listened to	12	4	9	31	259	290
	4%	1%	3%	10%	82%	92%

Appendix 6: Post-course capability, opportunity and motivation of attendees to have conversations with people about their mental health or to refer people for further support for their mental health

Post course	Strongly disagree		Disagree		Neither agree nor disagree		Agree		Strongly agree		Agree or strongly agree	
Physical Opportunity: I have the time, space and materials necessary to have MH conversations with people	4	1%	10	3%	25	8%	142	47%	119	40%	261	87%
Social Opportunity: People who are important to me think I should have MH conversations with people	4	1%	6	2%	45	15%	109	36%	136	45%	245	82%
Reflective motivation: I am motivated (have the desire and feel I want) to have MH conversations with people	3	1%	7	2%	7	2%	77	26%	206	69%	283	94%
Automatic motivation: Having MH conversations with people is something that I do automatically	4	1%	11	4%	35	12%	125	42%	125	42%	250	83%
Physical Capability: I have the skills necessary to have MH conversations with people	3	1%	9	3%	13	4%	134	45%	141	47%	275	92%
Psychological capability: I know how (I know what I am doing and why) and have the 'head space' to have MH conversations with people	6	2%	5	2%	17	6%	128	43%	144	48%	272	91%

Post course	Strongly disagree		Disagree		Neither agree nor disagree		Agree		Strongly agree		Agree or strongly agree	
Physical opportunity: I have the time, space and materials necessary to refer people to appropriate support for their mental wellbeing	2	1%	10	3%	21	7%	136	47%	123	42%	259	89%
Social opportunity: People who are important to me think I should refer people to appropriate support for their mental wellbeing	3	1%	5	2%	45	15%	107	37%	132	45%	239	82%
Reflective motivation: I am motivated (have the desire and feel I want) to refer people to appropriate support for their mental wellbeing	3	1%	3	1%	9	3%	95	33%	182	62%	277	95%
Automatic motivation: Referring people to appropriate support for their mental wellbeing is something that I do automatically	3	1%	12	4%	41	14%	115	39%	121	41%	236	81%
Physical capability: I have the skills necessary to refer people to appropriate support for their mental wellbeing	4	1%	3	1%	14	5%	117	40%	154	53%	271	93%
Psychological capability: I know how to (I know what I am doing and why) and have the 'head space' to refer people to appropriate support for their mental wellbeing	4	1%	4	1%	14	5%	128	44%	142	49%	270	92%

Appendix 7: Follow-up capability, opportunity and motivation of attendees to have conversations with people about their mental health or to refer people for further support for their mental health

Follow-up	Strongly disagree		Disagree		Neither agree nor disagree		Agree		Strongly agree		Agree or strongly agree	
Physical Opportunity: I have the time, space and materials necessary to have MH conversations with people	4	4%	13	12%	12	11%	52	50%	24	23%	76	72%
Social Opportunity: People who are important to me think I should have MH conversations with people	4	4%	7	7%	25	24%	38	36%	31	30%	69	66%
Reflective motivation: I am motivated (have the desire and feel I want) to have MH conversations with people	7	7%	1	1%	7	7%	33	31%	57	54%	90	86%
Automatic motivation: Having MH conversations with people is something that I do automatically	6	6%	3	3%	17	16%	42	40%	37	35%	79	75%
Physical Capability: I have the skills necessary to have MH conversations with people	4	4%	6	6%	10	10%	47	45%	38	36%	85	81%
Psychological capability: I know how (I know what I am doing and why) and have the 'head space' to have MH conversations with people	5	5%	5	5%	11	10%	53	50%	31	30%	84	80%

Follow-up	Strongly disagree		Disagree		Neither agree nor disagree		Agree		Strongly agree		Agree or strongly agree	
Physical opportunity: I have the time, space and materials necessary to refer people to appropriate support for their mental wellbeing	5	5%	9	9%	16	15%	54	51%	21	20%	75	71%
Social opportunity: People who are important to me think I should refer people to appropriate support for their mental wellbeing	5	5%	3	3%	29	28%	42	40%	26	25%	68	65%
Reflective motivation: I am motivated (have the desire and feel I want) to refer people to appropriate support for their mental wellbeing	6	6%	0	0%	9	9%	44	42%	46	44%	90	86%
Automatic motivation: Referring people to appropriate support for their mental wellbeing is something that I do automatically	4	4%	9	9%	26	25%	38	36%	28	27%	66	63%
Physical capability: I have the skills necessary to refer people to appropriate support for their mental wellbeing	5	5%	5	5%	16	15%	45	43%	34	32%	79	75%
Psychological capability: I know how to (I know what I am doing and why) and have the 'head space' to refer people to appropriate support for their mental wellbeing	6	6%	4	4%	15	14%	46	44%	34	32%	80	76%

Appendix 8: Capability, opportunity and motivation of attendees to have conversations with people about their mental health or to refer people for further support for their mental health: Table to show those who agreed or strongly agreed

	Pre		Post		Follow-up	
	Agree or strongly agree		Agree or strongly agree		Agree or strongly agree	
Physical Opportunity: I have the time, space and materials necessary to have MH conversations with people	216	54%	261	87%	76	72%
Social Opportunity: People who are important to me think I should have MH conversations with people	227	57%	245	82%	69	66%
Reflective motivation: I am motivated (have the desire and feel I want) to have MH conversations with people	320	80%	283	94%	90	86%
Automatic motivation: Having MH conversations with people is something that I do automatically	259	65%	250	83%	79	75%
Physical Capability: I have the skills necessary to have MH conversations with people	208	52%	275	92%	85	81%
Psychological capability: I know how (I know what I am doing and why) and have the 'head space' to have MH conversations with people	207	52%	272	91%	84	80%

	Pre		Post		Follow-up	
	Agree or strongly agree		Agree or strongly agree		Agree or strongly agree	
Physical opportunity: I have the time, space and materials necessary to refer people to appropriate support for their mental wellbeing	207	53%	259	89%	75	71%
Social opportunity: People who are important to me think I should refer people to appropriate support for their mental wellbeing	199	51%	239	82%	68	65%
Reflective motivation: I am motivated (have the desire and feel I want) to refer people to appropriate support for their mental wellbeing	311	80%	277	95%	90	86%
Automatic motivation: Referring people to appropriate support for their mental wellbeing is something that I do automatically	206	53%	236	81%	66	63%
Physical capability: I have the skills necessary to refer people to appropriate support for their mental wellbeing	200	52%	271	93%	79	75%
Psychological capability: I know how to (I know what I am doing and why) and have the 'head space' to refer people to appropriate support for their mental wellbeing	210	54%	270	92%	80	76%