NHS
Health Education England

# MECC for Mental Health – Delivery and Evaluation Report

June 2022



RSPH
ROYAL SOCIETY FOR PUBLIC HEALTH
VISION, VOICE AND PRACTICE

# Contents

# Acknowledgements

This was project commissioned by Health Education England.

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### Appreciations:

Our thanks go to everyone who was involved in the design, delivery and evaluation of the MECC for Mental Health project. This includes: Nelly Araujo (Project Manager), Sam King (Training Lead), Zoe Louca (E-Learning and Digital Resources Developer), Dawn Mitchell and Karan Thomas (Lead Training Developers), Clare Baguley (North West Clinical Workforce Lead, HEE), Mike Lewis (North East and Yorkshire Mental Health Programme Manager), Andra Chiscop and Polly James (Project Managers).

We would like to especially thank the Lead Trainers for delivering the sessions that upskilled 100 Local Trainers who, in turn, were able to cascade the training to over 1000 professionals:

1. Alicia Clare, Director at Bluesci in Greater Manchester
2. Hasan Sidat, Senior Operational Manager at Lancashire South Cumbria NHS Trust in Lancashire and South Cumbria
3. Jan Campbell, Health and Social Care Officer at Sefton CVS in Cheshire and Merseyside
4. Jason Feavers, Independent Trainer in Humber, Coast and Vale
5. Katharine Lonsdale, Mental Health and Wellbeing Trainer at N-Compass in Lancashire and South Cumbria
6. Louise Harlanderson, MECC Development Lead at Gateshead Public Health in North Cumbria and the North East
7. Phil Anastasi, Mental Health Wellbeing Coach at Humber Teaching NHS Foundation Trust in Humber, Coast and Vale
8. Roberta Pomponio, Strategic Partnership Manager for Mental Health at Active Cheshire in Cheshire and Merseyside
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11. Tina Dransfield, Wellbeing and Engagement Advisor at Spectrum People in West Yorkshire and Harrogate.

A big thank you to all the Local Trainers who participated in the project, their work and commitment has delivered change for better mental health promotion.

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Finally, we would like to thank the members of our multidisciplinary Expert Reference Group (named in Annex 1) for their advice and support throughout the project.

For more information on MECC for Mental Health, please contact Nelly Araujo at naraujo@rsph.org.uk

# Foreword

Mental health problems are incredibly common across the UK, with 1 in 4 of us experiencing one at some point in our lives.[1] Yet seeking help for our mental health is far less common. Whether it's shame, a lack of information, fear, or logistical obstacles, it is estimated that one fifth of adult population would delay seeking help for their mental health for at least 6 months.[2] With mental health being a leading cause of disability in the UK, and the fact that people with mental health conditions, on average, experience poorer health and wellbeing outcomes, there is a clear need to break down these barriers to accessing support. There is, in other words, a need to 'make every contact count for mental health'.

Through the Making Every Contact Count (MECC) approach, millions of interactions every day are used as opportunities to improve health and wellbeing, meaning each of us can play a part in achieving population-level change. Applied to mental health, the MECC approach not only provides important signposting and support, but it also helps to normalise speaking about a subject which otherwise can be seen as stigmatising and taboo. MECC for Mental Health, then, can help reduce the barriers presented by both lack of awareness and confidence in talking about mental health and concerns about asking for help.

This report offers an overview of how Royal Society for Public Health, in partnership with Health Education England North-West and North-East & Yorkshire, designed and delivered the MECC for Mental Health training programme to frontline health and care professionals. The independent evaluation of the training, also included in the report, demonstrates both the interest in the training offer and promising results in terms of increasing confidence to have conversations about mental health and changing professional practice to include them on a daily basis.

We hope that the long-term impact of this training is that these conversations will, like pebbles in a pool of water, send forth ripples – ripples into individual lives, enabling people to access the support and make the changes they need to feel better; and ripples into our wider society, making it okay to say, "I'm not okay".

**Clare Baguley**
Psychological Professions Network Programme Manager and North West Clinical Workforce Lead, Health Education England

**Kiran Kenth**
Director of National and Regional Programmes,
Royal Society for Public Health

[1]McManus, S., Meltzer, H., Brugha, T. S., Bebbington, P. E., & Jenkins, R. (2009). Adult psychiatric morbidity in England, 2007: results of a household survey.
[2]https://mentalhealth.surgoventures.org/uk

# Executive summary

This report represents an overview and independent evaluation of the MECC for Mental Health programme undertaken by Royal Society for Public Health, in partnership with Health Education England. The programme aimed to equip frontline health and care professionals 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:

- 12 Lead Trainers and 100 Local Trainers from 83 organisations in primary and community care organisations were recruited.

- Between July 2021 and May 2022, 67 out of 100 Local Trainers included in the project had delivered MECC for Mental Health training to 1,086 end-users. The total number of end-users is expected to be 1,138 by Summer 2022.

- An independent evaluation of the training was conducted using data from 450 participants collected through questionnaires, interviews, focus groups and observations of training sessions.

- This evaluation found statistically significant increases in participants' capability, opportunity and motivation to have conversations with people about their mental health, and to refer people for further support. The follow-up stage of the evaluation also found a statistically significant increase in the number of conversations about mental health and wellbeing which participants were having, compared with before the training.

- At the follow-up, more than 3/4 of participants reported avoiding using stigmatising language, signposting, asking open questions, listening reflectively, asking people twice if they were ok, and responding empathetically.

- On average, each participant reported seeing 12 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 13,000 interactions every 2 weeks.

- The evaluators found a high level of fidelity in how the training was delivered, and both the Local Trainers and end-users reported finding the training a positive experience. Lead Trainers and Local Trainers, appreciated the ability to adapt the training for different audiences and the practical support from RSPH. The main areas for improvement for how the training was delivered concerned face-to-face delivery and the timings of the sessions.

- MECC for Mental Health has been adapted and further developed during the roll-out with new iterations developed for cancer care settings (in collaboration with Greater Manchester Cancer Alliance and The Christie NHS Foundation Trust) and to raise awareness about the menopause (in partnership with Bluesci).

# Introduction

## 1. Policy background

The Health and Social Care Act 2012 introduced the first explicit recognition of the Secretary of State for Health's duty towards both physical and mental health. This led to a commitment by the NHS to achieve parity of esteem between mental health and physical health – its constitution states that the NHS is "designed to improve, prevent, diagnose and treat both physical and mental health problems with equal regard". Accordingly, the NHS Long-Term Plan included a pledge to invest in protecting 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, including those working in the NHS, to understand how to promote mental wellbeing and support those experiencing mental health problems. Accordingly, Public Health England in 2015 published the *Public Mental Health Leadership and Workforce Development Framework* and Health Education England developed an *Action plan for mental health promotion and prevention training and the Mental Health Workforce Plan for England* to increase the availability and uptake of accessible, high-quality training courses in public mental health.

Once the core and wider public health workforce have a good understanding of how to support mental wellbeing, prevent mental health issues, and the wider needs of those with diagnosed mental illnesses, this can help shape the countless conversations they have with members of the public, patients, and colleagues. A practical, evidence-based framework for this is provided by the Make Every Contact Count (MECC) approach. MECC enables the opportunistic delivery of consistent and concise healthy lifestyle information through short conversations (no more than a few of minutes).

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 have not progressed so quickly or with a high degree of coordination. The Royal Society for Public Health was commissioned by Health Education England (HEE) North to address this by rolling out MECC for Mental Health training across the frontline health and social care workforce in the region.

# Delivery report

The MECC for Mental Health Project to equip the frontline, non-specialist health and care workforce to integrate mental health and wellbeing messages and interventions into routine clinical consultations. The focus was to deliver this training to those working in primary and community care services delivered or commissioned by the NHS across the North of England (North West, North East and Yorkshire). RSPH had 6 specific objectives which included:

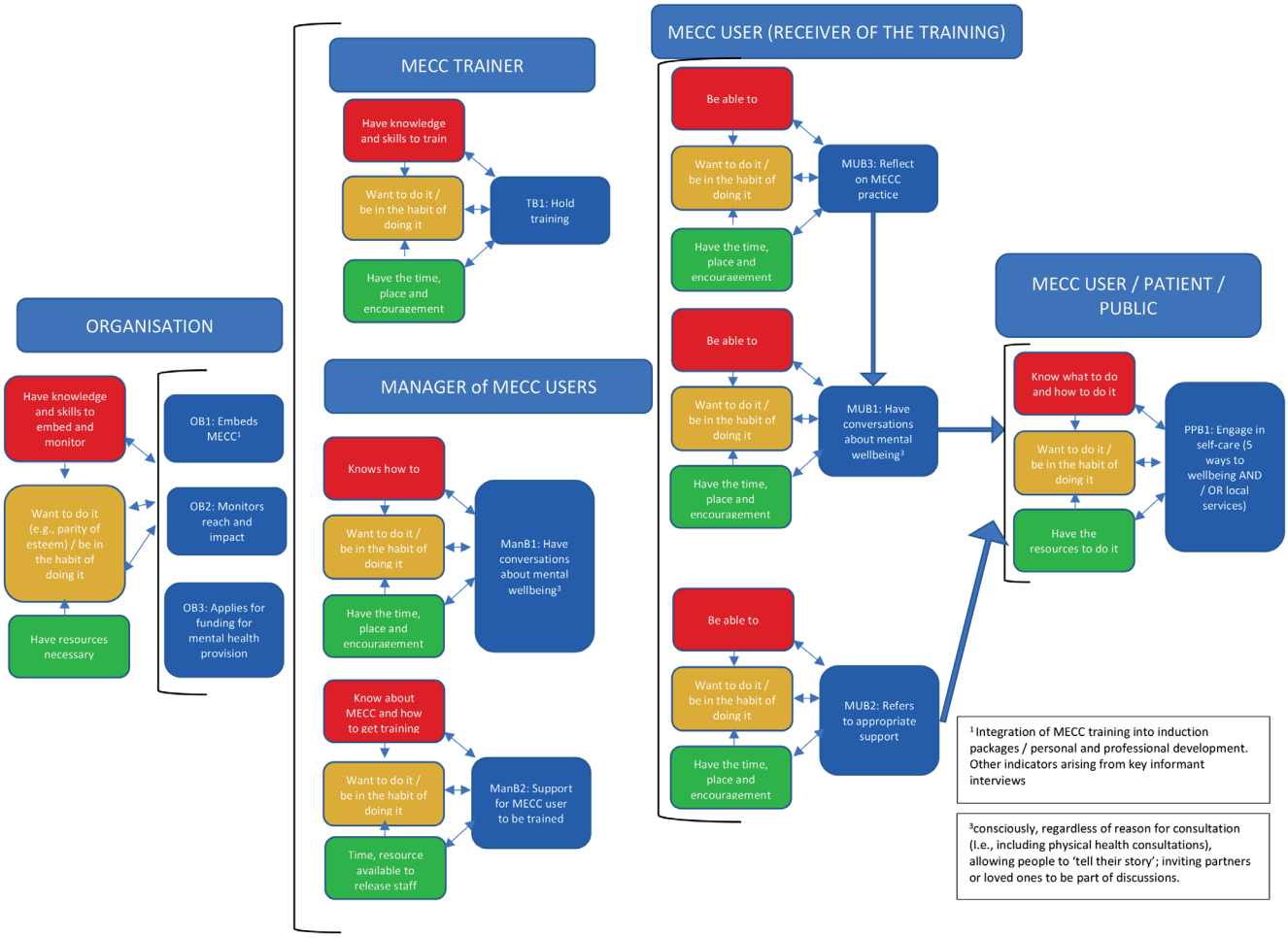
- To design a mental health promotion training programme which responds to the needs and expectations of the non-specialist health and care workforce in the NHS and NHS-commissioned primary and community care settings.
- To recruit 14 Lead Trainers and 84 Local Trainers to lead the cascade of the training 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.

## Designing the Training

The process of designing the MECC for Mental Health training began with mapping existing training programmes covering MECC and mental health promotion which were available in the North of England, the level of need for further training, and the gaps in provision. To do so, we engaged with a wide range of stakeholders to identify current assets, in terms of training and mental health support resources and services, as well as training needs across the workforce.

To ensure that our training offer resulted in behaviour change in the workforce, and hence improved mental health and wellbeing outcomes in the people with whom they interacted, RSPH guided by MISC developed a Theory of Change (Figure 1) with project stakeholders. This identified influences on behaviour at 4 different levels which the project would need to address in order to effectively and sustainably change frontline professionals' behaviour. Similarly, in line with contemporary evidence for behavioural change interventions, the design and development of the Making Every Contact Count for Mental Health (MECC for MH) programme was informed by the **COM-B** model (Susan Michie, 2011), which seeks to drive behaviour change by ensuring individuals have the **C**apabilities, **O**pportunities, and **M**otivations necessary to do so.

## Figure 1: MECC for MH Theory of Change




**In this chart, behaviours are coded in blue; influences on behaviours are indicated using arrows and colour coded as follows: red represents capability; yellow indicates opportunity; and green stands for motivation.**

In order for the training to be sustainably delivered and become embedded in local systems, RSPH used a cascade model with the end-user training being delivered by Lead Trainers and Local Trainers based within local primary and community care organisations.

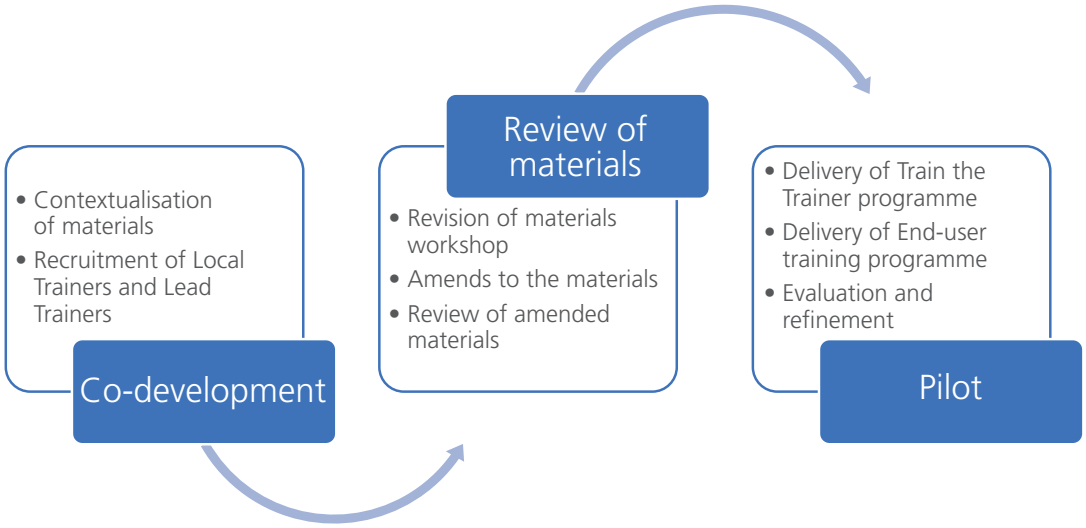
The end-user training programme consisted of 9 guided learning hours in total, divided equally between 3 modules (though as standalone modules, they could also be delivered independently):

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

Lead Trainers and Local Trainers were equipped to deliver this content over a 2.5 days training session which included experiencing the end-user programme as well as practical delivery experience. RSPH also provided a full set of training materials, which were developed and tested with Health Education England, local stakeholder organisations and an Expert Reference Group including subject matter experts and those with lived experience. These materials included: a slide deck with Tutor notes, 3 30-minute online learning programmes (1 per module), and learner workbooks. In addition, the digital hub which hosted these materials enabled all Trainers to interact with each other and share learnings.

### *Cancer care pathway adaptation*

In addition to the development of the core training, MECC for Mental Health was adapted for delivery to staff in cancer care settings through a collaborative process with staff from Greater Manchester Cancer Alliance and the Christie NHS Foundation Trust. The process involved:




### *MECC for Menopause module*

In partnership with Bluesci, a local mental health promotion organisation in Greater Manchester, we developed a menopause awareness and support module using the MECC approach in response to unmet demand for training on this topic. As with MECC for Mental health, the aim of this module was to develop professionals' knowledge, skills and confidence to integrate conversations about the menopause within health services and workplaces.

During 2.5 hours of guided learning, participants are encouraged to:

1. Review their knowledge of menopause
2. Reflect on the relevance of menopause as part of their organisation's work
3. Discuss recognition of menopause and associated risks of missed diagnosis
4. Make action plans on what they can do to progress practice within their service or organisation

### Recruiting Lead Trainers and Local Trainers

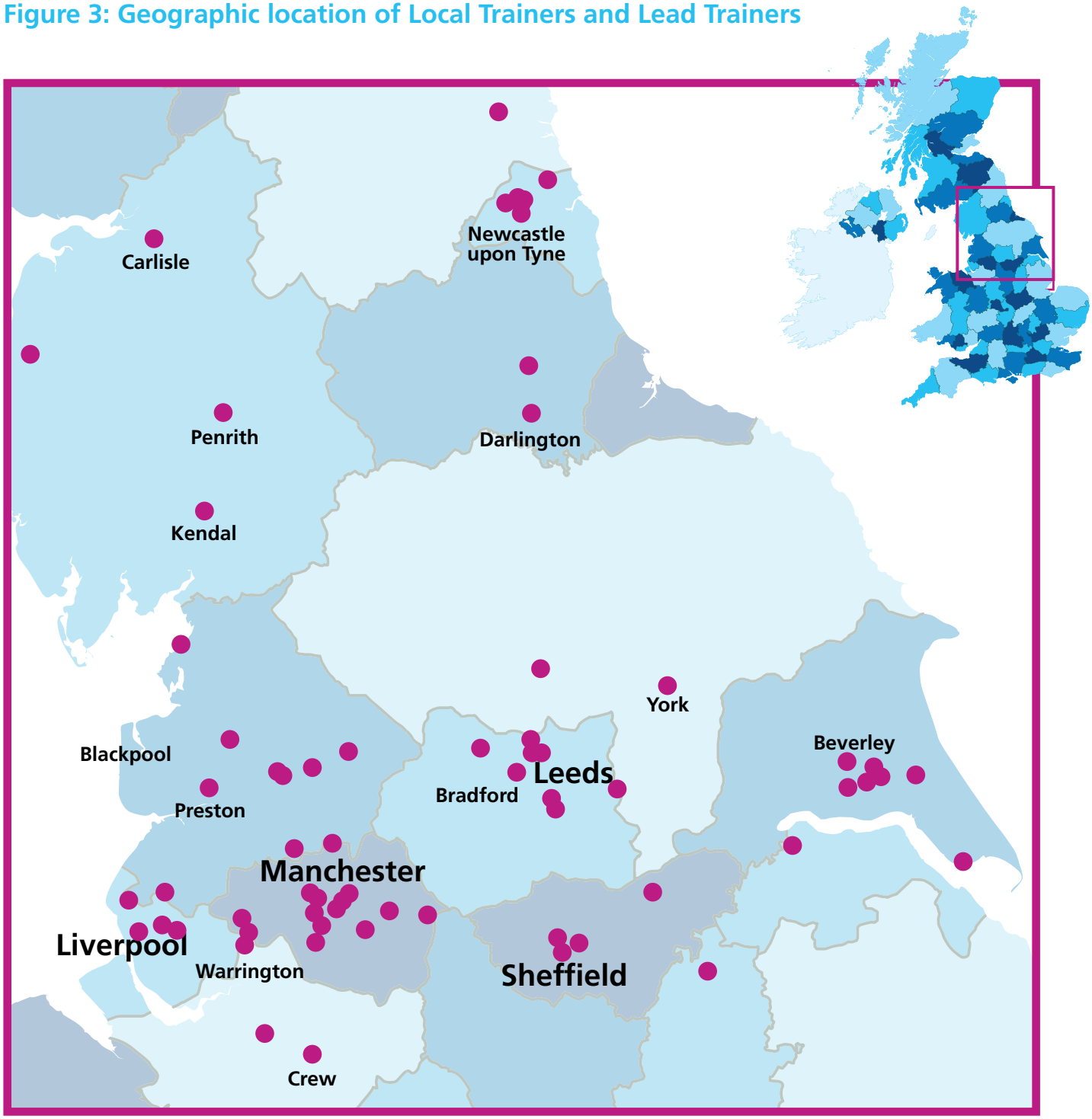
Our objective was to recruit around 2 Lead Trainers and 12 Local Trainers in each of the 7 Integrated Care System (ICS) areas of the North of England. To do so, we used a competency-based role description which was disseminated through a call for expressions of interest, targeting relevant organisations. To support and encourage individuals to apply for the role, we offered 2 years of RSPH membership at Associate grade for Local Trainers, and Member grade for Lead Trainers and provided a training grant of £1000 for organisations hosting Lead Trainers, and £200 for organisations hosting Local Trainers.

In total, 12 Lead Trainers and 100 Local Trainers from 83 organisations were recruited. These numbers are presented by ICS area and geographic location in Figures 2 and 3. A list of the organisations at which Local Trainers were employed can be found in appendix 2.

## Figure 2: Lead Trainers and Local Trainers Recruited by ICS Area

| ICS Area | Lead Trainers | Local Trainers |
|---|---|---|
| Cheshire and Merseyside | 2 | 8 |
| Greater Manchester | 2 | 20 |
| Lancashire and South Cumbria | 2 | 9 |
| North Cumbria and the North East | 2 | 29 |
| Humber, Coast and Vale | 2 | 17 |
| South Yorkshire and Bassetlaw | 0 | 6 |
| West Yorkshire and Harrogate | 2 | 11 |
| TOTAL | 12 | 100 |

## Figure 3: Geographic location of Local Trainers and Lead Trainers




**Please click here to see a map showing exact locations of all 83 organisations hosting Local Trainers and Lead Trainers.**

https://www.google.com/maps/d/u/0/viewer?mid=1GVAznf_Bpx8_IhkMGqK7N6ncjDhKcNyY&ll=55.006146284518316%2C-1.5732590265625124&z=8

**Lead Trainer case study**

Alicia Clare is Director of Bluesci Support, a community health and wellbeing service in Trafford and Lead Trainer of MECC for Mental Health programme. Alicia delivers the Train-the-Trainer programme across Greater Manchester to people who will roll out the training to a larger number of frontline staff and volunteers. As a Lead Trainer Alicia says *"the training gives you really good techniques to have conversations with people in a way they can easily understand, rather than being too clinical or medicalised. There's a lot of visual content in terms of images and diagrams, like the stress container, which can really help open the door to conversations about mental health."*

Alicia believes the MECC for Mental Health training helps both the Trainers and organisations to grow. She highlights that *"for the trainers, they've learned a whole new set of skills and they've grown in confidence. For Bluesci, as a third sector organisation, having a number of MECC for Mental Health trainers on our team means we now have a training arm to our organisation which we didn't have before. So that strengthens our position as an organisation, as well as bringing real value to the community we serve."*

## Assuring the Quality of Training

To ensure the cascade training was delivered with fidelity and consistency in terms of the content and methodology, we developed a quality assurance process which ran through the whole programme. This process was:

- **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 Theory of Change).

- **Supportive** – offering the resources and assets which Lead Trainers 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.

The mechanisms by which we quality-assured the training programme included:

- **1:1 sessions** – to make sure Lead Trainers 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 one-hour webinars designed to complement the core training and to enhance existing skills. Based on suggestions from Local Trainers, RSPH delivered 4 sessions on: equality and diversity in training, online training skills, the 3As framework, and the Five Ways to Wellbeing.

- **The MECC for Mental Health Trainer Hub** was designed to make sure all Local Trainers and Lead Trainers had access to the latest version of the materials and a wide range of relevant resources and information. This is hosted by the Futures NHS platform which is a widely available tool for the health system. This platform also provided a forum to interact with others within the MECC for Mental Health Network.

- **RSPH membership**, offered to Lead Trainers and Local 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 Lead Trainers and Local Trainers.

**Trainer case study**

GP Dr Bori Jassim from Wakefield became a MECC for Mental Health Local Trainers in order to support her organisational objectives around improving their mental health support to patients.

In describing her experience becoming a Trainer, Dr Jassim says *"I attended several sessions and workshops with our local Lead Trainer and covered the content and delivery of the 3 core modules. I got to meet other Local Trainers during the face-to-face workshops which I really enjoyed, and we made some great connections and shared invaluable experiences. We do still keep in touch and receive regular updates about training and relevant events in our community."*

Bori thinks the project has been positive for her wider development

*"The project has been very inspiring and has allowed me to develop connections locally and nationally and improve my networking. I have also become a member of the Royal Society for Public Health and have access to their resources and training."*

She adds, *"I have enjoyed the training and the delegates I delivered the training to have also found it really useful. I have also made a detailed entry to my GP e-portfolio as part of my personal development plan and quality improvement activities."*

### Fidelity Markers

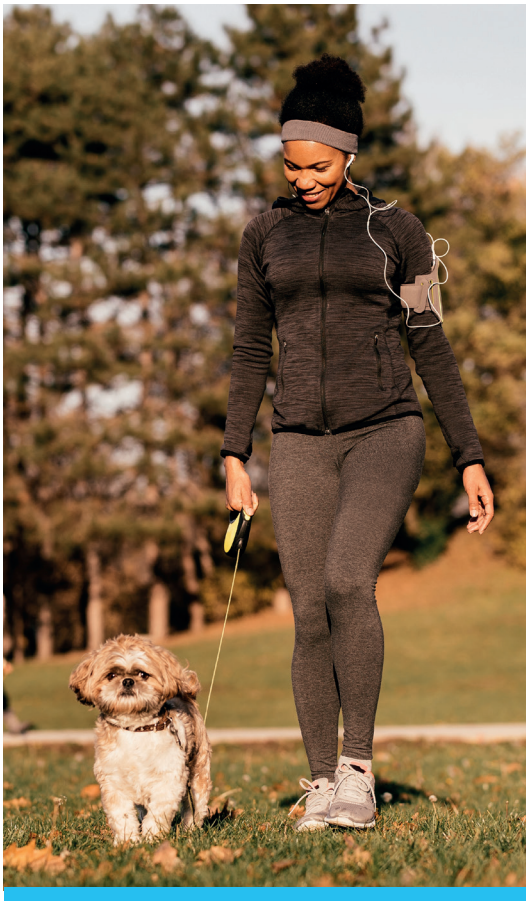
In order to ensure that the training sessions delivered were faithful to the original design, project stakeholders (including Local Trainers and Lead Trainers) identified evidence-based fidelity markers which would indicate whether the core aspects of the Theory of Change behind MECC for Mental Health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

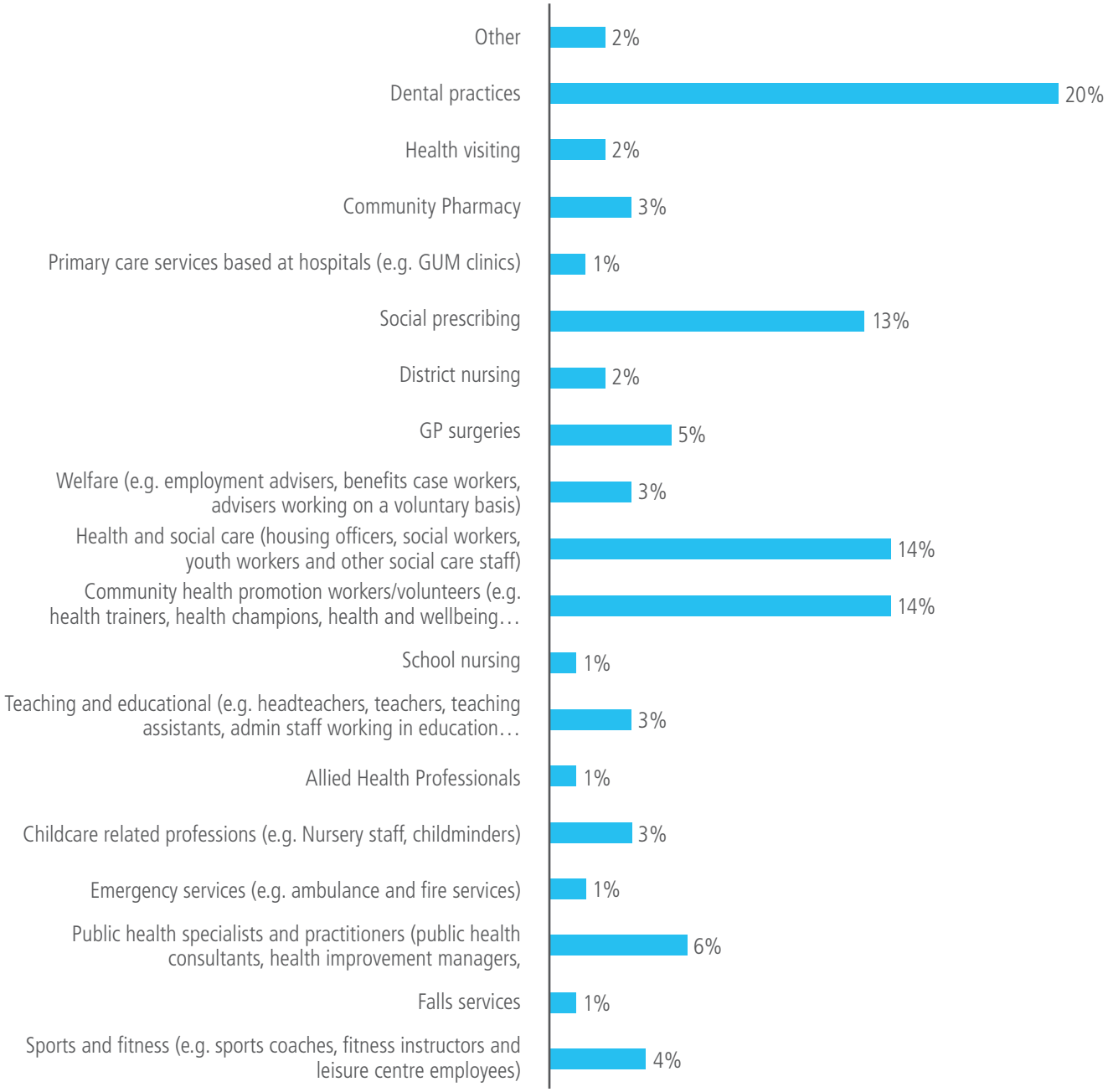
## Reach of Training

The delivery of the training to end-users began during the summer of 2021. However, due to the pressures on the health system from the Covid-19 pandemic, the momentum behind training delivery picked up noticeably from February 2022. By May 2022, 67 out of 100 Local Trainers of the project had delivered training to 1,086 end-users. The charts below show the type of services and geographic locations where end-users were based. Furthermore, several Local Trainers had bookings to deliver training by end of Summer 2022, bringing the total number of end-users for the project to 1,138.

End-users came from a wide range of settings, including primary care, public health services, community-based services, early years and education, health promotion, and welfare services.

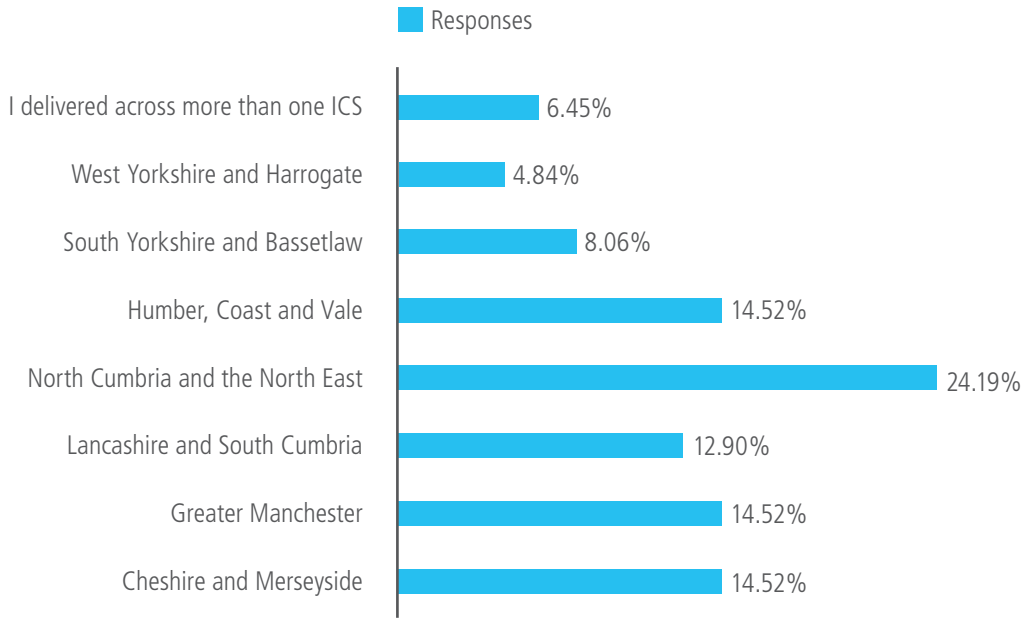


## Figure 4: Settings or services of End-users of MECC for MH training




End-users came from all 7 Integrated Care Systems in the project area, with the highest uptake from North Cumbria and the North East (25%), followed by Greater Manchester (14%), Cheshire and Merseyside (14%), and Humber Coast and Vale (14%).

## Figure 5: Integrated Care System (ICS) where End-user training was delivered




### Reach of training case study

Beverley Moorhouse is a Dental Education Programme Manager at Health Education England (HEE), leading on a mental health and resilience initiative for the dental workforce across the North-West England.

Bev and her team have delivered MECC for Mental Health to health champions in 120 dental practices across the North West.

Bev says *"The RSPH MECC for Mental Health training fits really well with all of this work and it is great to be part of the first wave of train-the-trainer sessions. I found the sessions informative and thought-provoking, and the training has given me the confidence to talk with others about mental health. This programme will definitely have an impact on the dental workforce, as we have identified there is a huge need for mental health support for staff, their relatives, and patients. It will help staff to identify when support is needed and […] to make having conversations around mental health and wellbeing easier and help to lift the stigma of discussing mental health."*

# Evaluation

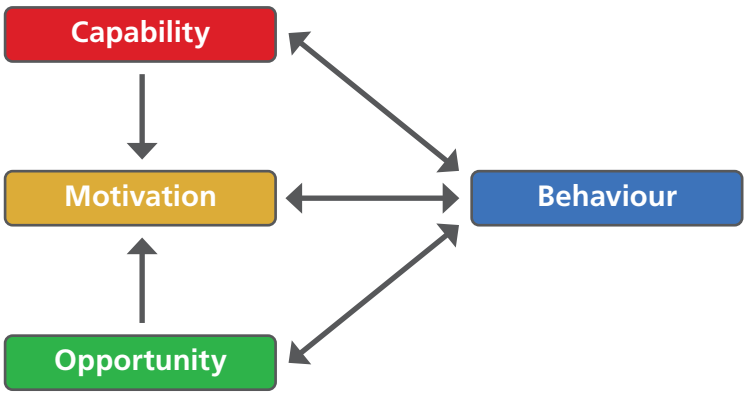
MECC for Mental Health was independently evaluated by behavioural scientists Professor Lucie Byrne-Davis and Professor Jo Hart with the support of Dr Nia Coupe, Natalie Carr, and Rosie Horton from MISC Training Consultancy. MISC's expertise lies in using psychological theory, specifically behaviour change frameworks, to assure and evaluate the effectiveness of education and training. To evaluate the MECC for Mental Health training, they used both quantitative and qualitative means of collecting data, including interviews, focus groups, observation, and questionnaires. Over 450 people involved in delivering and receiving the training participated in the evaluation of MECC for Mental Health.

## The evaluation framework

The evaluation framework for MECC for Mental Health is based on a wide range of behavioural theories, summarised by the COM-B Model.

According to the COM-B model, the influences on someone's behaviour can be understood under the umbrella terms of capability, opportunity and motivation. Capability refers to knowing how and what to do and having the 'head space' to do the behaviour. Opportunity refers to having both the physical opportunity (like time and equipment) and social opportunity (believing that other people accept or support the behaviour). Motivation is 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.

## Figure 6: The COM-B Framework




Source: The behaviour change wheel: A new method for characterising and designing behaviour change interventions (Susan Michie M. M., 2011)

This evaluation is based on the Theory of Change (Figure 1) which was developed by the project delivery team, MISC and project stakeholders. This theory of change suggests that, if the training were effective, end-users would, as a result, be:

a) Having conversations with people about their mental wellbeing

b) Referring people for more support for their mental wellbeing

To understand the typical behaviour of end-users, and any changes after the MECC for Mental Health training, the evaluators asked whether end-users expected to, as part of their routine practice, a) have conversations with people about their mental wellbeing and b) refer people for more support for their mental wellbeing. This was asked before and after the training, and at the follow-up. The evaluators also asked end-users, before the training and at the follow-up, to estimate how many times they engaged in these behaviours, compared to the numbers of patients or service-users they saw.

In line with the COM-B Framework, the evaluators sought to understand the capability, opportunity and motivation of the end-users to engage in these behaviours and whether these also changed after the training course.

The evaluators were also interested in the fidelity of the training delivered by MECC for Mental Health Local Trainers, and so end-users were asked whether their Trainers used the key behaviours of transformational educators.

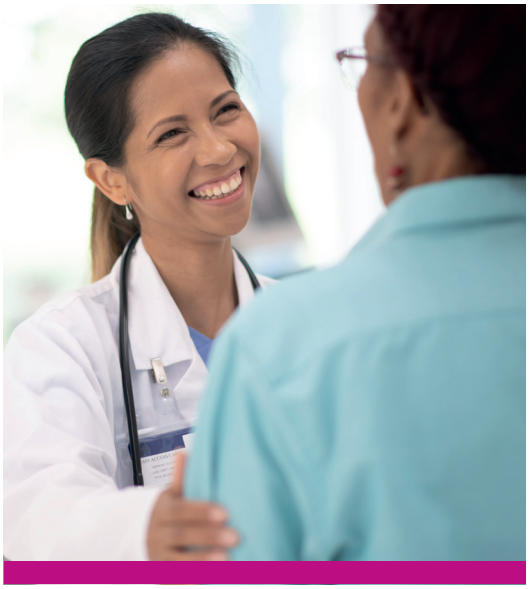
## What did people think and feel before the course began? Baseline data[3] (N=416)

### Support from Managers

Management support is a form of social opportunity, as defined in the COM-B model, and is an important influence on behaviour. Therefore, to assess how effectively the MECC for Mental Health training would be applied in practice, it was important to explore how supported end-users felt by their managers:

- 79% agreed that their manager supported them in having conversations about mental health.
- 88% agreed or strongly agreed that their manager supported them being trained in MECC for Mental Health.

Since role modelling is an important way that people learn in work organisations (Bandura, 1977), using a 10-point scale (where 0 is strongly disagree and 10 strongly agree) the evaluators asked end-users to what extent their manager talks to other people about their mental health. 78% of trainees agreed that their manager has conversations with colleagues about their mental wellbeing.

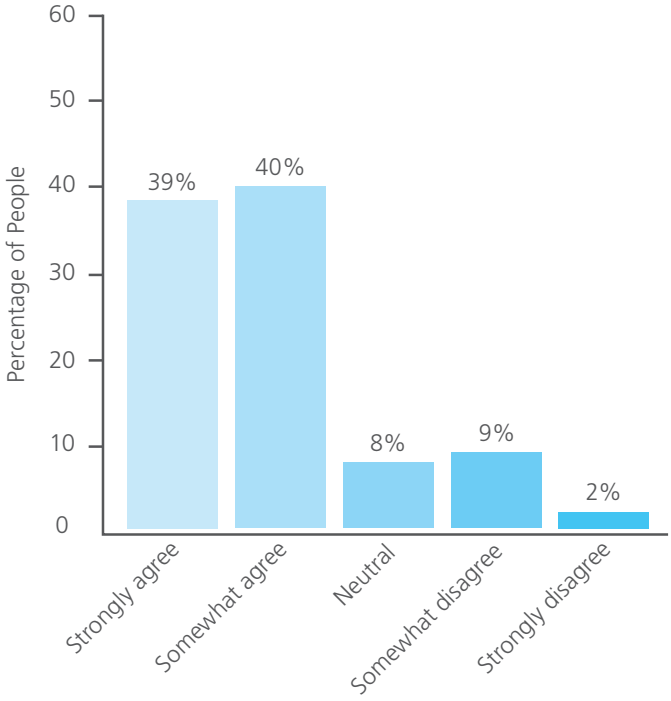


[3] The baseline data is based on 416 participants who submitted the baseline questionnaires.

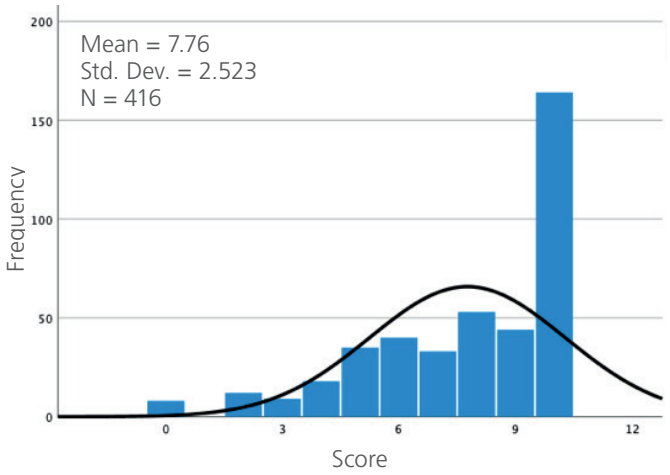
## Figure 7: Managers' support for having conversations about mental wellbeing

### Data

**My manager supports me having conversations about mental wellbeing**

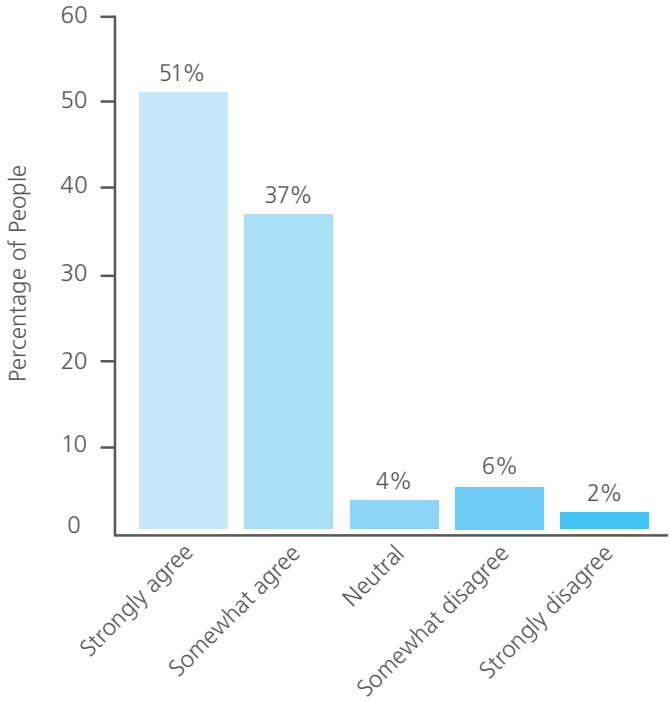



**My manager supports me having conversations about mental wellbeing**

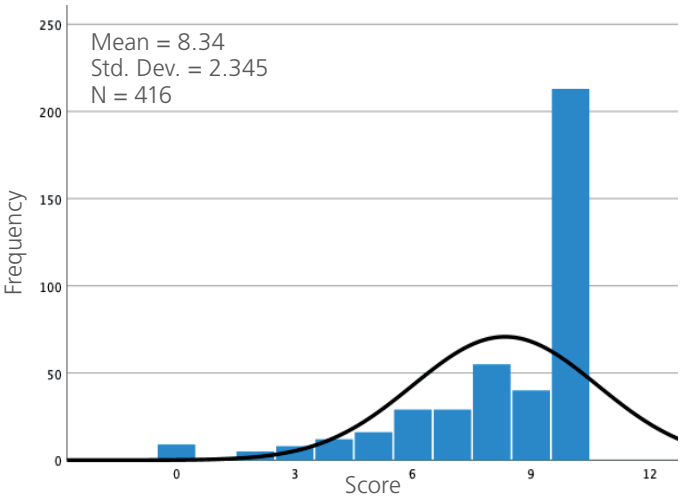



## Figure 8: Managers' support for being trained to have conversations about mental wellbeing

**My manager supports me being trained to have conversations about mental wellbeing**

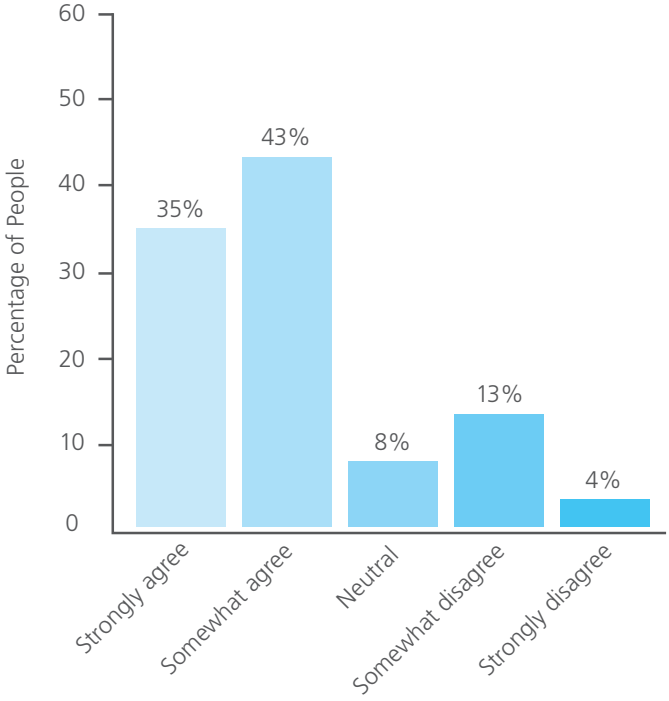



**My manager supports me being trained to have conversations about mental wellbeing**

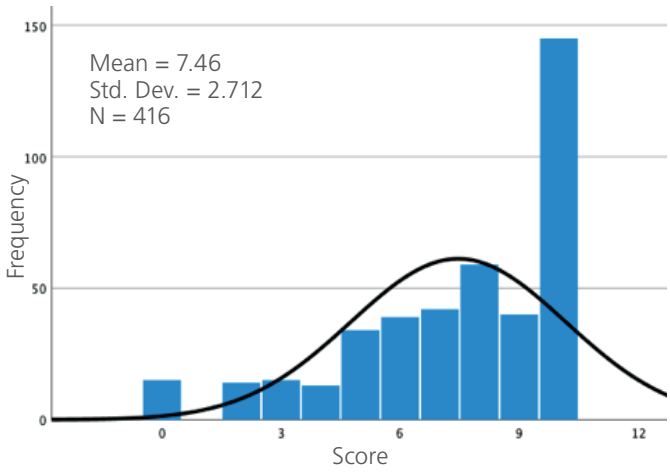


## Figure 9: Manager conversations with participants about their mental wellbeing

**My manager has conversations about mental wellbeing with me and other colleagues**




**My manager has conversations about mental wellbeing with me and other colleagues (e.g., in team meetings, in appraisals, in policy documents etc.)**




**Usual levels of conversations and referrals for mental health support**

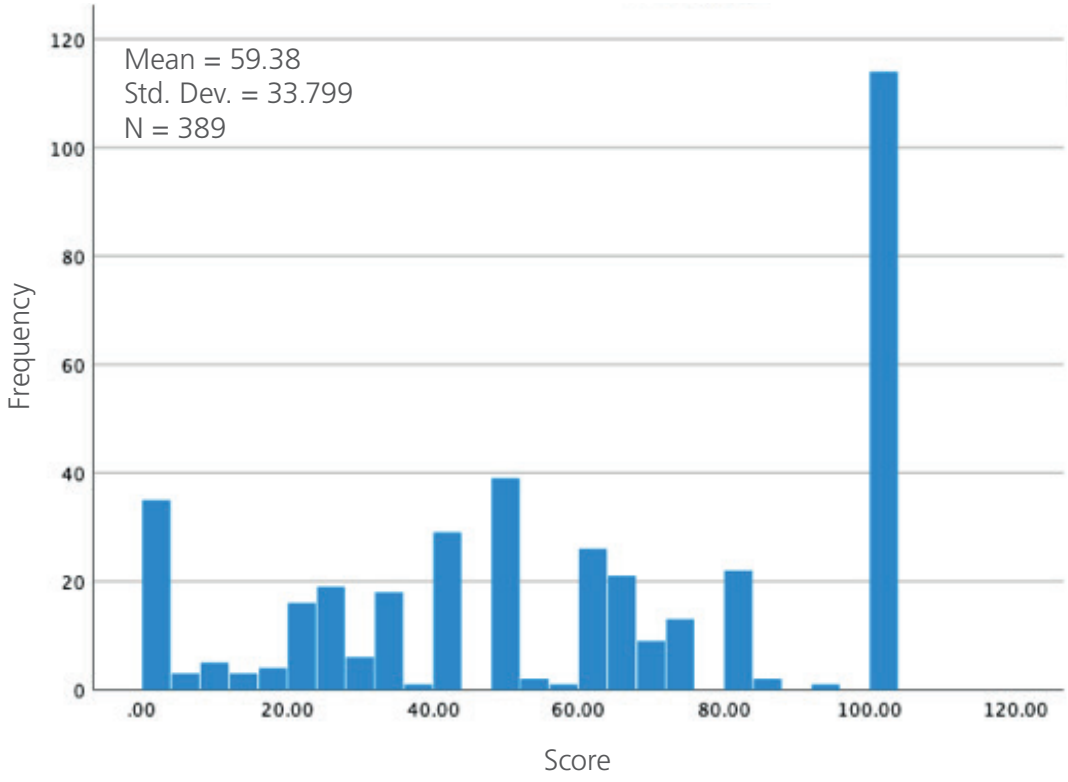
416 participants were asked how many people they had encountered in the last 2 weeks who could have benefited from a conversation about their mental health and wellbeing. The majority (87%) identified between 0 and 20 people and 6% (24) reported that they saw no one who would have benefited from such a conversation. There were 4 outliers, who gave estimates of between 100 and 1,600. With those outliers removed, the mean number was 12 (standard deviation of 12.3).

After answering how many people they had encountered in the last 2 weeks who could have benefited from a conversation about their mental health and wellbeing, participants were asked with how many of those people they had had such a conversation. Removing those whose responses were invalid[4], the proportion ranged from 9% (34/389) who did not have any conversations about mental health and wellbeing to 30% (114/389) who said they had such conversations with everyone who they identified as people who would benefit from talking about their mental health and wellbeing.

When asked how many, of the people they identified as standing to benefit from a conversation about mental health, had participants referred for further support, the proportion ranged from 50% (197/390) who had not made any referrals to 4% (16/390) who had referred everyone they identified as someone who would benefit from a conversation about mental health and wellbeing.

## Figure 10: How many people of those who training participants had decided would have benefited from a conversation about mental health, had had such a conversation

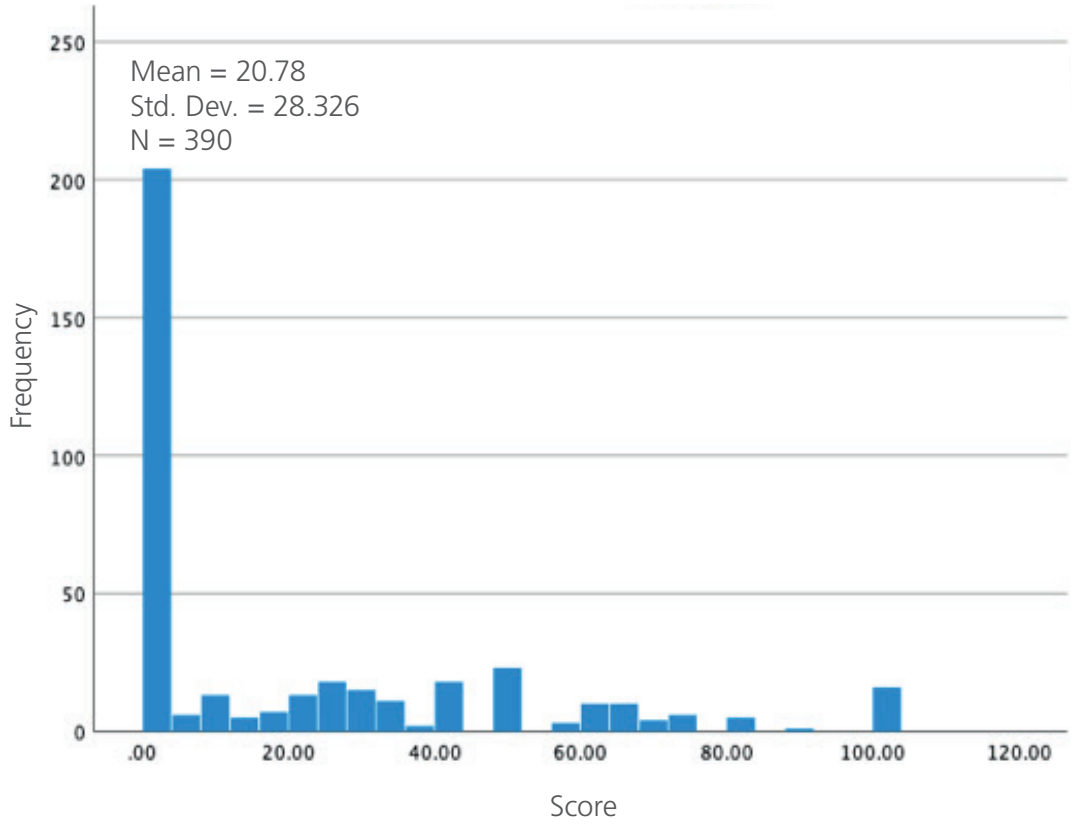
### Histogram




[4] 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,

## Figure 11: How many people of those who training participants thought would have benefited from a conversation about mental health they had referred them for further support

### Histogram




### What happened in the course?

**Behaviour change techniques and their behavioural influence(s) targeted**

Behaviour change techniques (BCTs) are the active ingredients in any training or intervention that aims to change how people practice. There are 93 discrete behaviour change techniques in the Behaviour Change Technique Taxonomy (BCTTv1) (Susan Michie M. R., 2013). Just under 50 of these are, or can be, used in education and training for healthcare professionals. Behaviour change techniques theoretically target specific influences on behaviour. For example, instruction on how to perform the behaviour will influence a person's capability.

The evaluators annotated each of the behaviour change techniques found in MECC for Mental Health training to illustrate theoretically the extent to which the techniques were addressing capability, opportunity or motivation. The evaluators coded the behaviour change techniques observed, and detailed where these were almost present: "near misses". These "near misses" represent an opportunity for the behaviour change techniques to be added in their entirety, with just a small change to how they are delivered.

Observations:

module 1 n=4 (plus 1 pilot)
module 2 n=4 (plus 1 pilot)
module 3 n=3 (plus pilot)
Train-the-Trainer – n=1 x all 3 modules

Across the 12 sessions, 13 BCTs were observed (see figure 12 for details). The most frequent BCT observed was 'instructions on how to perform the behaviour'. Across the sessions, 9 different BCTs were missed across the sessions. The most common of these was action planning. From the total number of observed BCTs (148), over half (53%) targeted capability, 39% (57) targeted motivation and 11% (16) targeted opportunity.

## Figure 12: Behaviour change techniques observed, observed as 'near misses' and theoretically related to behavioural influences

| Behaviour change technique | Observed | Near Misses | TOTAL | Addressing C, O or M? |
|---|---|---|---|---|
| Instruction on how to perform the behaviour | 51 | 13 | 64 | C |
| Information about health consequences | 16 | 3 | 19 | M |
| Information about social and environmental consequences | 14 | 0 | 15 | M |
| Problem solving | 12 | 7 | 19 | O |
| Demonstration of the behaviour | 13 | 0 | 15 | C |
| Behavioural practice/rehearsal | 11 | 17 | 28 | C |
| Information about emotional consequences | 9 | 0 | 9 | M |
| Goal setting (behaviour) | 5 | 5 | 10 | M |
| Action planning | 5 | 34 | 39 | M |
| Feedback on behaviour | 4 | 0 | 4 | C M |
| Social support | 4 | 2 | 6 | O |
| Information about antecedents | 3 | 0 | 3 | M |
| Comparative imagining of future outcomes | 1 | 0 | 1 | M |
| Goal setting (outcome) | 0 | 3 | 3 | M |
| Problem solving | 0 | 3 | 3 | O |

Each module was observed 3 or 4 times. In those sessions, Local Trainers were observed using different numbers of BCTs, with an average of between 13 to 20 per module (see figure 13).

## Figure 13: Range and mean of numbers of behaviour change techniques used per module.

| BCTs per session (11 sessions not including Train-the-Trainer) | Range | Mean |
|---|---|---|
| Session 1 | 6-36 | 20 |
| Session 2 | 8-20 | 13 |
| Session 3 | 15-20 | 18 |

**Behaviours identified by Local Trainers**

Local Trainers explained and demonstrated 30 types of behaviours in relation to MECC for Mental Health during their training. The most frequent behaviours identified were putting the 3As (Ask, Assist, Act) into practice, avoiding stigmatising language, responding to a mental health emergency, and asking people twice if they are OK (see figure 14).

## Figure 14: Behaviours identified by Local Trainers and frequency with which these were identified

| Behaviour | Frequency |
|---|---|
| 1. Implementing/Putting 3As into practice | 18 |
| 2. Avoid stigmatising language | 15 |
| 3. Respond to mental health emergency | 14 |
| 4. Ask people twice if they are OK | 14 |
| 5. Generate list of local support pathways | 11 |
| 6. Asking patients/service users about their mental health | 10 |
| 7. Use MH continuum to understand patient's status | 8 |
| 8. Identify/explore antecedents and healthier coping strategies | 7 |
| 9. Improving patients' access to healthcare | 6 |
| 10. Stress container homework | 5 |
| 11. Participants to download/utilise MECC Link | 5 |
| 12. Understanding the importance of helpful coping strategies | 4 |
| 13. Use reflective listening | 4 |
| 14. Spend time reviewing activity | 3 |
| 15. Applying MECC in practice | 3 |
| 16. Avoid stigmatising language in practice | 3 |
| 17. Use Check, Chunk, Check and Teach Back techniques | 3 |
| 18. Improve access to health information | 2 |
| 19. Avoid stigmatising language and ask patients about their mental health | 2 |
| 20. Develop understanding of antecedents | 2 |
| 21. Provide clear information and ensure patient/service users have understood correctly | 2 |
| 22. Sharing resources with patients/service users | 2 |
| 23. Asking more open questions | 1 |
| 24. Balancing physical and mental health | 1 |
| 25. Completion of activity 4 | 1 |
| 26. How to create a safe environment for patients | 1 |
| 27. Identify personal 5 ways to wellbeing | 1 |
| 28. Sharing stories without breaking any confidentiality/ respect for others | 1 |
| 29. To discuss stigma/language matters when delivering training session | 1 |
| 30. Use person centred approach in practice | 1 |

## What changed during the course?

### Changes in influences on behaviour from pre to post course (N=162)

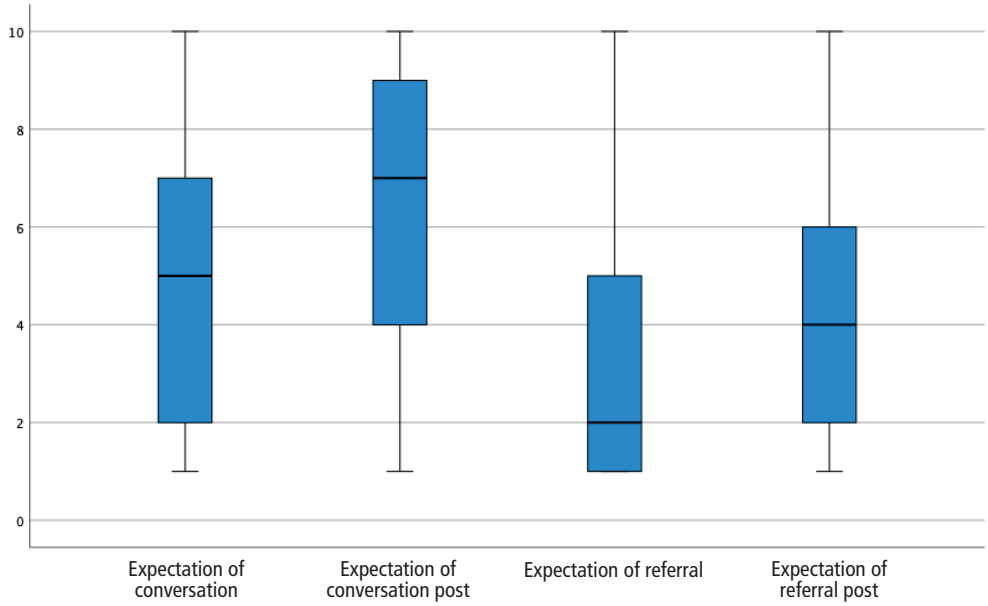
The outcomes data presented here is based on 162 participants for whom the evaluators had full pre- and post-training data that could be matched via their ID and / or IP address.

### Behavioural expectations

Behavioural expectations of having conversations about mental health and wellbeing changed significantly from a median of 5 out of 10 (interquartile range of 2 to 7) before the training to a median of 7 out of 10 (interquartile range of 4 to 9) after the training.

Behavioural expectations of referring people to further support for their mental health and wellbeing changed significantly from a median of 2 out of 10 (interquartile range of 1 to 5) before the training to a median of 4 out of 10 (interquartile range of 2 to 6) after the training.

## Figure 15: Box plot showing behavioural expectations for having a conversation and referring for support pre and post course.

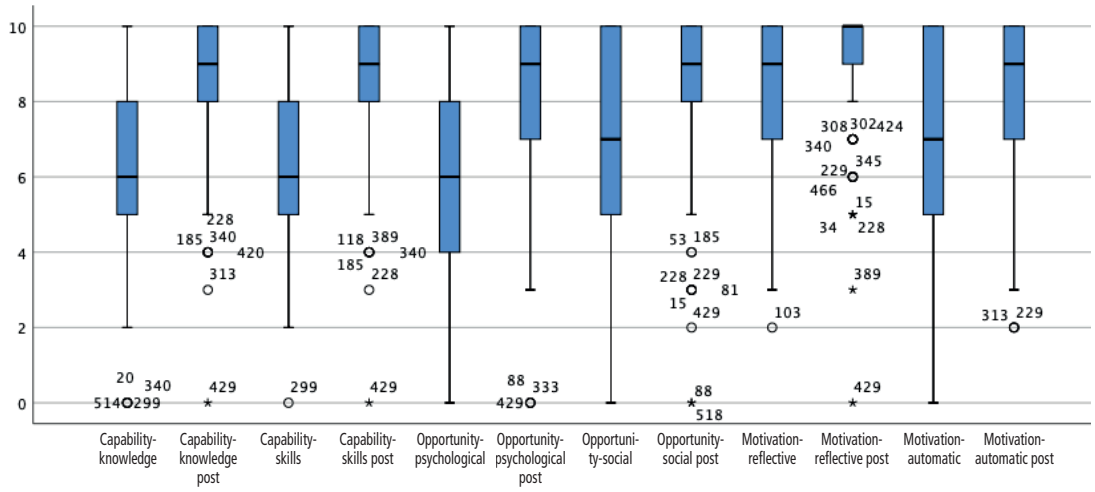



## Behavioural influences

The evaluators assessed change in the influences (capability, opportunity and motivation) on the behaviour of having conversations about mental health and wellbeing and the behaviour of referring for support.

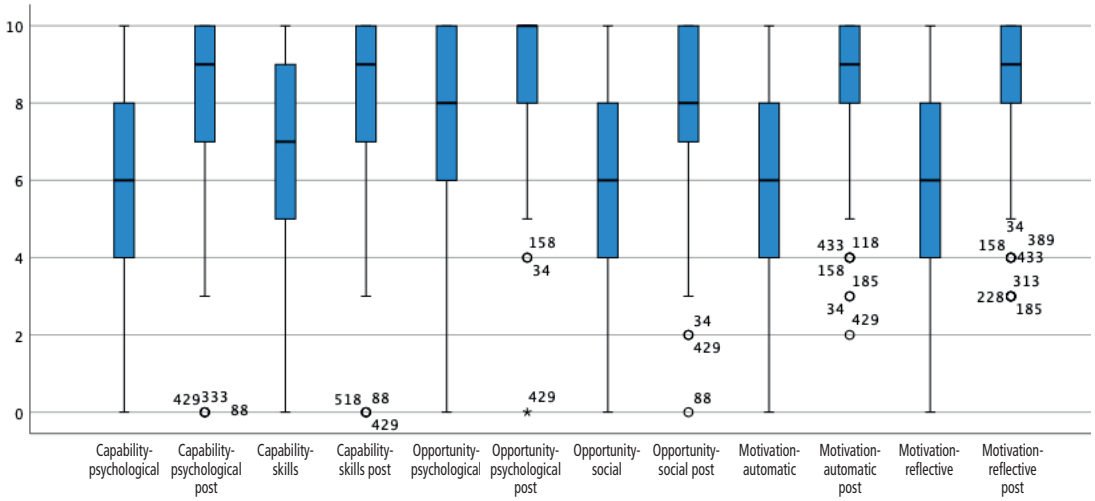
Compared to before the training, participants' capability, opportunity and motivation to have conversations about mental health increased after the training. These differences were all statistically significant (Wilcoxon Signed Ranks Test range from -8.672 to -3.785, all $p<.001$). The mean magnitude of change in scores from pre- to post- training was greater than 2 points for physical opportunity (time) and psychological capability. This suggests that the trained shifted participants' perceptions about the time they had to have conversations about mental wellbeing, and their ability to do so. The smallest mean change was for reflective motivation, but this is likely the result of a ceiling effect – people attended the training because they were already motivated to have conversations with people about their mental health and wellbeing.

## Figure 16: Box plot showing capability, opportunity and motivation for having conversations about mental wellbeing pre and post course




The capability, opportunity and motivation of the trainees to refer patients for further support also increased. These differences were all statistically significant (Wilcoxon Signed Ranks Test range from -9.313 to -6.683, all p<.001).

## Figure 17: Box plot showing capability, opportunity and motivation for referring for support pre and post course



## What is happening to people's routine practice after having received the training?

**Behaviours at follow-up (N=68)**

At the follow-up point of the evaluation, between 4 to 6 weeks after their training, participants were asked which of the MECC for Mental Health behaviours they were doing. The most common, reported by almost all of the 68 respondents, were: listening reflectively and responding empathetically. The least common were: using the technique 'teach back' and discussing Five Ways to Wellbeing - less than 40% of participants said they had been doing these.

## Figure 18: Participants reports of behaviours used at follow up

| Behaviour | Number (/68) | % |
|---|---|---|
| Using the communication technique: check, chunk and check | 39 | 57% |
| Using the communication technique: teach back | 25 | 37% |
| Using communication appropriate to the health literacy of the person | 48 | 71% |
| Using language that was not stigmatising | 51 | 75% |
| Listening reflectively | 66 | 97% |
| Responding empathetically | 64 | 94% |
| Discussing Five Ways to Wellbeing | 27 | 40% |
| Asking twice | 59 | 87% |
| Using open questions | 61 | 90% |
| Signposting | 59 | 87% |

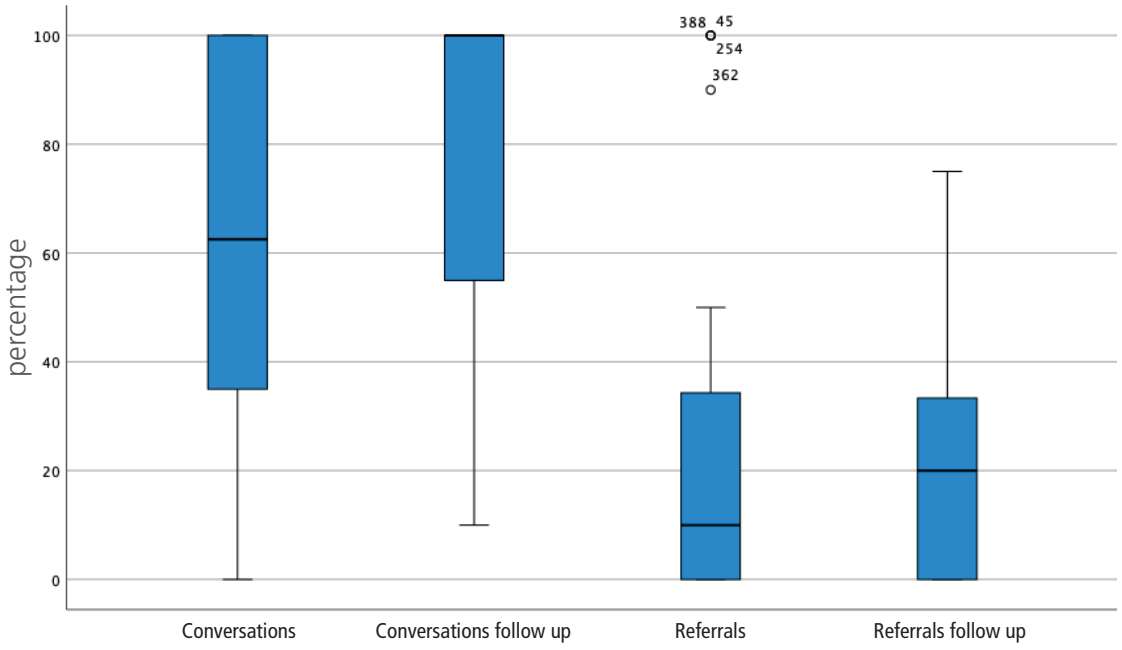
**Changes in behaviour from before the training to follow-up (N=31)**

The outcomes data presented here is based on 31 participants for whom the evaluators had full data from before the training and follow-up that could be matched via their ID and / or IP address.

The proportion of participants who spoke to the patients or service-users they identified as needing support with their mental health and wellbeing increased from a median of 60% (interquartile range of 33 to 100) before the training to a median of 100 (interquartile range of 52 to 100) at follow-up. This change was statistically significant (Wilcoxon Signed Ranks Test: z=-3.078, p<0.01). Over half (58%) of the participants increased the number of conversations they had about mental health and wellbeing; around a third (32%) had the same number of conversations after the training as they had before; and 3 participants (10%) had fewer conversations about mental health and wellbeing.

The median percentage of service-users or patients who participants referred for further support increased from a median of 0% (interquartile range of 0 to 35) to a median of 18% (interquartile range of 0 to 45). However, this change was not statistically significant. 9 participants (29%) made referrals to a greater proportion of people they identified as needing support with their mental health, while another 9 (29%) made fewer referrals. 13 participants (42%) said they referred the same number of patients or service-users to further mental health support as they had done before the training.

## Figure 19: Box plot showing increases on the number of conversations and referrals participants had at follow-up, compared to before the training



## Fidelity to MECC for Mental Health (N= 308)

As explained in the quality assurance section of this report, the training has a set of 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.

The data presented here comes from the questionnaires administered after the training. Participants were asked a series of questions about what their Trainer did, with their responses being structured on a Likert scale from 'Strongly Agree' to 'Strongly Disagree'.

The median score for each of the educator behaviours was 10 out of 10, with very little variation across the Local Trainers. Except for some outliers, it was very clear that the Local Trainers were behaving as transformational, active learning educators.

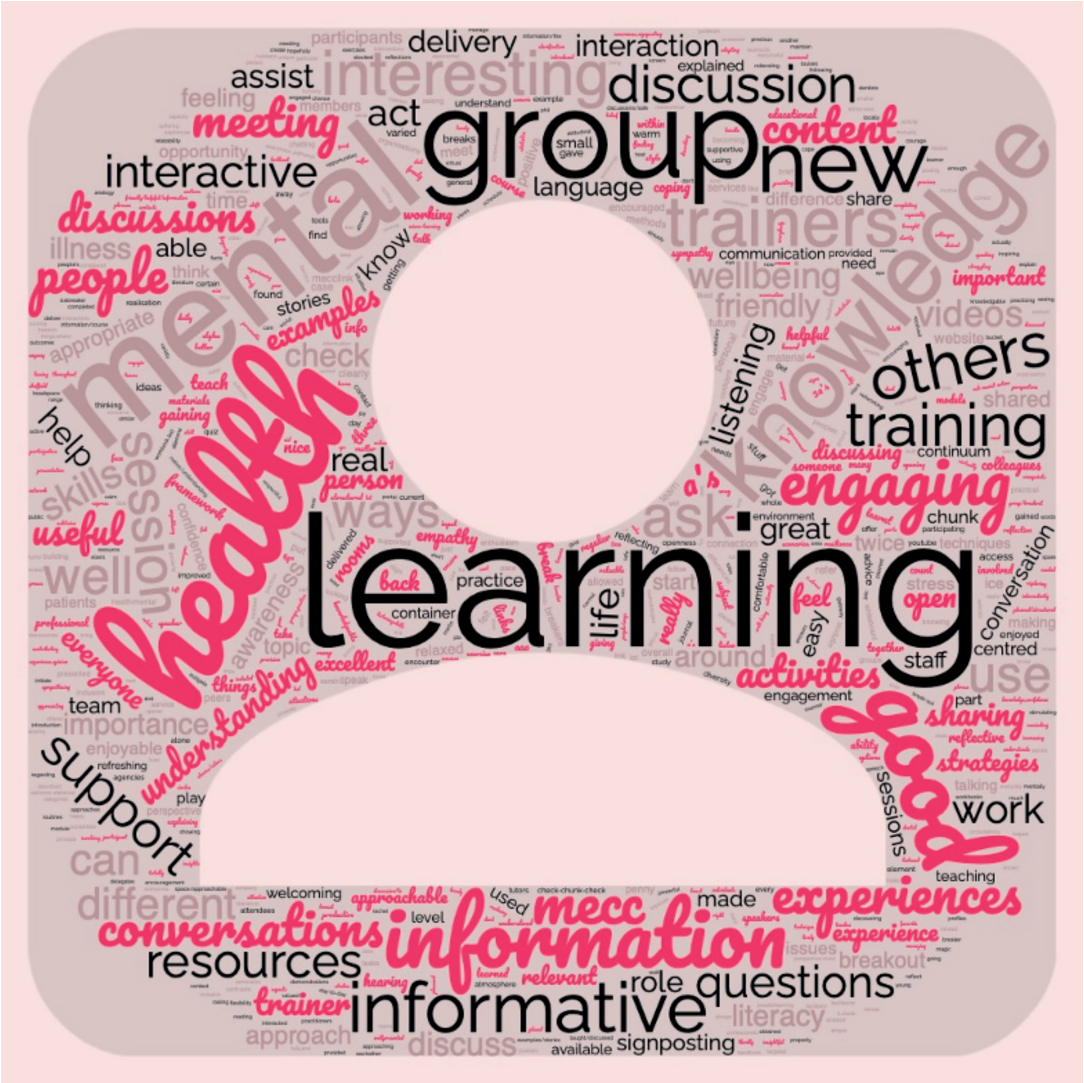
## Figure 20: Table showing participants' perceptions of their Trainer's adherence to the MECC for Mental Health fidelity markers

| | | Trainer Described Context | Trainer Asked Expectations | Trainer Told Stories | Trainer Monitored Us | Trainer Encouraged Discussion | Trainer Encouraged Own Experience | Trainer Encouraged Feed | Trainer Encouraged Reflect | Trainer Pos Questions | Trainer Praised | Trainer Showed Important | Trainer Showed Self | Trainer Encouraged Needs | Trainer Welcomed | Trainer Fun |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| N | Valid | 307 | 307 | 307 | 307 | 307 | 308 | 307 | 307 | 307 | 307 | 307 | 308 | 307 | 308 | 308 |
| | Missing | 1 | 1 | 1 | 1 | 1 | 0 | 1 | 1 | 1 | 1 | 1 | 0 | 1 | 0 | 0 |
| Percentiles | 25 | 9.00 | 8.00 | 9.00 | 9.00 | 9.00 | 9.00 | 10.00 | 9.00 | 10.00 | 10.00 | 9.00 | 9.00 | 9.00 | 10.00 | 9.25 |
| | 50 | 10.00 | 10.00 | 10.00 | 10.00 | 10.00 | 10.00 | 10.00 | 10.00 | 10.00 | 10.00 | 10.00 | 10.00 | 10.00 | 10.00 | 10.00 |
| | 75 | 10.00 | 10.00 | 10.00 | 10.00 | 10.00 | 10.00 | 10.00 | 10.00 | 10.00 | 10.00 | 10.00 | 10.00 | 10.00 | 10.00 | 10.00 |

### Highlights and suggestions

Trainees were asked for 3 highlights from their experience of the MECC for Mental Health training. These were combined to make the word cloud below.

## Figure 21: Word cloud showing highlights of training as reported by trainees




When asked to provide recommendations for improvement, 175 participants said that they had no recommendations because of the high quality of the programme, 2 comments are representative of this group: "I would recommend this training to any of our partnerships/colleagues/friends/family/young people" and "very good training, right level of repetition to encourage the subject matter to be retained but prevent boredom".

55 participants did make recommendations, which fell into the following themes:

- A desire for the training to be face-to-face
- Specific details for how the online training could be improved e.g. everyone putting cameras on, having facilitators in break-out rooms.
- Longer or shorter training sessions

## A thematic analysis of interviews

The evaluators conducted 30 interviews (12 at baseline and 18 at follow-up) with stakeholders, Lead Trainers, Local Trainers and participants. The evaluators also conducted 1 focus group at the follow-up stage with Lead Trainers and stakeholders who were identified as having made the Train-the-Trainer programme work well.

The baseline interviews were conducted with employers and Lead Trainers - they were asked questions about the readiness of the organisations and expectations about the training. The follow-up interviews were held with end-users of the training and 11 Local Trainers. To ensure that a wide range of perspectives were explored, interview participants were assigned a random order and approached to participate accordingly.

The interviews were audio-recorded, transcribed and then checked to ensure that the transcriptions were accurate. The data was then thematically coded, and the following themes were identified.

The quotations used in this section have been extracted word-for-word from the interview's transcriptions with the aim of illustrating people's perspectives and their voice regarding a particular theme.

**Theme 1: Filling a gap for all**

Participants reflected that there were a number of mental health training packages, some of which they had been involved in before, but that MECC for Mental Health was unique in being suitable for all staff, and providing a joined-up approach.

> *"So I've done quite a bit of work around Mental Health previously, but there's always been a gap. So MECC for mental health offers us the opportunity to plug that gap if you like. So it's very much looking at the health and wellbeing of our teams, and how they develop clinical supervision and review of work that they carry out. And also self-resilience. And in addition to that, how they, in effect, make every contact help with customers."*
>
> *"This is amazing. This is going to be a really important offer for people to feel more confident in talking to individuals who might be desperate […] because sometimes staff can feel, and volunteers for that matter, can feel a little bit out of their depth in how to have that conversation for fear of making it worse. So it was definitely something that we felt was needed. So when I came across the MECC training, and it was like, Oh, that's it in a nutshell, it's a really comprehensive package and covers all of the things that staff and volunteers have said, would help them. Definitely".*

Participants felt it would be accessible for many groups of professionals and across the health and social care workforce. They could see also the benefits for personal networks.

> *"Mental health belongs to everybody. So in my kind of communications that I have, and you know, I'll be running a session for a group of professionals. But they'll say that'll be really good for my mum, that'd be really good for such and such. So it's not just about kind of the patient and the professional, it's about, like, kind of everybody having a stake in that, you know, and breaking down some of those kinds of other, then like, barriers, I think really, yeah. So we can impact the kind of wider social circle around the patient as well".*
>
> *"So for me, that's what MECC is, is it's kind of that bridge between somebody saying, 'I'm lonely', and somebody saying, 'Oh, well, this is a really good service', or 'this is a really good group, why not try this?'. And it's that link in the chain really. So as well as everyone just feeling better able just to have chats and better able to have conversations and not be frightened of having those conversations because they don't know what to do. If somebody says I'm struggling, so it's, I guess it's, for me, it's levelling up everybody around mental health and well-being".*
>
> *"It's been fantastic. But what I have always tried to do is take it away from a workplace environment, and focus that conversation on how they would like to be spoken to if they were in that situation, how they would speak to a friend or family member. And then from that point, extend it out further".*

**Theme 2: The quality and flexibility of the training**

Participants had many positive things to say about MECC for Mental Health, particularly referring to how the initial training was delivered. Those who went on to become Local Trainers received the content first as participants, and this was a widely valued feature as it gave them a better understanding of how they should deliver it themselves.

> *"The actual delivery of the training was really good as well. And it's pretty excellent, because I learned quite a lot from it, you know, in terms of just speaking to patients about it and guiding them".*

Local Trainers described receiving positive feedback from their sessions and that they found delivering the training to be an interesting experience which was of value to their own areas of work.

> *"The verbal feedback has been very encouraging. It's something that I would like to continue developing".*
>
> *"It's been one of my favourite trainings, because it's been so flexible as well, that's the thing about it. So work with all those sectors who make it bespoke. And you can change and insert those case studies to make it really work for each of those people who come on board".*
>
> *"So it's tailored to what people need and the way that they need it as well, not just content, but the way in which you package that up at the end".*

Most of the participants had positive things to say regarding the training content and materials, with many commenting on its comprehensiveness. Many commented on the practicality of the training, particularly how encouraging the group to share experiences with one another builds the foundations of the future conversations within the training.

> *"Resources do have a very comprehensive amount of info which fully filled the 3 hours."; "the practical side of it was really good"; "I think what it's done is broaden my scope, about mental health, some of the exercises"*

Timing was a contributory factor to the ease of facilitating the training, with many participants mentioning that there was a lot of content to cover within the allocated time. Several stated that it may be easier to conduct the training in a 1 day session rather than over 3 3-hour sessions, or potentially longer sessions;

> *"I've done it over a full day rather than 3 of 3 hours."*
>
> *"Because I've done other training programmes where it's seen as quite fixed and set in a way and you're not allowed to change anything. And it's all copyrighted. It's very difficult to deliver somebody else's slides when you're not allowed to adapt it. And I don't think some, you know, a lot of organisations would take that into consideration. Whereas here, you know, the flexibility, which I think most of you have said, is just amazing, and the feedback, they genuinely welcome feedback so that they know what you know that people can do things in a unique way without losing the quality. And there's something about the trust of the trainers, that we are living and breathing it and passionate about it, that there's that trust in us to deliver it at a quality and I think that is always well, well received."*

**Theme 3: Sustainability and impact of MECC for Mental Health**

Participants were proactive in commenting on how the MECC for Mental Health training would add value to their service and how it could be built on in the future.

> *"We have had staff and patients that have been at crisis point. And they've been able to feel comfortable to be able to use […] signposting".*
>
> *"But when you've got a framework in a training programme, like this, which is so accessible, it makes it so much easier. And it's so you know, having that credibility of this is the framework in which you can start having those conversations that has really helped."*
>
> *"By doing the MECC for Mental Health, we hopefully make the services easy to access, rather than those communities being seen as hard to reach"*
>
> *"I just think it's so important that everybody has the opportunity to feel confident in having those conversations and those discussions, and it becomes quite a normal way of life, you know, that you can be talking about MECC with the family members, you know, so that there's an understanding of how you have those conversations, and it becomes the everyday conversation rather than something that's got to be seen as specialist".*
>
> *"And I think as well, it's about that commitment and freeing up people's time who are already trained, so we don't lose that resource. You know, where people have been trained, and then don't use it, you know, there's just the danger, that that can then get lost. So we've set up a network so that we can support each other and keep each other up to date with resources and information, which is really helpful because the Royal Society for Public Health, they've set up the hub so we've got access to resources and connections that we've made to the training. So there's an opportunity there to keep that momentum going".*

It was expressed in several interviews that there should be "more opportunities in the NHS to have the training" as it was relevant to all areas due to the universal nature of mental health conversations. Others hoped that the training would be made available more widely, not just for healthcare professionals, as the conversations outlined in the training have scope to be used in all settings:

> *"I think, I know it's funded by Health Education England, and it's specific to a group of colleagues. But I think it's got potential for being […] really spread out. It will be a good investment, I think".*

Participants also had ideas about what could make the MECC for Mental Health training successful and sustainable.

*"It would be something that would be able to be built into those bids that I think that would be able to either say, all of our staff are trained in this kind of work, and we might look for funding that would you know, sort of embed that work even more to give us that chance to get that funding to work with those communities".*

*"You know, show that there is a difference, then it will be successful".*

*"Mostly to work with the most vulnerable marginalised communities, so mostly voluntary community sector and those people who would have the reach into those communities. So that's where we started off, trying to support those and to make sure that they got all of the latest information, and knew how to have a MECC conversation, doing their everyday bits and pieces".*

*"Hopefully will help people, you know, be healthier and happier".*

*"it's a good ideology behind it: it's changing the behaviour of people to help each other, how to utilise other people's emotional support […] the peer support is very, very important and MECC is embedded into that very easily."*

**Theme 4: Development of MECC for Mental Health**

Many participants had ideas as to how MECC for Mental Health could be further adapted or developed to address other training needs.

> *"I am very passionate about menopause training. And as a result of doing the MECC training, I went on to do the MECC for Menopause module".*

A participant described working alongside RSPH to develop the MECC for Menopause training as a great development opportunity:

> *"When I approached the team at the Royal Society, they just welcomed it with open arms and really embraced it. And we've got to a point now where we've done the training, you know, we've launched it, and we're ready to go with it. So, you know, it's been something that I was just thinking I was coming in and attending a course, I feel as if I'm part of that, and part of that team."*

Many described the open nature of the team at RSPH and their interest in developing the training for many different areas of work.

Some participants felt that the MECC for Mental Health training could potentially go into more detail around the psychological frameworks and theories underpinning the techniques shared in the training. Without this, Local Trainers sometimes felt under-equipped to answer questions which were posed by participants. It was also suggested that there should be resources or training for those who delivered MECC for Mental Health training to support their own emotional wellbeing.

> *"So I feel like some sort of training to help us psychologically as our how to deal with our emotions, and then how to deal with other people's emotions as well."*
>
> *"I think, possibly a little bit more time and training around how to how to deliver the courses and the nuances, like we went through the content that we were delivering, but there wasn't a lot of, you know, well if this happens, what do you do?"*

There was some concern amongst a couple of interviewees that the content of the training may be too simplistic for the individuals receiving the training:

> *"I'm not sure that targeting primary care workers, link workers, social prescribers, community connectors […] is possibly the right audience".*

However, it was acknowledged that this may be due to their own area of work and that some participants may not have the same background within mental health.

> *"it's suitable for anyone really that has an interest in understanding a bit more".*

This was not a comment which was frequently made, and some individuals enjoyed the 'beginner friendly' nature of the training:

> *"It would be very useful for those new to the role or those who haven't dealt with patients before. It could even be beneficial for those who had their communications training a while ago as a helpful recap"*

**Theme 5: An embedded approach**

Interviewees were already thinking about how this work could and should be embedded in their organisations, and also how RSPH might support that through further briefings

*"And at the end of this, all of our staff will have been trained in this particular area of MECC for Mental Health, we do a lot of one-to-one work with lots of different kinds of communities … And so we're really looking forward to being able to have all of the staff that do that work being trained on MECC for Mental Health to embed it in the work they do".*

*"I think it needs to be promoted by the right people […] those people that people listen to. So if they embrace it, and they talk about it and promoted, and people will start understanding what it is."*

*"And then we've kept a weekly MECC slot via Teams so people could come on board, discuss, share, and then highlight any things that they think need to tackle together".*

*"Maybe like refresher sessions once a year or something like that, you know, just a refresher, that's maybe not as intense a training session, but is a, you know, meeting up and discussing how it's gone".*

**Theme 6: Challenges and support**

There were some comments made which highlighted ways in which the training could be improved. Some of the issues related to human error, such as incorrect documents being sent out to participants of the training:

> *"Resources not being sent out to all of the participants in the training"*

Another concerned inconsistency in the frequency of training sessions, with a delay in completing the training caused by extended gaps between them:

> *"I don't know what happened exactly. But we had about a 2 month break from our last session so there was a gap."*

There were some reports of difficulties with using the booking system. Some Local Trainers chose to create their own booking system while others used the one provided by RSPH – neither option was without difficulties for participants. Nevertheless, everyone interviewed managed to work around or received help to address these issues:

> *"The only problem with that was they did it as like an Eventbrite type invite for the training. But because it was kind of internal training, especially to my staff they didn't understand what it was. So that's more, that's more my problem".*

Finally, some individuals in smaller areas struggled to identify other individuals to help facilitate the training programme within their regions:

> *"I suppose my only thought was I just couldn't identify somebody else within the [redacted] area who deliver the training as well".*

Participants found RSPH "really, really organised". Several commented on the efficiency of running the training with RSPH, and the support RSPH provided – some expressed that they would not have been able to facilitate the training without the help of RSPH's team. All individuals interviewed noted that their organisations were supportive of the MECC training, with many describing how their colleagues helped them. An individual delivered the training while a second member of their team served purely in the capacity of monitoring the attendees for signs of distress and offering support to anyone affected by the sensitive nature of the materials being discussed.

> *"I think the support from public health was a lifesaver, was really good",*
>
> *"he did like a one-to-one session with us afterwards and went through any questions and then emailed us after the first session to make sure that we were all right, and things like that. So he was very, very good.".*

This was a shared sentiment from the individuals who had engaged with RSPH and facilitated the delivery of the training:

> *"I said support from Nelly, and Sam were brilliant,".*
>
> *"I think there's something about the, the way that the Royal Society of Public Health have delivered and engaged with, with the trainers around this. I've never felt so supported and engaged with, with all of this and everything being possible ".*

At times when there were errors in training materials or confusion about how to use the technology to deliver the training, participants tended to report that they were able to easily gain help from the team at RSPH. When Local Trainers had delivered the planned training and wished to roll it out further, it was reported that this was supported by their organisations because the benefits of the MECC for Mental Health training were clearly seen and the feedback from participants had been positive:

> *"Others from work were interested in attending and my trust seemed supportive of this."*
>
> *"RSPH reacted straightaway and said, tell us what you want, what words you need in there, what images you need, do you want to add any other bits and pieces in, and then send it back and we'll make it into a PDF version, which makes your organisation safe, but they can still put all of the answers in. So every time we raised a barrier, or an issue RSPH, sort of just straight away reacted to it".*
>
> *"So I would really hope that those people really benefit from it, I think that the service users who would definitely benefit from it, and then again, from a staff perspective, I found it really useful. And I really enjoyed the 2.5 days of training on this, to just sort of embed it in, in my work, practice a little bit. And there was something that felt really supportive, that you don't always get out of mental health training, you know, often mental health training can be like 3 hours, something where you go, Yeah, well, I get this, but thanks for that, because I already knew it. Whereas this really felt like a community that was coming together".*

**Theme 7: Reflections on online learning**

The majority of the participants interviewed found some level of difficulty in running the training online, with some reporting technical issues. These issues included "NHS staff can't use break rooms in Teams for parts of the training so it is limited due to this"; *"for the Zoom, specifically for Zoom audience, which I know, personally, it's a real nightmare, in fact, absolutely. I'm so glad stuff's going back face-to-face."*

Most participants expressed a preference for running this training face-to-face: they thought it might be easier to have some of the conversations in person, and that some individuals may feel more comfortable asking questions privately rather than using a group chat.

> *"I have set precedents, it's all done face-to-face, as opposed to online, over Teams. The reason for that is, personally, I feel we get better engagement, when it's face-to-face, people are more inclined to open up […] I think some of the barriers, of course, are always getting numbers in, in timescales, particularly when you are doing face-to-face it's not that someone can just jump on or jump out at the last minute."*

For some groups, online delivery was better because it enabled participants from a broad geographical area to participate.

> *"We think that it's actually been received better because we've done it online, because we can reach into our pharmacies' daily lives, to book them in for that time. And then they're still either sometimes in the place of work, or then they can go to their place of work, rather than actually trying to get into a location. And with us being stretched. So really, it's just made our lives so much easier".*

There were a number of individuals who found delivering the MECC training itself helped build their IT skills as most people had to deliver it online due to the Covid-19 pandemic. Some participants commented that an introduction to the technology to be used, such as teaching them how to use breakout rooms and send invites could be of benefit.

> *"Maybe some more awareness on some skills in terms of around IT."*

## Conclusions

Every individual interviewed and those that completed questionnaires, who engaged in the MECC for Mental Health training enjoyed it and found it valuable. It is clear that the Lead Trainers and Local Trainers served as transformational educators and had a positive impact on attendees.

Many of the participants who ran the MECC for Mental Health training found it difficult to run online and would have preferred to run it in person. However, several mentioned the benefits of delivering it through video conference facilities such as MS Teams and Zoom as they have learned a new skill alongside the MECC for Mental Health training content itself. Everyone who had received support from RSPH's team was pleased with the nature of that support; many explicitly named members of staff at RSPH who had been particularly helpful in organising and facilitating the training.

Local Trainers consistently remarked positively on having the flexibility to adapt the training for the particular audience to which they were presenting, being able to request adaptations and suggest changes. This was found to be a refreshing experience as few training programme designers allow Local Trainers to make changes based on their needs.

Some individuals felt that the level of the training may have been a little simplistic for end-users. However, they thought it was a helpful refresher or a starting point to open up conversations within a group. Some would like more in-depth follow-on or top-up training to be included, such as the MECC for Menopause module, and several mentioned looking forward to future modules.

Time was the main barrier which participants identified to running MECC for Mental Health: finding availability to run multiple 3 hours sessions was difficult, particularly within NHS settings. As a result, one participant changed this to one full-day session, and they found this to be easier to facilitate.

The training programme increased participants' capability, opportunity, motivation to have conversations with people about their mental health, and to refer people for further support. It also increased their expectations that they would do so in the future. For those that completed follow-up questionnaires, findings suggest that the number of mental health conversations they were having was had increased from before the training. Despite the relatively low response rate, the results were statistically significant. These are all indicators that, as a result of the training, someone would be likely to have more conversations about mental health and refer more people for support. We can conclude, therefore, that the training programme has achieved its aims.

## Data strengths and limitations

Mixed methods evaluation is an ideal way to capture and triangulate the impact and influence of a training programme such as MECC for Mental Health. Because of this mixed methods multi-faceted approach, the evaluators were reasonably confident in their conclusions – there was consistency in findings across the different methods of data collection; and similar themes were emerging from the qualitative research methods. This suggests they had reached data saturation and had captured the full range of views.

However, it is important to highlight, as a limitation, that the response rates to the questionnaires varied - some of the Local Trainers did not administer the questionnaires consistently or did not use them at all. Moreover, the evaluation was based on data from training delivered between 1/07/2021 and 30/03/2022, which means it did not capture around 30% of the total training, which took place between April 2022 and June 2022. This meant the evaluators were only able to use and match a proportion of the data, and that responses at follow-up were particularly low.

## Recommendations and next steps

### Expansion and sustainability

Health Education England North West has secured funding to extend the project with a focus on sustainability from July 2022 to June 2023. Given that this project has shown that MECC for Mental Health fills a current gap in training provision for this workforce and the effectiveness of a cascade model of training in reaching a high number of end-users, we recommend it is rolled out nationally.

Although the project was aimed originally at primary and community care organisations, RSPH also received a high level of interest from individuals in secondary and tertiary care services as well as the VCSE sector. This suggests a significant appetite for MECC training amongst frontline professionals across a wide range of settings. Having developed modules specific to the menopause and cancer care (and MECC for Mental Health in Stroke care pathways, also underway), it is clear that the core MECC for Mental Health programme can be effectively contextualised and connected to other health topics. We recommend, therefore, that further adaptations are considered and developed so that health promotion messages are embedded in clinical conversations across the system.

### Approach to training

The evaluation results indicate that Local Trainers and end-users benefited from the adaptability of the training programme which meant it could be tailored to specific audiences, delivered either face-to-face or online. This was coupled with a supportive quality assurance process to ensure that, at the same time, the quality and effectiveness of the training was consistent. Similar projects should consider build on the experience of this project by developing supportive and flexible ways of delivering training on key topics to workforces with different training needs.

Another learning which future projects should take forward is the preference for face-to-face delivery which both Local Trainers and end-users expressed as part of the evaluation process. The majority of MECC for Mental Health training was delivered online, due to Covid-19 restrictions. This had the benefit of reaching participants across a broader geographical range and developing Trainers' IT skills. Nevertheless, the sensitive nature of the content, and some of the technological difficulties associated with delivering training online means that we would recommend face-to-face training remain an option in future roll-outs.

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# Appendices

## Appendix 1: MECC for Mental Health Expert Reference Group

| Name | Job title | Organisation |
|---|---|---|
| Andrew Morris | Workforce Development Programme Manager | Cheshire and Merseyside Mental Health Programme Board (NHS) |
| Anita Solanki | Mental Health Training Programme Director | Health Education England |
| Charlene Mulhern | Mental Wellbeing System Lead | Greater Manchester Health and Social Care Partnership (GM Hub) |
| Cheryl Smith | Senior Public Health Practitioner: MECC | Lancashire County Council (post hosted for the ICS) |
| Daniel Maddison | Commissioning and Delivery Lead | Durham Tees Valley CCG Partnership |
| Deryn Bishop | Organisational Wellbeing Lead | Solihull MBC |
| Gordon Allan | Expert by experience | |
| Heather Davison | Professor | University of East London |
| Iain Marley | Senior Commissioning Support Officer | NHS North of England Commissioning Support |
| Ian Smith | Research Director, Lancaster University DClinPsy Programme | Lancaster University and Lancashire & South Cumbria NHS Foundation Trust |
| Jan Hopkings | Programme Manager, Population Health Team | Greater Manchester Health and Social Care Partnership |
| Jason Feavers | Trainer / Project Manager | Self-employed / Cancer Research UK |
| Roberta Pomponio | Strategic Partnership Manager for Mental Health | Active Cheshire |
| Ruth Thompson | GP | Manchester CCG |
| Saima Nafis | PhD researcher (Third phase) | Coventry University |
| Victoria Gould | Public Health Programme Manager | Oldham Public Health Team, Oldham Council |

## Appendix 2: List of organisations hosting MECC for Mental Health Local Trainers and Lead Trainers

- Mind in Bradford
- The Bureau
- Viaduct Care CIC
- Altrincham Health care Alliance
- Age UK
- Sale PCN
- Manchester Foundation Trust
- Health Education England
- Bury Voluntary Community & Faith Alliance VCFA
- Zest
- Yorkshire MESMAC
- Healthwatch York at York CVS
- Blackburn with Darwen Borough Council Wellbeing Service
- York CVS
- Burnley, Pendle & Rosendale Council for Voluntary Service
- Darnall Well Being
- Primary Healthcare Darlington Ltd
- Be Well
- Oldham children safeguarding partnership
- Care Merseyside
- Manchester City Council Population Health
- Alder Hey Children's NHS Foundation Trust
- Young Person's Advisory Service
- Sefton CVS
- Warrington Borough Council – Public Health
- Mersey Care NHS Foundation Trust
- Merseycare
- One Knowsley
- Your Health Your Way (Notts IWS)
- Cheshire East Council
- Armley Primary Care Network
- Pioneering Care Partnership
- Live Well Wakefield
- Advocacy Focus
- 4Doncaster
- Health Care First Partnership (Wakefield CCG)
- County Durham & Darlington NHS FT
- Carer Support South Lakes
- Carlisle Eden Mind
- Every Life Matters
- Sefton CVS/ Seaforth and Litherland Primary Care Network
- Divine Days Community CIC
- Northumbria Healthcare NHS Foundation Trust
- Holderness Health
- Mind in Harrogate District
- Leeds Community Healthcare Trust
- Humber Teaching NHS Foundation Trust
- Let's Talk Service Hull
- Leeds Community Healthcare
- North Lincolnshire Council
- Cornerstone Practice, Lambeth Street Surgery
- Community Pharmacy Cumbria
- Leeds Community Healthcare NHS Trust
- HEY Mind
- Riverside Group Practice
- GB Lubricants
- Northumbria Healthcare NHS Foundation Trust
- Human Resources and Organisational Development Directorate
- Newcastle City Council
- North East Lincolnshire Council
- CHCP- Let's Talk
- Burnley, Pendle and Rossendale Council for Voluntary Service
- Warrington Borough Council
- Burnley, Pendle and Rossendale Council for Voluntary Service
- Mountain Healthcare
- LiveWire CIC
- Heeley City Farm
- Tees Local Pharmaceutical Committee
- Active Cheshire
- Action Together
- ABL Health
- Northumberland County Council
- Healthworks
- The Comfrey Project
- 2 Way Tenancy
- Active Future
- Northern Care Alliance NHS Foundation Trust
- Unique Improvements
- GM Active CIC
- Healthwatch Newcastle
- The Comfrey Project
- Newcastle Futures Limited
- Trafford Council