Make your practice mental health friendly

Evaluation Report

Training in mental health for Primary Care Staff

Supported by:

LOTTERY FUNDED

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Introduction

BIG Lottery provided funding for a focused training programme for GPs and primary care staff. This funding was awarded to create opportunity to learn from the Education Not Discrimination (END) targeted training element of Time to Change Phase 1 (Sept 2007 – Sept 2011) and seek to develop a training model that is targeted and aligned with the needs of GPs and primary care staff, as well as meet the objectives of the new commissioning framework.

The training needed to challenge stigma and discrimination on the grounds of mental illness, by raising awareness and influencing positive practice within these settings.

The project commenced in July 2012 and after 5 months of research and design, delivered training to primary care professionals. The project finished on the 31st March 2013.

The *Making Your Practice Mental Health Friendly* (MYPMHF) has developed bite-size, face-to-face training for busy primary care staff, to help everyone working in the practice understand mental health and how they can better support patients with mental health problems.

Summary of training

The training is built around an innovative 10 minute training appointment delivered in the Practice, by a trainer with direct experience of receiving mental health care from their own local General Practice – these trainers are known as *Involvement Workers (IW)*. The team of IWs are coordinated and supported by the paid project workers and the project lead from Rethink when delivering the training. At the end of the 10 minutes, the trainees are given a bag (the '*training bag*') containing materials with the aim of continuing and sharing the learning. They are also asked to develop a personal 'promise' on a postcard regarding the question 'What will you do to make your practice mental health friendly?', as a result of the training. The involvement workers/project workers bring the promise back to the central office and it is sent back to trainees after 3 weeks, as a way of reminding them of their promise and the training. This training was delivered in Primary Care Practices from the beginning of January 2013 till 27th February 2013. This evaluation is based on data captured between 1st January and 15th February 2013.

To supplement the face-to-face training, three online modules have been developed which focus on:

- Being Mental Health Aware
- Making Adjustments within the Practice (Equality Act)
- Meeting People's Mental and Physical Health Needs.

Trainees are informed about the online during their face to face appointment and reminded of it in their 'training bag'. The staff in the Practice are asked to access the online training after having their 10 minute face to face training.

The Policy Context

The government published its mental health strategy, 'No Health Without Mental Health' in 2010 and have enshrined the parity of mental health with physical health in its 'Mandate to the NHS Commissioning Board' where they have stated that it is a government priority and therefore should

be part of the strategy of the NHS Commissioning Board. The NHS Commissioning Board is part of the new NHS architecture that was introduced via the Health and Social Care Bill (DH, 2010-2012) and laid out in the NHS Strategy 'Equity and Excellence: Liberating the NHS' (DH, 2010). Clinical Commissioning Groups (CCGs) have also been set up as part of this architecture and will commission local services and include GPs in a more involved role in commissioning than ever before. In addition 9 in 10 people with a mental health problem are only seen in primary care and 7 in 10 GPs report that there is an increase in the number of people are coming to see them with mental health problems. The demand on GPs has never been greater.

In the document, 'No Decision About Me, Without Me' which has grown from Liberating the NHS (DH, 2010), there is a vision set out about patients in the NHS participating in the decisions that are made about their care. Some people with mental health problems have complained about the way that they are cared for in primary care settings. The training that is being evaluated in this study was developed to try and change attitudes and behaviours towards people with mental health problems through improving knowledge.

Summary: Primary Care is under increasing pressure from growing patient number presenting with Mental Health problems. GPs are balancing the demands of being a clinician and a manager, and the Government is leading changes to improve commissioning and improve outcomes for people with mental health problems

Methodology

This evaluation employs both quantitative and qualitative methodologies and comprises of four distinct elements that focus on the key aspects of the 'Make your practice mental health friendly' training. The methodology for each element of the evaluation is set out below.

Element 1: Evaluation of the impact of training on participants who work in Primary Care

This element of the project evaluated the change in knowledge and attitudes through the use of questionnaires administered to participants at three potential data capture episodes and through analysis of Google analytics. Google analytics is a service offered by Google that generates detailed statistics about a website's traffic (usage) and traffic sources. Google Analytics can track visitors and give details as to who they are and where they are accessing the site from. In addition, trainees were asked to complete a separate monitoring form.

Survey data was captured at three time points, through a survey specifically designed for this evaluation:

Time 1 (T1) – Baseline (collected at 2 points)
The survey was administered before the face-to-face training took place, either on paper or by an online link given to the Primary Care Practice (PCP) after the appointment was made. This T1 questionnaire was also made available to those who only accessed the online training.

Time 2 (T2) – Post-training survey
The survey was administered after the 10 minute training appointment, or was completion via an online survey link.

Time 3 (T3) – Post- online training
Participants also had an opportunity to complete a T1 survey on commencement of the online training, if they hadn't been involved in a 10 minute training appointment, and one at the end of the online training.

Paper versions of the surveys were available for the Involvement Workers to take with them to training appointments, and online at SurveyMonkey. Participants in the online training were directed to the questionnaire at the beginning of the training and on completion of the course.

Additional data capture point: Rethink received 'Google analytics' data from the website which formed part of the evaluation.

We initially envisaged five sets of data in the evaluation design:

- Pre-course for those receiving the face-to-face training (baseline) – T1a
- Post-course for those who have received the face-to-face training – T2
- Pre-course for those who only access the online training (baseline) – T1b
- Post-course for all those who participate in the online training – T3
- Google analytics

As outlined in the Findings section of this report, there were very limited returns for the data capture points at T1b and T3, so only three sets of data were analysed. Reasons for this are discussed in the Results section.

The participants who took part in the survey were not tracked through this process, so the data analysis undertaken was for the participants as a group. The survey asked for the person's role within the PCP, to enable data to be grouped by discipline.

Survey - Questionnaire design

Due to the unique nature of the training programme and the variety of medical and non-medical professionals it was delivered to, it was felt that there was no specific scale readily available that best reflected the values of the programme, or the depth and nature of knowledge that the trainees were likely to have pre and post training. A new survey was therefore developed, pooling items from several existing scales. The survey was named '*Make Your Practice Mental Health Friendly'.*

It included a section on demographics, the trainees were asked to tick the box which best described their role in the practice. Following from that, the trainees were given 14 statements about mental health reflecting knowledge, behaviours and affect and asked to rate them on a 6-point-scale:

1. Strongly agree
2. Agree
3. Somewhat agree
4. Somewhat disagree
5. Disagree
6. Strongly disagree

The survey scores could range from 14 to 84 and lower scores indicate less stigmatising and more positive attitudes. Questions 6, 9, 10, 11, 12 required reverse coding. Below is the outline of all 14 statements, highlighting which existing scale the statement was adapted from.

Statement	Existing scale it was adapted from
1. I feel knowledgeable about mental health problems	CTF MHA
2. I feel knowledgeable about working to promote mental health and emotional well-being	CTF MHA
3. I feel confident at identifying the signs and symptoms of a mental health problem	CTF MHA
4. I feel able to identify how best to support people with their mental health and emotional well-being	CTF MHA
5. Empathising with people with mental health problems is difficult	Opening Minds Scale (OMS-HC)
6. The care of people with mental health problems is too time-consuming to deal with in the practice	Developed for this survey
7. People with mental health problems should be guided by their health professional more than other types of patients	Developed for this survey
8. People with mental health problems don't tend to recover fully	MICA-4

9.	**If I had a mental health problem, I would never admit it to my colleagues for fear of being treated differently**	MICA-4
10.	**If I had a mental health problem I would never admit it to friends for fear of being treated differently**	MICA-4
11.	**If a colleague told me they had a mental health problem, I would still want to work with them**	MICA-4
12.	**I feel as comfortable talking to a person with a mental health problem, as I do talking to a person with a physical illness**	MICA-4
13.	**It is important that any health/social care professional supporting a person with mental health problems also ensures that their physical health is addressed**	Developed for this survey
14.	**I understand how to make adjustments so that people with mental health problems can access the practice**	Developed for this survey

The data from the survey questionnaire, as well as the information about participants gathered via Google Analytics, was analysed using statistical software SPSS 21, using a range of parametric tests. These tests included a paired samples t-test and ANOVA with a post-hoc test.

A **t-test** is a statistical test which can be used to determine if two sets of data are significantly different from each other. Paired samples t-tests typically consist of one group of participants who have been tested twice (for instance pre- and post-intervention). The symbol is t.

ANOVA provides a statistical test of whether or not the means of several groups are all equal, and therefore generalizes t-test to more than two groups. The symbol for ANOVA is F. Post-hoc tests tell us which of the differences highlighted in ANOVA are significant. For instance if there are three groups of participants, ANOVA test will only indicate that there is a significant difference between one of the pairs. We used post-hoc tests to determine which two of the three groups have significant differences in scores.

Element 2: Evaluation of the impact of the training on two primary care practices

A qualitative evaluation focusing on two Primary Care Practices who had taken part in the *'Make Your Practice Mental Health Friendly'* training. These two practices were used as case studies to describe and analyse the experience of the *'Make Your Practice Mental Health Friendly'* training for participants in more depth. This part of the evaluation was an explorative study and was not intended to measure change, but to add a narrative to the delivery of training and its impact on the recipients. It consists of two sets of data that have been thematically analysed: semi-structured interviews and postcards.

Evaluation Design and Data Collection Instruments for the Practice Case Study

The evaluation of the participants' experience of receiving the training comprised of a 10-15 minute interview using a semi-structured interview which focused around the four levels of evaluation devised and developed by Kirkpatrick : Reaction; Learning; Behaviour; Results (Mavin at al, 2010).

Kirkpatrick's Stage	Aims of the stage
Stage One **Reaction**	How do the participants feel about the session in terms of content, structure and how it was delivered? To what extent are they satisfied customers?
Stage Two **Learning**	To what extent have the trainees learned the information and skills? To what extent have their attitudes changed? Evaluate own learning and identify how they believe their behaviours may change.
Stage Three **Behaviour**	To what extent has their job behaviour changed as a result of attending the training programme?
Stage Four **Results**	To what extent have results been affected by the training? ('Results' would include factors such as production quality, and morale)

Fifteen staff from the two practices were interviewed from a mixture of administration roles and clinical roles. Due to the small numbers of each role involved, roles have not been referred to in the quotes in the analysis to ensure confidentiality.

Participants were asked to complete a postcard at the end of the face-to-face training, and the text of these forms the dataset for a thematic analysis. The postcards are a promise that participants make to themselves after the training about how they intend to make their practice more mental health friendly, which are taken away by the trainers and sent back after 3 weeks to remind the participants what they intended to do. The 'postcards' that the participants wrote to send back to themselves in these two practices have been analysed as a separate dataset to the overall analysis of all the postcards. There were 35 postcards completed by the two Practices involved in the case study, which yielded a total of 47 promises between them. All postcard promises were anonymised before being analysed (apart from the practice that they came from).

All the participants had received the face-to-face '*Make Your Practice Mental Health Friendly*' training within the previous month. Some of their colleagues, who were not interviewed for the evaluation, had also taken part in the training but they weren't available for interview on the day.

Data Analysis

The interviews at the practices that acted as case studies were recorded and transcribed. The interview data was analysed using thematic analysis.

A thematic analysis was undertaken on the text of the 35 postcards.

Element 3: Thematic Analysis of the Postcard Promises from every Practice involved in Making Your Practice Mental Health Friendly

Participants of the face-to-face training completed postcards with a promise or an intention about what they were going to do to make their practice more mental health friendly following the training, which the trainers took away in order to return to the participants after 3 weeks, as a reminder. 242 of these promises were made, which were collated and a thematic analysis undertaken.

Element 4: Evaluation of the Experience of Delivering the Training for the Involvement Workers

Involvement Workers delivered the face-to-face training. The evaluation of the Involvement Workers (IWs) experiences of delivering the training comprised of a pre (T1) and post (T2) training delivery online survey of 21 items, based on the Empowerment and Social Capital survey questions developed for Time to Change and used in the Time to Change Omnibus baseline data collection. The IWs were asked to complete the survey before commencement of the training delivery and on completion of the training project, six weeks later.

For the purposes of this evaluation, 'Empowerment' is defined as the level of choice, influence and control that people with mental health problems can exercise over events in their lives. 'Social Capital' relates to features of social life — networks, norms, and trust — that enable people with mental health problems to work together more effectively to pursue shared objectives and solve problems. Broadly, these are collective efficacy, social trust/reciprocity, participation in voluntary and community activities and social integration for mutual benefit

The survey was both quantitative and qualitative. The quantitative questions focused on changes in empowerment (8 questions) and social capital (13 questions). Two qualitative questions in the T2 survey focused on experiences of being involved in the training and the benefits and skills gained that will contribute to their future. This part of the evaluation provided descriptive statistics about change. The sample size was very small (n=14) so it was anticipated that only small amounts of data would be available. The qualitative questions added a narrative to the delivery of training by people with lived experience of mental health and as users of primary care services.

The IWs were asked to score 21 statements on a 4 item scale, according to how able they felt they were to carry them out:

- Very able =4
- Fairly able =3
- Not very able=2
- Not at all able =1

The 21 statements in the questionnaire were as follows:

Empowerment

Speak up for your own rights
Speak up for others' rights
Say no/stand up to person treating you unfairly
Talk about mental health within your community/area
Talk about mental health outside your community/area
Talk about mental health at work/school/college
Talk about mental health with friends/family
Speak more openly about your mental health

Social Capital

Seek work or maintain employment
Get involved in new activities
Be involved with local action groups
Make friends
Get support when you need it
Give help if needed
Feel confident about the future
Feel confident in your daily life
Become involved in community/local events
Become involved in volunteering
Trust people who are like you
Trust people who are not like you
Use the facilities in your area

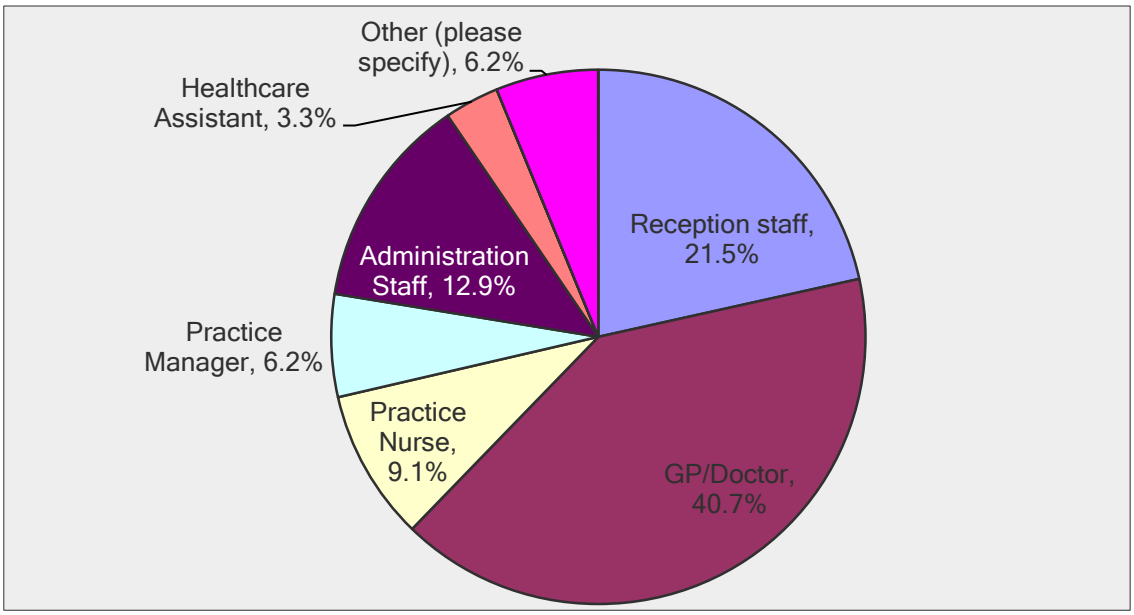
Missing data and returns of 'Don't Know' were scored at 0. The maximum score for each individual respondent on the Empowerment Scale is 32, and on the Social Capital Scale is 52.

The survey also included a small section on the number of training events undertaken and the length of time IWs had been involved with Time to Change or the Primary Care Education Project.

In addition, a secondary analysis of qualitative data collected following the training of the IWs for this project was undertaken.

Profile of the Participants

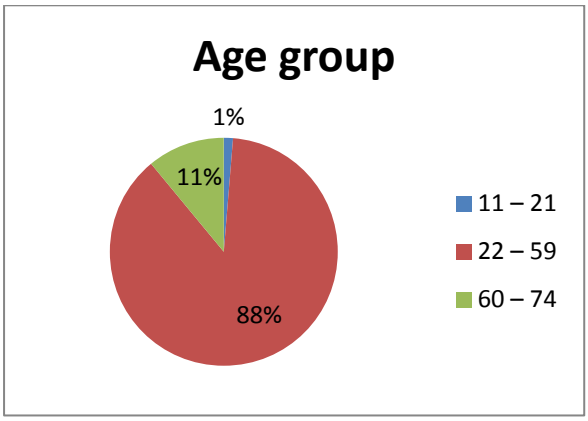
The evaluation is based on data taken from primary care professionals who received the face to face or online training between 1st January and 15th February 2013. During this period, 242 trainees took part in the training programme. The chart below shows the roles of the trainees within primary care:

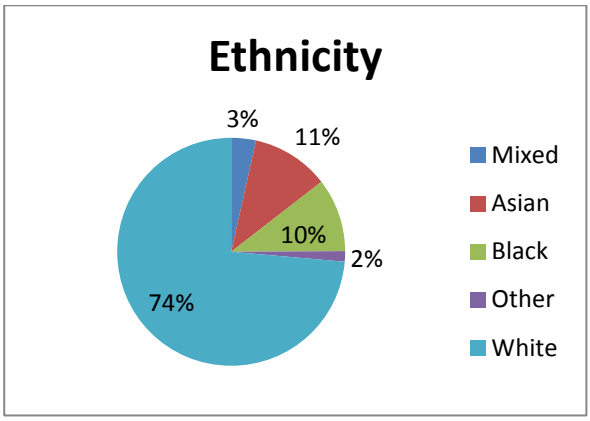


'Other' professions included: IT analyst, GP trainee, office manager, dispenser, medical students, and psychologists.

The majority of the trainees were women (71%) and 86% of the trainees came from urban communities (86%). Also only 5.5% of the trainees reported a disability.

The charts below illustrate the age and ethnicity of the trainees.





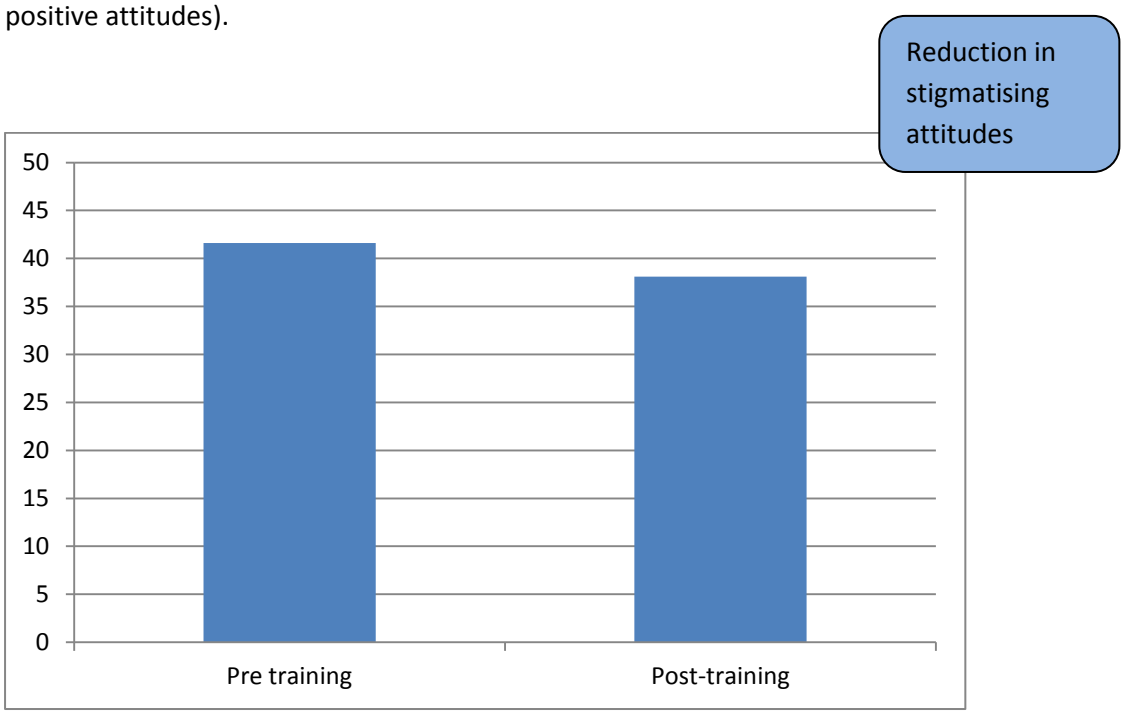
Out of 242 trainees, 209 people returned T1 survey and 203 returned T2 survey. The data sets were cleaned up and matched for responses pre and post training. 201 matched surveys (83%) were analysed.

Findings

Element 1: Evaluation of the impact of training on participants who work in Primary Care

Results

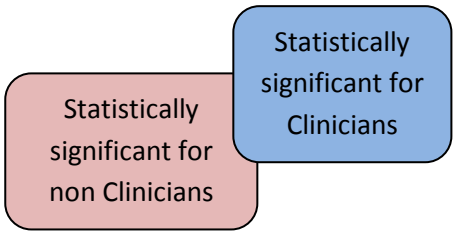
On the whole, the face to face training yielded positive results. There was a statistically significant improvement in attitudes following the training ($t=4.2$, $p<.05$) across all groups of respondents. The graph below illustrates the differences in average scores (smaller scores indicate less stigma/more positive attitudes).



The results indicate that pre-training most of the trainees gave somewhat ambivalent answers to the questions ('somewhat agree', 'somewhat disagree'). Post-training their answers became more confident, illustrating firmer opinions ('strongly agree', 'agree').

Due to poor response rates it was not possible to perform any statistical analysis on T1b (pre-online training) and T3 (post-online training) questionnaires. The limitations of this are discussed later in this chapter.

The section below highlights which of the 14 questions showed statistically significant improvement when observed individually.



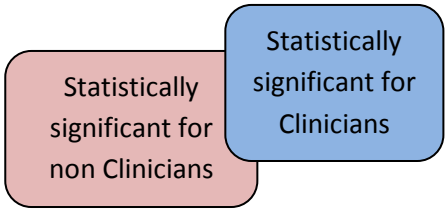
Question 1:

I feel knowledgeable about mental health problems

Before the training only 51% of trainees agreed or strongly agreed with this statement compared to 72% following the training (t=4.5, p<0.5). This means that there was a 21% increase in knowledge following training.

Question 2:

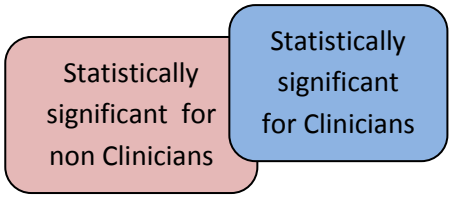
I feel knowledgeable about working to promote mental health and emotional well-being



Before the training only 37% of trainees agreed or strongly agreed with this statement compared to 72% following the training (t=7.3, p<0.5). This means that 35% of people felt more confident about working to promote mental health.

Question 3:

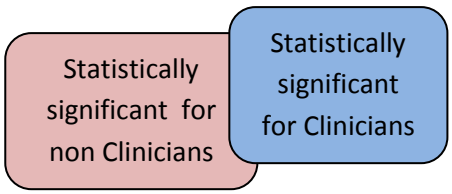
I feel confident at identifying the signs and symptoms of a mental health problem



Before the training only 46% of trainees agreed or strongly agreed with this statement compared to 64% following the training (t=3.7, p<0.5). This means that 18% of people felt more confident about identifying mental health problems.

Question 4:

I feel able to identify how best to support people with their mental health and emotional well-being



Before the training only 30% of trainees agreed or strongly agreed with this statement compared to 53% following the training (t=6.8, p<0.5). This means that there was a 23% increase in confidence about ways in which to support people with mental health problems.

Question 6:

Statistically significant for non Clinicians

The care of people with mental health problems is too time-consuming to deal with in the practice.

Statistical differences were found for some groups of trainees. There was a statistically significant improvement in attitude for Administration staff, Reception staff and Nurse practitioners ($F=5.93$, $p<.05$). There was no statistical difference for GPs who mostly disagreed with this statement even before the training (50%).

Question 7:

Statistically significant for Clinicians

People with mental health problems should be guided by their health professional more than other types of patients.

Statistical differences were found for some groups of trainees. There was a statistically significant improvement in attitude for 5% of GPs ($F=2.4$, $p<.05$), from 60% to 65%.

Question 12: I feel as comfortable talking to a person with a mental health problem, as I do talking to a person with a physical illness

Statistically significant for non Clinicians

Statistically significant for Clinicians

Before the training 70% of trainees agreed or strongly agreed with this statement compared to 82% following the training ($t=1.9$, $p<0.5$). This means that there was a 12% increase in comfort about communicating with mental health problems.

Question 14: I understand how to make adjustments so that people with mental health problems can access the practice

Statistically significant for non Clinicians

Statistically significant for Clinicians

Before the training 41% of trainees agreed or strongly agreed with this statement compared to 64% following the training ($t=4.6$, $p<0.5$). This means that there was a 25% increase in confidence about making adjustments to their practice to improve the patients experience

No statistically significant differences were found for questions 5, 8, 9, 10, 11, and 13, listed below. For all questions except 8 and 10 we would not expect to find the differences as the answers in all trainee groups were on the right side of the scale before the training. As for questions 8 and 10, trainees remained ambivalent ('somewhat agree' or 'somewhat disagree') after the training.

5. Empathising with people with mental health problems is difficult.

8. People with mental health problems don't tend to recover fully

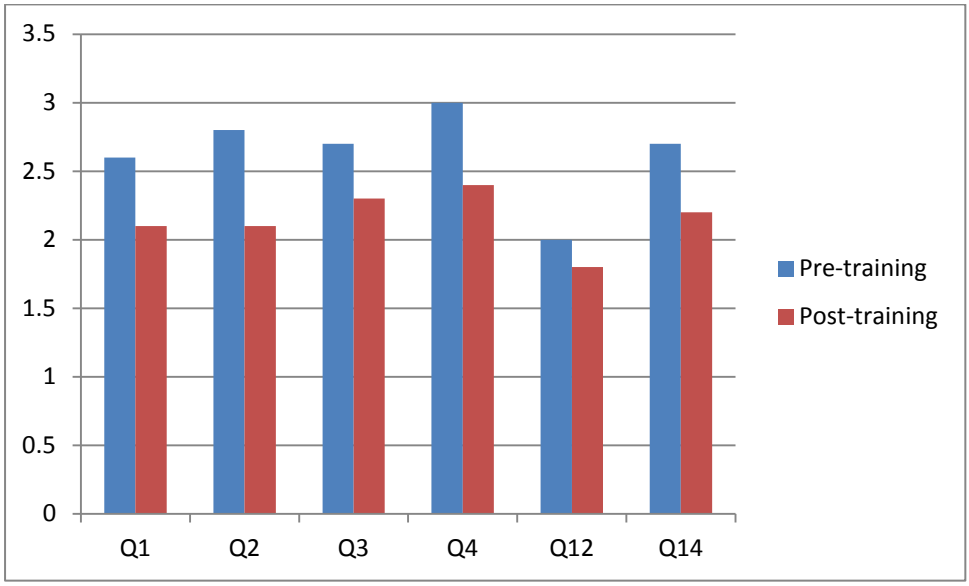
9. If I had a mental health problem, I would never admit it to my colleagues for fear of being treated differently

10. If I had a mental health problem I would never admit it to friends for fear of being treated differently

11. If a colleague told me they had a mental health problem, I would still want to work with them

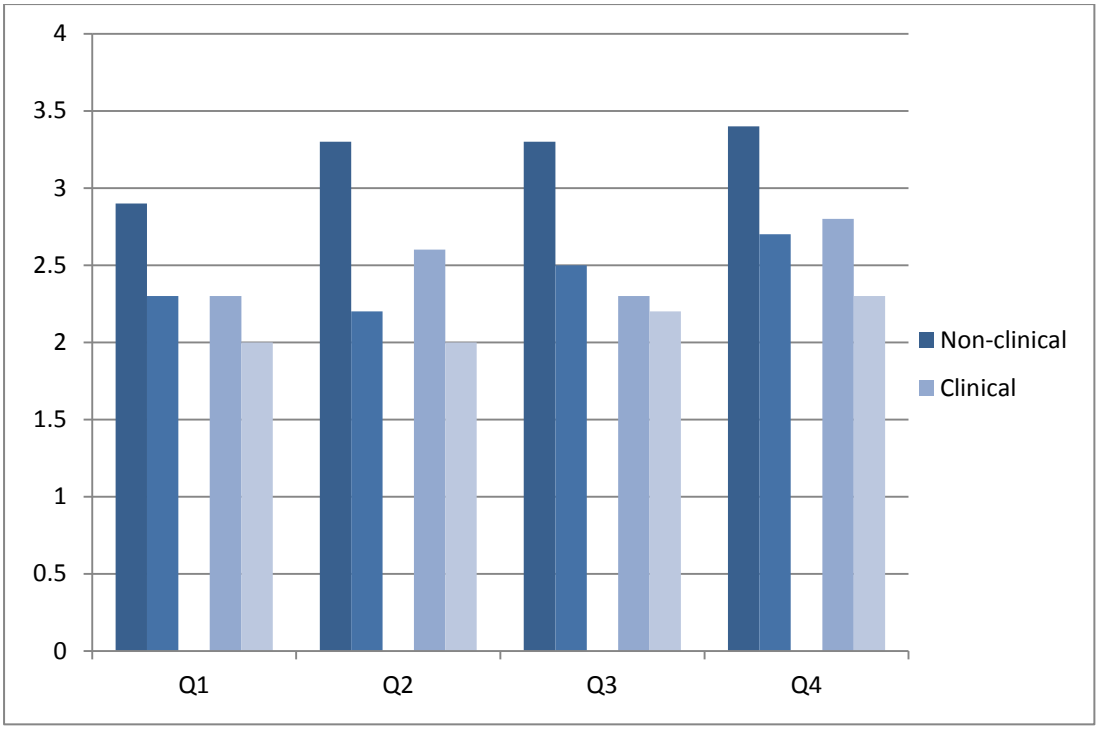
13. It is important that any health/social care professional supporting a person with mental health problems also ensures that their physical health is addressed

Below is a graph highlighting mean differences in responses to the questions 1,2, 3,4, 12 and 14 before and after the face-to-face training. The graph illustrates improvement in responses (lower scores indicate less stigma, therefore more positive attitudes).



The graph below illustrates differences pre and post face to face training for clinicians vs. non-clinicians. Define which job roles in each category

Only the questions where statistically significant differences have been found between clinicians and non clinicians are represented. On the whole, there was more impact on clinicians, as illustrated below.



T1b and T3 surveys (pre and post online training)

Due to low response rates for pre and post online training surveys (T1b=17 surveys and T3=2 surveys) it was not possible to include these in the statistical analysis. *This means that it was not possible to assess the impact of the online training on the trainees or compare it to the effectiveness of face to face training.*

153 unique visitors online

Using Google analytics it was inferred that no less than 153 unique visitors (Unique IP addresses) visited the TTC Primary Care online training programme 430 times. From the average time they spent logged into the training programme (15.29 mins) we concluded that they had time to start the surveys but perhaps not to complete them. It was not possible to unpick how many actual persons visited the training (one IP address, i.e. one computer may have been used by more than one person).

One of the reasons for low response rates may be the daily time pressures on the trainees and the need to prioritise. Also there was no incentive for the trainees to complete these surveys before and after the online training, and so in that sense the training or surveys were not mandatory. Furthermore, data capture periods for the surveys were fairly short (between 21st December and 18th February) and the trainees are in fact still accessing the training. We found that 30 additional visits by 23 unique users were made to the TTC online training programme in the 10 days following the cut-off point for the study (18th February) which indicates that there continues to be take-up of the online training.

Summary The Participants Questionnaires Pre and Post Training

- **There was an overall statistically significant improvement in attitudes following the face-to-face training**
- **The areas where the trainees seem to improve the most were the areas of knowledge e.g. recognising signs of mental illness**
- **Overall, the face-to-face training had more impact on clinicians than non-clinicians, especially in the areas of knowledge**
- **Due to low response rates, we could not compare the effects of online training with the effects of face-to-face training. However, as indicated in qualitative findings, participants did refer to it when they spoke about the benefits of the training programme**

Element 2: Evaluation of the impact of the training on two primary care practices

Overall data from ten Primary Care Practices was used to evaluate the *'Make Your Practice Mental Health Friendly'* training. A qualitative evaluation was undertaken with two of those Primary Care Practices and within these Practices, 35 staff had received the face to face training. These two practices are used as case studies to describe and analyse the experience of the *'Make Your Practice Mental Health Friendly'* training for participants in more depth.

The evaluation of the participants' experience of receiving the training comprised of a 10-15 minute interview using a semi-structured interview which focused around the four levels of evaluation devised and developed by Kirkpatrick (Reaction; Learning; Behaviour; Results). A thematic analysis of the data from these interviews was undertaken.

Participants were asked to complete a postcard at the end of the face-to-face training, and the text of these forms the dataset for a thematic analysis. There were 47 comments on the 35 postcards completed by the two Practices involved in the case study. A thematic analysis of these 47 statements was completed.

Participants

A total of 15 staff were interviewed. The interviews were undertaken on an 'as and when available' during planned visits to the two practices on consecutive days by two interviewers.

The numbers of staff interviewed compared to the numbers of staff trained were:

Staff role	Number trained	Number interviewed
2 GPs	12+ 1GP Registrar	2
4 Practice Nurses	5	4
1 Practice Manager	2	1
4 Receptionists	11	4
3 administrators/secretaries	3	3
1 Patient Service Manager	1	1

Due to the small numbers of each role involved, roles have not been referred to in the quotes in the analysis in order to preserve confidentiality.

All the participants had received the face-to-face '*Make Your Practice Mental Health Friendly*' training within the previous month. Some of their colleagues who were not interviewed for the evaluation had also taken part in this training but they weren't available for interview on the day.

The table below shows the themes and the sub-themes identified through the thematic analysis of the interviews:

Theme:	Incorporating the Sub-Themes:
Theme 1: Reaction to the training opportunity	1.1 Reaction to the Face-to-face training 1.2 Reaction to the training bag 1.3 Reaction to the online training
Theme 2: Learning from the face-to-face training	2.1 Attitudinal change from experiencing the face-to-face training 2.2 Understanding of mental health problems 2.3 Stigma around mental illness 2.4 Knowledge and Understanding gained from taking part in the face-to-face training 2.5 Knowing someone with a mental health problem 2.6 Skills and behaviours needed, as identified by practice staff
Theme 3: Change of Job Behaviour	3.1 Changes in own behaviour 3.2 Changes in colleagues' behaviour 3.3 Reinforcing the learning
Theme 4: Results from the face-to-face training	4.1 Time and Pressure 4.2 Intentions to do things differently as a result of the face-to-face training

1. Theme 1: Reaction to the training opportunities

(incorporating sub-themes of: reactions to the face-to-face training; reactions to the training bag; reactions to the online training).

1.1 Sub-Theme – Reaction to the Face-to-Face Training

All the participants were positive about how the training had been delivered and the style, qualities and experiences of the trainers were critical to this. Some participants felt that it wasn't like training, it was more a chat and they were able to be open about their own experiences and ask questions – some of which they would not necessarily ask in other training-type situations.

> "I thought it was really, really one of the best training sessions I've had I think. I thoroughly enjoyed it"

There was a preference for training in this style over more traditional styles because of the short amount of time taken, as well as the sharing of the trainer's personal story. Having the training over a short period of time (10 to 20 minutes) was found to be helpful by participants, although one participant would have liked more time with the trainer. Participants recognised that there were other things that they could do to follow up on their learning, such as the online training and finding out about local services.

> "... if you go to a long boring meeting that just drags on and on you get tired of listening but this just hit the point straight away."

The qualities of the people delivering the training mattered greatly. The key qualities were making people feel at ease, being 'nice' people, being honest and open and the fact that the trainers were sharing their own personal experience.

> "they was really nice people...really open...really honest"

> "..the person I saw and spoke to he was very helpful...."

The trainers talking about their own life experiences made it feel more personal and participants felt it was more effective, interesting and enjoyable because of this. Hearing the personal experiences of the trainers, whether this was their own experience of mental health problems or as a carer, made it more real to participants and made them think about how people might behave as patients coming into the surgery and how they, as staff, might react and respond to this more positively. The fact that the trainers were sharing their own experiences was viewed very positively and participants were able to relate to the person.

> "Personal experience... is good, but not good for him, obviously, but...in telling people...I think you can get the message across better."

> "...I think it works better because you sometimes misunderstand the way things are either written down or put up....and you can ask questions .... more personal"

> "..she had her own life experiences to share with me, and for me ....that was very important"

> "how can somebody explain how to deal with something if they have not had that experience, or really dealt with it?"

> "She wasn't somebody who had read a book..."

Participants found the flexibility of the training delivery important. They were either given specific time slots in the day when it was convenient to them or they were able to say when they were free and that's when a trainer would see them, which enabled them to continue to do their work. However, one participant did feel that it couldn't be really be called training because of the short timescale but did feel that it was their responsibility to find out more about what services were available for patients with mental health problems as a result of the face to face training.

All the participants would recommend - most quite emphatically - the training to other people or other practices because of the reasons outlined above. Appointments for those staff who had missed the training were already being made.

There was a feeling from a few clinical staff that they should already know about mental health and therefore do not need the training, but when considering the non-clinical staff they realised that they may have lived experience of mental health issues, and that not all clinical staff would already know about mental health, so recognised it was not viable to select who got the training. They also recognised that discussions could occur in the surgery because everyone had undergone the training. These discussions are important to reinforce the learning so it is important that all members of practice staff receive the training so that they can take place.

> *"And you've spoke about it, you think actually, yeah, we should do this and we should do that...."*

"I have only one scenario don't know about the others....sitting together everybody said her scenario and what happened and what we learnt from it....."

1.2 Sub -Theme: Reaction to the Training Bag

All of the participants knew about the training bag. Generally the contents had been noted, but not all participants had engaged beyond a brief look, other than eating the chocolates. The chocolates helped recall of the training as everyone we spoke to remembered them and remembered that they were in the training bag thereby reminding them of the bag and its contents.

"..yes, very nice thank you very much.."

"...It seemed to have lots of sweets and goodies in it"

"But I haven't, erm, engaged with that yet."

Although the bag wasn't looked at in depth at straight away for most participants, it has been placed in prominent places and helped people to continue to consider mental health and what they want to do as a result of the training.

".....afterwards I kept looking at the bag and it reminded me every time I looked at the bag."

"I've still got it in my room. On the floor."

One person suggested that the bag should have information within it that they could use in the surgery:

"....it would have been nice to have something big enough to display in the surgery.....that would have been nice or at least some information so that we could then put something up in the surgery...."

For those who hadn't had a look at the contents of the training bag, the reasons were due to feeling overwhelmed and other time pressures or feeling that they already knew about mental health.

1.3 Sub-theme: Reaction to the online training

All the participants were aware of the availability of the online training, however most of the participants had not undertaken it due to issues such as not having the time, being short staffed (therefore reducing time available at work), and other e-learning taking priority. Most seemed to have intentions to do the online training but these issues had prevented them. One person said they had not done the online training as face-to-face training helped them to remember more.

"..in fact I was gonna do the online training on Friday but I didn't get the time...."

A few people had visited the online training website. One person had visited the online training and expected to find further resources to use in the surgery but had not found anything available to order.

Summary of Theme 1: Reaction to the Training

- **The training was received positively because of the amount of time taken being very short and because the trainers shared their personal stories.**
- **All participants would recommend the training to their peers and other Primary Care Practices**
- **The training bag acted as a reminder to people about the training and therefore mental health.**
- **Time pressures and other priorities have prevented participants going onto the online training.**

2. Theme 2: Learning from the face-to-face training

(incorporating the sub-themes of: Attitudinal change from experiencing the face-to-face training; understanding of mental health problems; stigma around mental illness; Knowledge and Understanding gained from taking part in the face-to -face training ; knowing someone with a mental health problem; and Skills needed as identified from experiencing the face-to-face training/identifying how they believe their behaviours will change)**.**

2.1 Sub-theme – Attitudinal change from experiencing the face-to-face training

The training highlighted for participants that the behaviour of people who are in mental distress is not that person being difficult or annoying and the participants started to understand that people with mental health problems are not deliberately behaving in a challenging way. This enabled participants to look at this behaviour differently, to try and understand it, to listen to people, be open-minded and to be more person-centred.

> *"....they could have mental health... or some serious condition...you just don't realise just to you they are just annoying people but you don't stop and think that they really need your help...."*
>
> *".....you realise that...they can't help it and it has highlighted that for me..."*
>
> *"....keep in mind that everybody's different and to be more tolerant."*

The training was emotionally involving for participants mainly because the trainers were sharing their personal stories. The emotions came from both the trainers and the participants. The participants found hearing the stories humbling and touching and there was some sadness about how the trainers had been treated by health services.

Emotional level involvement in the training

Taking part in the training did encourage participants to talk to other people about the training and what they'd learnt, both inside the surgery and outside, to family. Participants were also starting to make links between how a physical illness is viewed and treated and how the same view and treatment should be made for mental illnesses.

> *"...if somebody has cancer or if someone has a....physical problem....it's all a very different story."*

A major learning point was being open to listen to the story of the individual in order to understand it and their behaviour, rather than having pre-conceptions and judgements. Participants also wanted consider how the mental health problem might impact on that individual and therefore being able to think what needs that gives rise to. A lot of this was building on previous practice, particularly for clinicians. Participants also reflected on how they might approach people in a different manner/way, or look at things differently.

> *"...accepting that every person is an individual and listening to what they say and what their issues are rather than your perception of compartmentalising everybody into a box and dealing with them in a uniform standardised way...."*

> *"...we need to give some more time to patient, to listen to them more..."*

> *"...treat people how you would like to be treated yourself...."*

2.2 Sub-Theme: Understanding of mental health problems

There is an understanding shown that mental health is not all about major mental illnesses and that stresses in life may affect someone's mental health, including bereavement, work stress and physical illness. Participants were also starting to think how having a mental illness affected someone's life.

> *"...mental health runs through every aspect that we deal with..."*

> *"....there may be huge issues with depression or low mood which are effecting their ability to manage their physical condition as effectively as they might be...."*

2.3 Sub-Theme: Stigma around mental illness

Reflection on causes and impact of stigma

Participants recognised the stigma around mental illness and were aware that this may affect the behaviour of staff, people with mental health problems and those caring for people with mental health problems. Participants felt this was due to people not understanding mental health problems. This effect may be around finding it difficult to help someone, a lack of empathy, negative feelings such as anger, and the person with the mental health problem being blamed for their condition. Help-seeking may also be affected as patients do not want to become labelled.

> *"...getting people to acknowledge that it's alright to have a mental illness, there's nothing wrong with that...."*

"...people with mental health issues don't always access their GP as they should for various reasons, some because they don't wish to engage, but some because they are frightened of being labelled..."

"....perhaps a person with a mental health problem is pushed to one side sometimes not taken quite so seriously and sort of blamed for their own as though it's their fault and they have created it or made it that way or they just sort of playing up....."

2.4 Sub-Theme – Knowledge and Understanding gained from taking part in the face-to-face training

The training raised awareness of mental health issues and made people think about mental health problems and to pay more consideration to the needs of people with mental health problems who come into the surgeries. It highlighted the issues and developed their understanding around mental health.

Taking part in the training provoked reflection on previous work experience for participants. The positive elements of previous work practice identified included the surgery already being perceived as holistic, being open to new learning, and listening to people when they are upset. The negative elements of previous practice identified were a lack of training and therefore unhelpful practices occurring that displayed a lack of sympathy; perceiving patients as being difficult; difficulties for patients with mental health problems in accessing health services; and patients ending up at a higher tier of service than they could have.

"...we were just told not to look them in the eye..."

The training reinforced participants' knowledge and positive practice such as being open to listening to people and helping distressed patients access health professionals, and having hope that people can recover from mental health problems.

"I have always been open to listening to people"

"...you think there isn't a way forward for them, but there always is...."

A couple of health professionals who felt they were already aware of mental health issues thought that receptionists would benefit more from the training than health professionals. However, change in all parts of the patient experience in the surgery was identified as key.

"....the first signs and greetings can have a massive impact on how somebody feels they are going to be handled and it can be very off-putting almost to the extent that somebody wants to turn around and walk away..."

2.5 Sub-Theme –Knowing Someone with a Mental Health Problem

Knowing someone personally, whether that is a relative, friend or colleague who has a mental health problem did make participants feel more informed about mental health and mental illnesses. Participants who did know someone with a mental health problem did talk about this and expressed empathy. A number of people were able to share their experiences and this may have helped them deal with issues that they have come across in their own lives. A positive change in a colleague, who had experienced a mental health crisis, was reported after they had received the training:

"it is something that is sort of in my mind that I am aware of anyway....there is obviously people that that don't know people with mental health difficulties so I suppose I felt I was already relatively informed."

"I have a history of mental illness.....I could relate to her."

2.6 Sub-Theme – Skills and behaviours needed as identified by practice staff

Having the face-to-face training did enable people to think about the changes that they might want to make within themselves and within the surgeries. It was acknowledged that in order to make these changes people needed to act.

Intentions to change behaviours

"...brought it home that we need to do something. It's not just having it in thought, it's got to be practical."

Ideas for responding to the needs of patients with mental health problems were generated as a result of the training. The key ideas were putting up posters in waiting rooms, having leaflets in reception and consulting rooms and having either an area in reception for those who were in distress to wait, or ensuring that they did not have to wait long.

Some participants had started to think about young people and their needs and how they might present in the surgery, and the issue that young people may find it difficult to ask an adult for help, as adults may be where their problems stem from.

"...if the child if eight or above we can ask the carer or the Mum or the foster Mum to go outside and to see his view."

Summary of Theme 2: Learning from the face-to-face training

- **The major learning from the face-to-face training was around changing attitudes and raising awareness**
- **Attitudes towards people with mental health problems have changed – participants think about people's behaviour, were emotionally involved in the training and talked to family about mental health matters, as well as starting to equate mental health with physical health**
- **Stigma about mental health problems may affect staff, carers and people with mental health problems. It affects attitudes and help-seeking**
- **The training raised participants' awareness of mental health problems and the needs of people with mental health problems.**
- **Participants are more open to listening to individuals in order to understand more**

3. Theme 3: Change of Job Behaviour

(incorporating the sub-themes: changes in own behaviour and Changes in colleagues' behaviour and Reinforcing the learning).

3.1 Sub-Theme: Changes in own behaviour

Reflection on previous practice made some people think about how the training had reinforced that they already felt informed about mental health problems and for these participants the training did not provoke any thoughts about changing their job behaviour. However, for one person it brought up the inadequacy of what they had been told previously about how to deal with patients with mental health problems.

> *"...it was reinforcing what you know already...."*
>
> *"...I feel quite aware of mental health issues..."*
>
> *"...don't antagonise her...and that's all we were told."*

Participants who did feel that they had developed their knowledge through the face-to-face training thought about how they could be more aware of the signs of mental health problems/mental distress in the patients that attend the surgery, they were also developing more empathy towards people with mental health problems and becoming more person-centred. One specific idea for change in behaviour was to ensure knowledge of the services within the local area and another was to have posters and leaflets on mental health in the reception area.

> *"...discussing with colleagues, peers, service users, looking at relevant website and things and making yourself aware of exactly what it available."*

3.2 Sub-Theme: Changes in Colleagues' Behaviour

Overall, participants hadn't seen a difference in the job behaviour of their colleagues other than one change that had been noted by one person was the receptionists trying to be more patient and clear with information that they are giving to patients. The reasons for not seeing changes in colleagues was predominantly that clinicians see patients separately so there had been no witnessing of each other's job behaviour, or being short of time due to being short-staffed and really busy, or that the time-period since the training had not been very long. However, most people had discussed the issues at some point with colleagues either in informal settings such as lunch, or more formal settings such as practice-wide meetings which in one instance had allowed people to talk about handling consultations differently.

> *"....handled consultations differently and people have said to them that a really good...consulta…*[consultation]*.....the patient's actually said, so it must have made a difference."*

3.3 Sub-Theme: Reinforcing the learning

Most participants mentioned talking about the training after it had occurred and these discussions reinforced the learning and kept the focus on mental health. Some of these discussions occurred at informal times such as lunch, and others at a specific meeting where the idea was to share the learning from each person's training experience. They felt this broadened the learning that they had taken from the face-to-face training.

> *"..sitting together everybody said her scenario and what had happened and what we learnt from it and the learning point from it. So I learnt about other people's scenarios as well."*

> *"I have discussed how we might approach a particular individual's needs and discussing what services might be available and how we might help somebody more effectively..."*

A person in a leadership role in a practice who is keen to see change seems key to considering and driving changes that might be made following the training.

> *"....was quite passionate about us ... taking this on board and all becoming more aware as a practice which is why she called the meeting with everybody...which is why she's laid down guidelines which she feels we should be aware of and what we should do to help people."*

Summary of Theme 3: Change of Job Behaviour:

- **The training provoked reflection on previous knowledge**
- **Some people felt they knew enough already in order to be able to do their jobs**
- **Participants of the training had started to develop empathy towards people with mental health problems.**
- **Changes in empathy were demonstrated through participants starting to think what the life of someone with a mental illness might be like and how they might understand their behaviour better**
- **Discussing the training afterwards with colleagues broadens the learning of each individual**
- **Having leadership around these issues is key**

4. Theme 4: Results from the face-to-face training

(incorporating the sub-themes of Time and Pressure; and Intentions to do things differently as a result of the face-to-face training)

4.1 Sub-Theme: Time and pressure

The staff in the practices were feeling under time pressure because of competing priorities and being short-staffed so there weren't any direct results from the training apparent to them as yet. There was also a feeling that it had been a short time-period since the training so it was too early to demonstrate results.

"....we are just plate spinning that's all we are ever doing...."

"...I think it is probably too soon to say because it was only a few weeks ago..."

There was intent to try and use resources effectively both within and outside of the practice itself and a desire to get people the help when they needed it whilst knowing the limitations of the expertise and time within the primary care practice. There was an awareness that referrals to mental health services are going up.

4.2 Sub-Theme: Intentions to do things differently as a result of the face-to-face training

Although some people did not feel that they needed to change what they do as a result of the face-to-face training, there were many ideas came up from participants about what needed to change and what intentions had already been discussed or thought about within the practice.

Having more information about mental health for patients, particularly in the form of posters and leaflets was the most widespread intention for the future in order to make practices more mental health friendly. These means of communication - the leaflets and posters - would enable patients to feel like the practice is open to talking about mental health; would raise awareness of mental health; make people feel comfortable about asking for help with their mental health and also would help professionals know where to refer and signpost people. One participant thought that having a leaflet to give patients would help them to build rapport. People had been identified in the practices to find leaflets that could be used.

Staff are aware of services that are around for patients who need a higher level of service than primary care can provide. However, they demonstrate that patients should have access to this information too through wanting information available for patients directly, and are encouraging of self-referral. However, having up to date information is hard as services that are available do change.

"...having...posters or things that mental health isn't just to do with what people perceive as mental health ....you've got depression you've got...all sorts of different issues within that so you've got to...so people are aware 'oh well, I'm feeling like that perhaps I could contact them.'"

"...in the queue waiting to be seen.....looking around there is nothing about mental health...there was no leaflets, pamphlets there's nothing no posters on the wall...."

Another idea that had been considered was having a side room in reception where patients who were distressed could sit, and also somewhere that reception staff could talk to patients whilst maintaining confidentiality, which they can't always do over the desk. This demonstrates an increase in the thinking about how the situation is for the patient and developing some empathic responses to them.

A useful means to plan how to go forward is having a meeting amongst practice staff. Where this had occurred it seems to have helped transfer learning into practice – such as identifying someone to start finding leaflets – other people we were waiting for a meeting before they could decide how to move forward. The establishment of a meeting for action-planning seems to enable the practice to move forward as a whole rather than as individuals, and also allows those who feel more familiar and knowledgeable about mental health to be engaged in forward thinking.

Summary of Theme 4: Results from the face-to-face training:

- **No observable behaviour changes were apparent to participants at the time of evaluation; however the opportunity to witness behaviour changes have not been available as primary care practitioners tended to work separately.**
- **There were many intentions to change things, of which having information about mental health available for patients was the major one**
- **A meeting to plan for change helped to transfer learning to practice**

Postcard Promises from the Case Study Practices

47 Postcards have been analysed from the two practices that form the case study. The table below outlines the themes that emerged, along with illustrative quotes, and the narrative around that theme.

Theme	Narrative
Information for Patients and Staff *"Work on notice boards in the waiting room and in the toilets."* *"Investigate posters/leaflets for display in waiting room and clinical rooms."* *"More information on display and leaflets promoting where you can get help and advice."* *"Use the websites you have give me details of to signpost patients who might be in need of help."*	Participants want to have information about mental health in the form of posters and leaflets for patients to look at, read, and take home. The waiting room is the main area for the information, but toilets and consultation rooms are also mentioned. On the whole is seems that it is hoped that this will promote a feeling of openness about mental health in the surgery and that patients can access the help they want themselves by having the information or staff could direct them by having the information to hand.
Listening to Patients and their Stories *"Listen more attentively."* *"To listen more and be more aware."*	A key element of what participants want to do more of is listening to patients and not making assumptions about a patient's circumstances but finding out more about them. This emerged about carers too. The reason for listening is an increase in understanding of the patient and their needs.
Structural Changes to help patients get a better service *"Also a quiet side room for people to discuss any problems."*	There are some very practical ideas about how processes and structures can help them to help their patients. In clinics, these are around time for the patient to be able to talk

"Make continuity of care for initial doctor easy." *"Identify mental health problems on computer so that all staff are aware of how to treat that person appropriately if necessary."* *"..if necessary booking double time slots."*	over the issues with a clinician and ensuring that a patient sees the same doctor each time. In the reception, staff want to be aware when a patient has a mental health problem so that they can be more prepared to deal with that person, and also a side room to talk to people so that confidentiality can be maintained.
The Skills Needed to Develop Positive Relationships with Patients *"Continue treating patient with mental health problems as individuals and communicate with them in a sensitive way."* *"Encourage trust and empathy."* *"To make good relationship with the patient so he can discuss all interventions."* *"...act with respect in all consultations."*	This involves building on skills already in place for some staff and considering what skills need to be developed for others. Skills such as empathy and being positive whilst building trust with and empowering patients are key. The training had promoted empathy amongst some staff and it had made them reflect on their own lives. Some people want to work across their team to develop practice-wide trust, positivity, friendliness and openness and therefore supporting patients to talk over options for interventions rather than immediately prescribing.
Considering Children's Needs "*Consider children's mental health needs."* *"Be more aware especially for young children."*	Being aware of the mental health needs of children and the importance of listening to the child from their perspective was something that participants want to build into their practice.
Discussing the Issues with Colleagues *"Support for stressful situations that colleagues may be experiencing."* *"Discuss this tremendous training experience with colleagues in the practice."* *"Staff meeting to look at ways to address the issues."*	Being able to talk to colleagues to get a commitment to all the changes that participants wanted to share is important, as well as understanding that colleagues may be experiencing difficult and stressful situations and feeling able to support them at these times.

Summary of the Postcard Promises from two practices: The themes were:

- **Have more information about mental health for patients and staff**
- **Listen to patients and their stories**
- **There are some structural changes that can be made to help patients get a better service**
- **There are skills that need to be developed in order to develop positive relationships with patients**
- **Children's needs have to be considered**
- **Discussing the issues with colleagues is important**

Overall Summary of Phase 2: The Evaluation of the Impact of the Training on Two Particular Primary Care Practices.

- **The face-to-face training was well received. The online training opportunity has not been taken up.**
- **Awareness has been raised about mental health problems and the needs of people with mental health problems**
- **Attitudes towards people with mental health problems have improved**
- **Participants are more open to listening to patients and are demonstrating empathy and an intention to develop this further**
- **Some participants felt aware of mental health problems, appropriate to their roles, prior to the training**
- **Participants had not observed a change in their behaviour of their colleagues but have not been in a position to witness this as practitioners work separately. In discussion between practitioners. A patient had mentioned an improvement in their experience of a consultation**
- **The training has provoked a plethora of intentions to change structural and relationship issues with patients.**

Element 3: Analysis of the postcards from all primary care practices

A total of 242 people were trained in the evaluation period. The trainees were asked to complete postcards with a personal pledge on making their practice more mental health friendly or their thoughts/insights about the training they had undergone.

Qualitative analysis was performed on 242 received pledges and the summary of the main themes along with illustrative quotes for each is presented below.

Theme	Narrative
Dedicating more time to clients "*I will try to identify more time specifically for patients with mental health problems so that there is enough time to listen"* *"Allow sufficient time for appointments if necessary booking double time slots"* *"I feel that more time should be spent talking things through, rather than immediate prescribing, to achieve more empathy with individual needs"* *"Appropriate use of double appointments – currently 'not allowed' at my practice"*	A number of trainees emphasized the importance of dedicating appropriate amounts of time to clients with mental health problems. Some have even argued that it would be advisable to book double time slots for them, although two clinicians pointed out that this would slow down the working process. A number of participants also noted that dedicating more time also meant that they would have an opportunity to get to know the client better and find out about different areas of their lives where they may also need assistance.
Better awareness of personal sentiments/attitudes towards people with mental illness as a result of direct contact with IW *TTC 'Rethink' made me rethink* *Remember to always listen and show empathy* *Remember that the first presentation of a person with mental illness can be bad, but don't judge everyone on first impression* *We need to do more and more to help people with mental health they are human beings just like me, who needs a bit more care.* *Have respect for them and make sure it's at least one thing they remember.* *Try to be more understanding and helpful give time when needed and understand that it is an illness that cannot be helped.*	Trainees largely praised the face to face training, not the least because it made them look at the proverbial mirror and face some of their own sentiments and attitudes that they may have been harbouring towards persons with mental health problems. They talked a lot about the need to develop empathy towards people with mental health problems by allowing sufficient time in the consultation to get to know one another. The trainees also talked about the need to encourage and support their clients as well as show more understanding and appreciation of their daily challenges.
Importance of sharing knowledge with colleagues in the PCP/ importance of continued learning *Will try to access mental health training to improve my confidence and skills when seeing patients with a MH history.*	The trainees highlighted the benefits of the face to face training they had undergone and several people talked about wanting to access www.ttcprimarycare.org.uk to gather more information. This is quite important as it tells us that the training was timely, well received and much needed by all groups of trainees (medical

Discuss my role with colleagues to promote thinking about mental health and referrals to the IAPTs *Identify mental health problems on computer so that all staff are aware of how to treat person appropriately if necessary* *I hope to get a GP hotline to support them [i.e.clients], e.g. medication changes, when they need expert opinion* *I will look at the TTC website and think about what else we might do*	and non-medical). This also suggests that clinicians would appreciate easy-access training resources where they can explore independently how best to apply their knowledge to their practice. Also the trainees discussed the need for more awareness of mental health training to be offered regularly at the practice and the importance of it in keeping the staff updated on how to make mental health friendly and supportive.
Signposting to other services in the area which clients can access/advocating for client's needs and continuity of care *Need for holding CPA meetings in the practice* *Continue to advocate for better services for patients and better support of patients* *Community doctors need to be aware of other referral avenues of acute psychiatric episode not just A&E* *Ensure that when I identify a patient with 'undiagnosed' mental health issues- I make the patient an appropriate appointment with an appropriate service.*	Interestingly, the trainees also discussed the need to share their newly acquired knowledge with the rest of their practice in order to improve service delivery on all fronts. Also, it was encouraging to see that a number of trainees decided to put their knowledge to the test by applying it directly on establishing better and more direct referral pathways for their patients. The trainees were also eager to acknowledge the limitations of their knowledge in the specialist field of mental health and the importance of working with other services in ensuring that clients get the best possible care.
The importance of considering the family/carers when working with a client with mental health problems *Mental illness can bring families together ,need to think about that* *The notion that behind the patients (often) are bewildered relatives* *To make good relationship with the patient so he can discuss all interventions* *Enable relatives of patients with mental illness to be able to tell their story*	The trainees highlighted the need to consider the families' and carers' needs and opinions when making decisions about the clients. They said that their perspective is often omitted, somewhat unwittingly, from the decision-making process. Also the trainees emphasized the need for more awareness of their needs and challenges that they as carers go though on a daily basis and be able to refer them to services where they can get support. The most important point that some trainees made is the need to work in partnership with the carers, who can be doctors' best allies in ensuring continued care for the client.

Communicating information about mental health more visibly in the PCP *More information on display and leaflets promoting where you can get help and advice* *To make the surgery more mental health friendly posters could be put up on the walls and there could be leaflets which offer help for people who think that they may have a problem with mental health. Also a quiet side room for people to discuss any problems* *Put up more posters and information leaflets. Make sure staff as well as patients are aware of local resources available*	The trainees said that one of the ways in which mental health friendly attitudes could be promoted in the PCP is to have the information about mental health as well as local supporting services made more visible. This would include posters in the waiting rooms and leaflets on the counters that people could take home with them. Ideally this would be useful not only for clients and their carers and families, but also for PCP staff who may wish to consult them when recommending services to clients. Furthermore, the posters and leaflets would ideally keep the idea of mental health fresh and current for the staff.
Using the professional knowledge of mental health to improve personal relationships with friends/colleagues/ family members with a mental health problem *It was nice to talk about mental health. It reminded me of members of my own family who are suffering. We should talk about it more often.* *A heads up to the mental health of my colleagues* *Importance of social inclusion, support and awareness, amongst colleagues as well not just patients*	This topic was not the most widely identified pledge following the training, but nonetheless, the information gathered from a handful of trainees who talked about it, identified how they have acquired some transferrable skills in this training, not just pure academic knowledge. Whilst some of the trainees spoke about being more in tune with their own mental health problems others pledged to offer more support to colleagues with mental illness as well as to their family members.

Summary of: Analysis of the Postcard Promises

- **The trainees on the whole reported raised awareness of the issues faced by people with mental health problems as well as their carers**
- **They also identified ways for the PCPs to improve access to services for these groups, such as making appointments longer, signposting local mental health services via posters and leaflets, and building links with local services in order to provide more joined up care for this group**
- **The trainees emphasised the need for continued learning and refresher courses and in that they mentioned the online training at ttcprimarycare.org.uk as a valuable source for clinicians and non-clinicians alike**
- **The trainees also talk about the transferrable skills acquired in the face to face training and how these can be used not only to improve working relationships but also personal relationships with members of the family who may have a mental health problem.**

Element 4: Impact on empowerment and social capital of delivering the training for the Involvement Workers

Participants

Of the 14 Involvement Workers (IWs) that worked on the project, a total of 13 completed T1 and T2 surveys were returned. Additional T2 surveys were attempted (17), but had skipped questions through-out or were duplicate entries, so the data had to be discarded.

The IWs were involved in between 2 and 7 training events delivered in primary care practices. The participants taking part in the survey delivered a total of 56 training events between them, averaging at 4.3 sessions per IW.

The participants had been involved with the Time to Change and the Primary Care Education project for a little as 3 months and some for over 18 months. The majority (n=7) had been involved with the project for between 4 and 6 months.

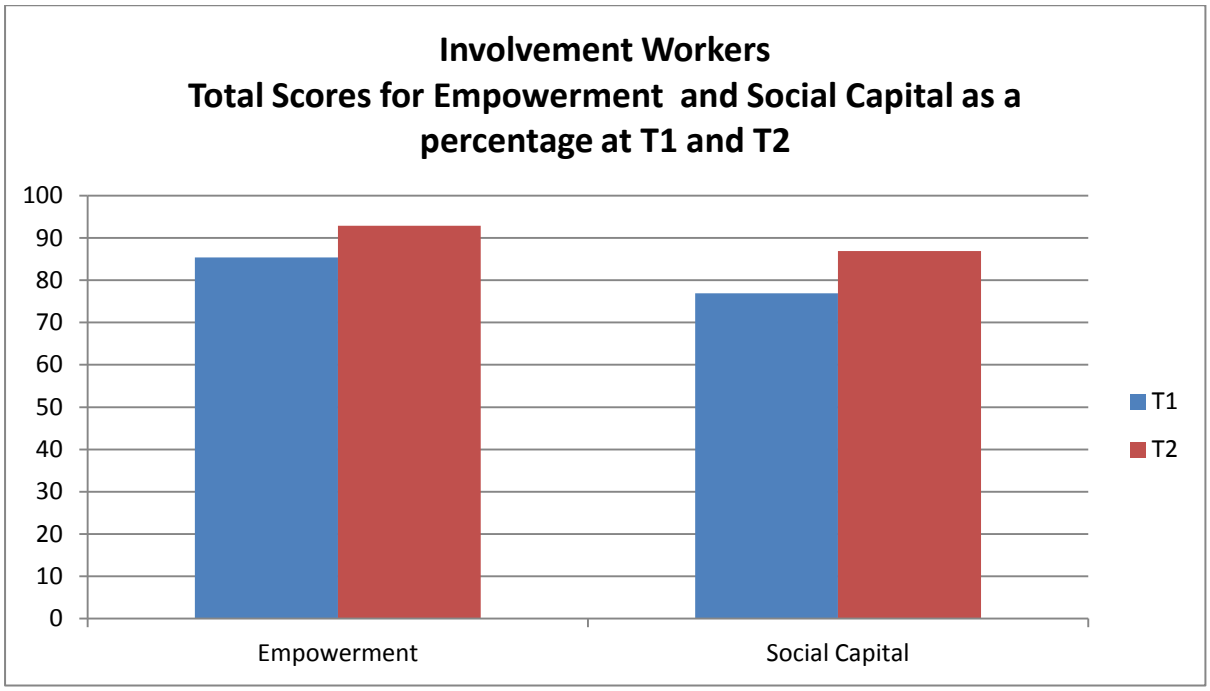
All of the IWs participated in a two day training programme, before delivering the '*Make Your Practice Mental Health Friendly'* training in practices. Each IW has lived experience of mental health problems.

Data Analysis

Due to the small sample size, only descriptive analysis was performed on the data. The qualitative data was analysed manually, using thematic analysis.

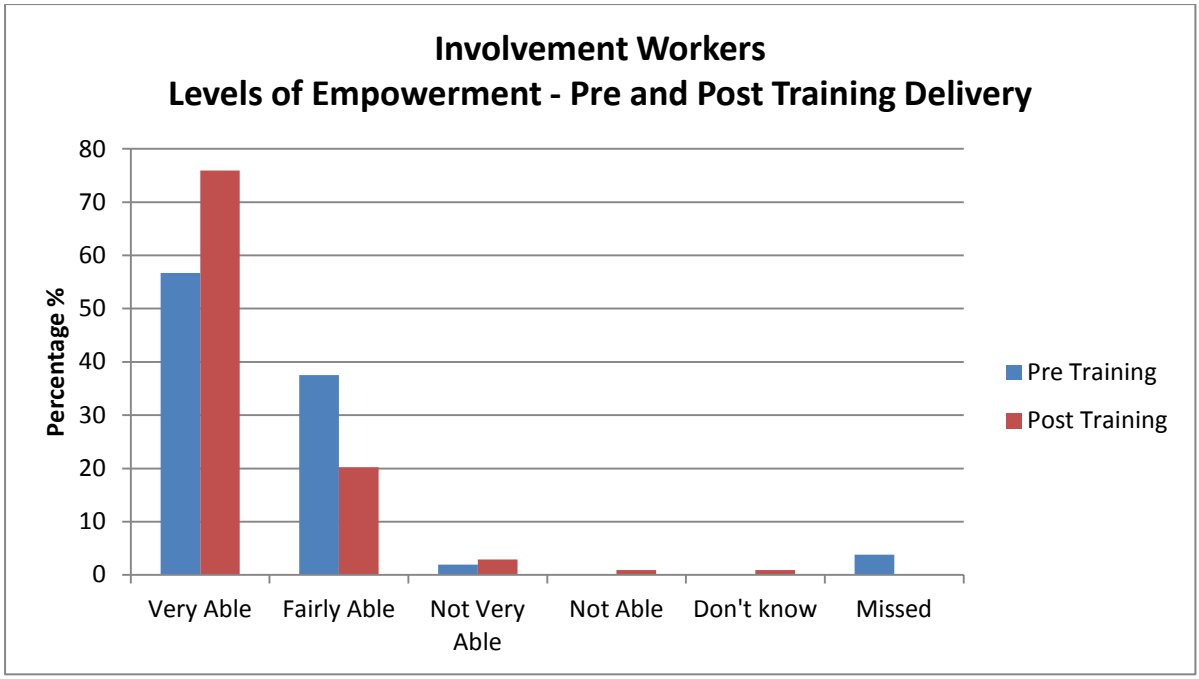
Findings

On the whole, the Involvement Workers scored highly in their levels of ability in both areas of the survey at T1 and T2. At T1, the IWs scores were at 85.4% of the total maximum score for the Empowerment questions, and 76.9% of the maximum total score for the Social Capital questions. Following involvement in the delivery of the training, the overall scores for the Empowerment questions had improved by 6.9% and by 11.1% for the Social Capital questions, with an overall improvement of 9.5% across the 21 items in the survey.



Empowerment

The IWs responses were mainly located in 'Very Able' and 'Fairly Able', with very few selecting other options at both pre and post training delivery, showing a high level of perceived empowerment. The improvement in levels of empowerment following the training in the 'Very Able' category was 19.2%. However, there was a very slight increase in participants choosing the 'Not Very Able' and 'Not At All Able' categories, post training delivery (0.9%).



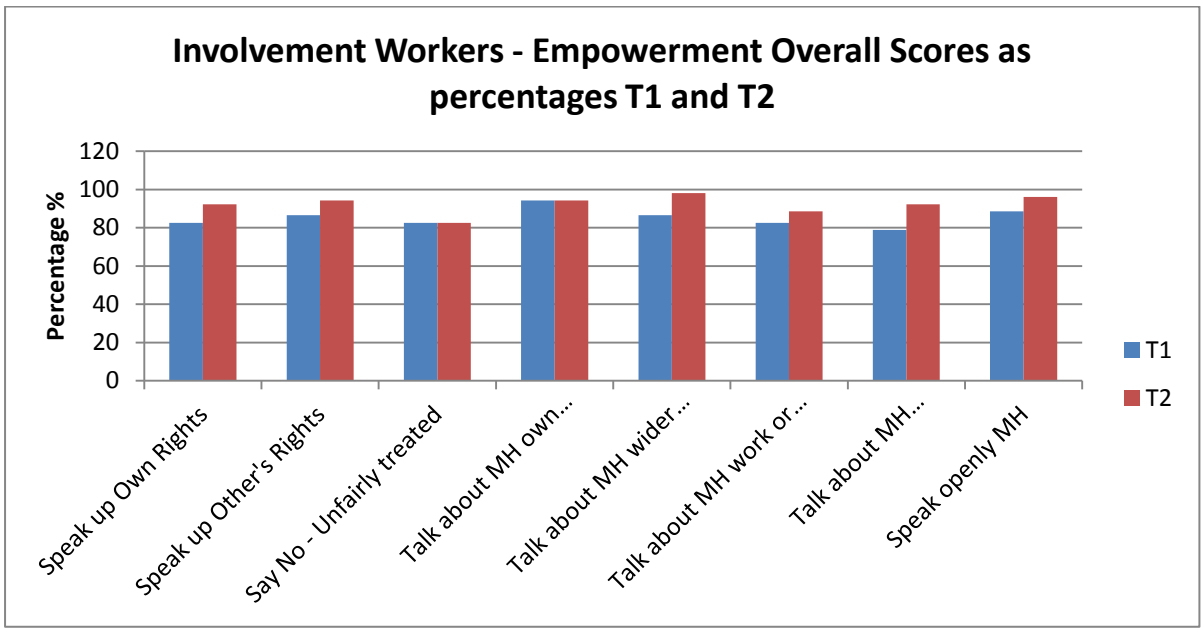
At T1, the top two areas where IWs felt most empowered were :

- Talking about mental health in their own community
- Speak openly about their own mental health

At T2, this changed with 'Talking about mental health in the wider community' becoming the area with highest levels of empowerment.

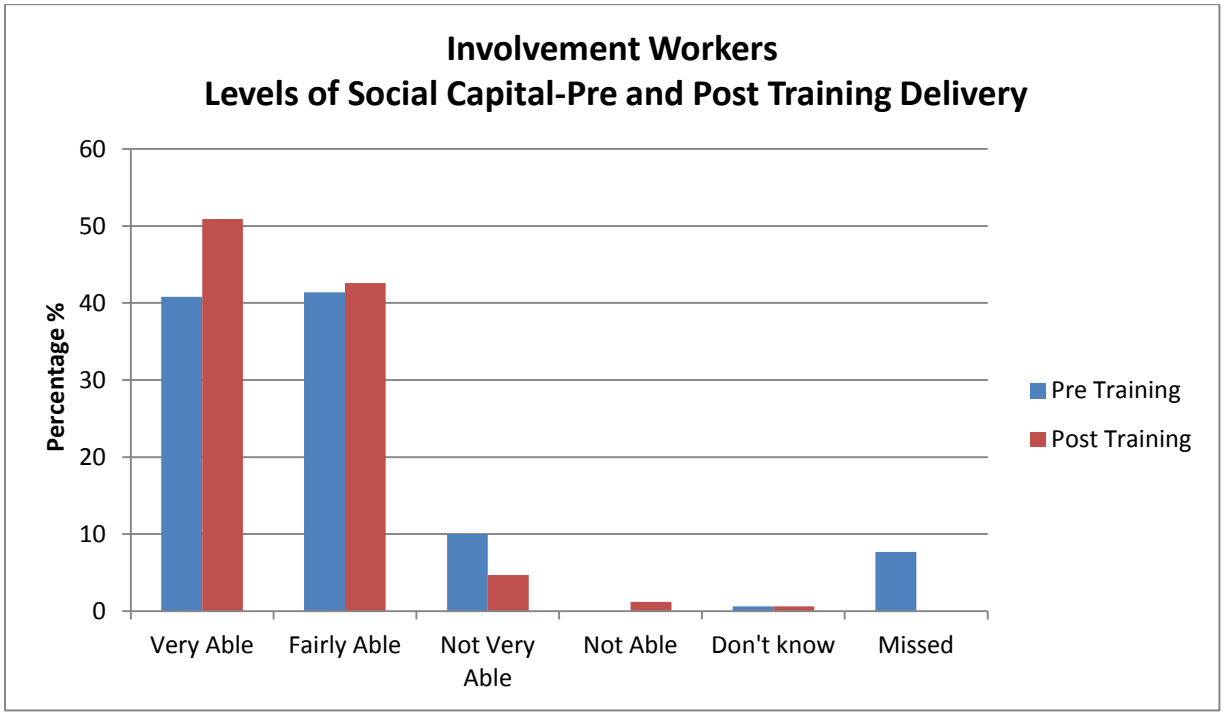
The lowest scoring area of empowerment at T1 was 'Talking about mental health with friends and family ', however, at T2 this improved, moving three places higher.

All but two areas of empowerment showed improvements at T2, except for 'Saying no to being treated unfairly' and 'Talking about mental health in my own community', which stayed the same.



Social Capital

As with the Empowerment scale, the IWs again reported high levels of social capital, with the majority of the responses being located in 'Very Able' and 'Fairly Able' categories. IWs again showed improvements in percieved social capital, with a 10% rise in social capital scores for 'Very Able' at T2 overall.



All areas of the social capital showed improvement following the delivery of the training in primary care practices. The top two areas of social capital that scored highest at T1 were:

- Giving help to others when needed
- Making friends

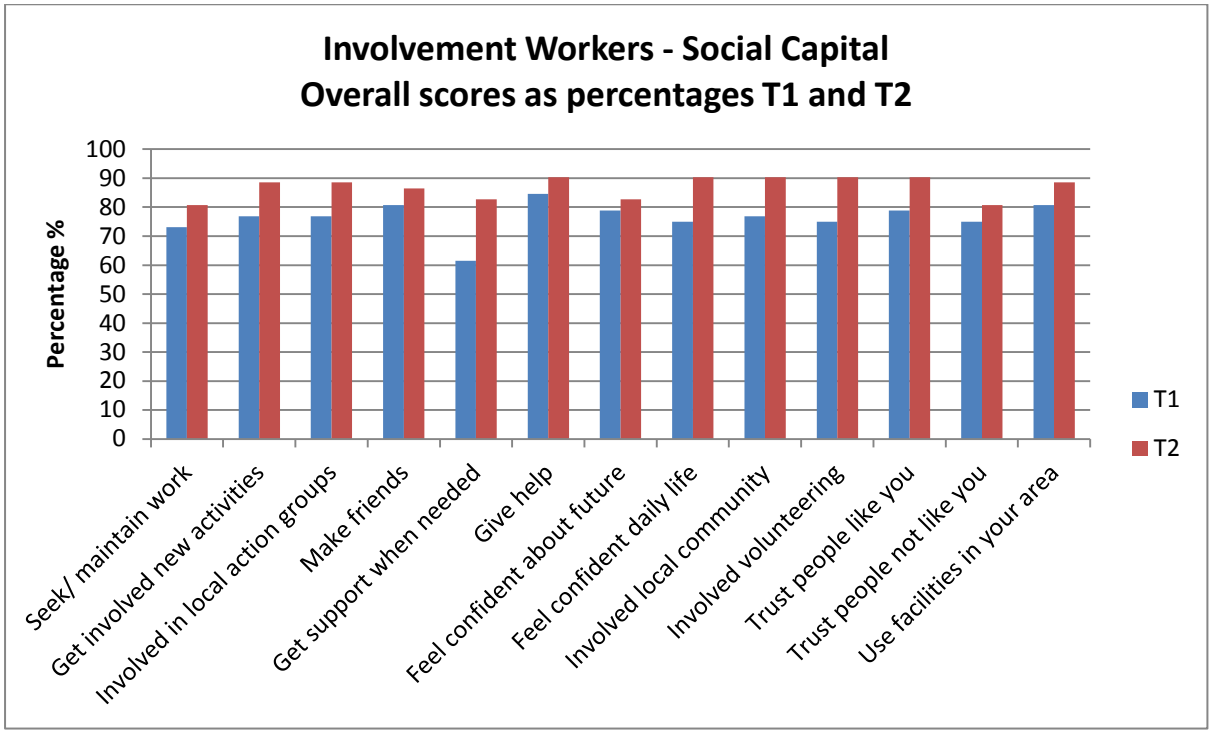
The lowest scoring areas were:

- Getting support when needed
- Seeking and Maintaining Work/Employment

This changed at T2, with five areas becoming the joint highest scoring:

- Giving help to others, when needed
- Feeling confident in daily life
- Begin involved in the local community
- Getting involved in volunteering
- Trusting people like you

There was little change in the lowest scoring areas, with 'Trusting people not like you' also becoming one of the lowest scoring areas.



Summary: Empowerment and Social Capital Questionnaire

- **Involvement Workers had high levels of empowerment and social capital both pre and post delivery of the training**
- **After delivering the training, the highest area of empowerment was 'talking about mental health in the wider community'**
- **'Saying no to being treated unfairly' and 'talking about mental health in own community' stayed the same**
- **All areas of social capital showed improvement following delivery of the training programme**

Comparing the findings to the Time to Change Omnibus Baseline

When comparing the findings from the IWs to the Time to Change Omnibus (Dec 2012) findings for the 'Very Able' category (a baseline survey conducted with 1014 adults with mental health problems), the IWs scored higher in the 'Very Able' category in all but 5 areas across both Empowerment and Social Capital at T1, with an overall percentage score at 27.5% higher than the Omnibus baseline. These lower scoring areas are:

- Speaking up for your own rights (Empowerment)
- Speaking up for others' rights (Empowerment)
- Saying No/standing up to discrimination (Empowerment)

- Getting support when you need it (Social Capital)
- Becoming involved in volunteering (Social Capital)

At T2, improvements were seen in the overall score for 'very able' with an increase of 17.2% on the T1 scores, and with an overall percentage score at 34.9% higher than the Omnibus baseline.

In contrast to T1, the IWs scored higher than the baseline in all but one areas at T2. This area is:

- Saying No/Standing up to a person treating you unfairly

One specific area of Empowerment 'Saying No/Standing up to a person treating you infairly', produced a slightly lower score at T2, suggesting that some IWs may have had a negative experience following delivery of the training.

The table on the following page shows the percentage changes in 'Very Able' categories in comparision to the Omnibus baseline data. The stars on the table denote the areas that fall lower than the baseline data score, however overall the scores are much higher than the baseline for the IWs.

Involvement Workers – Overall percentage changes in 'Very Able', in comparison to the Omnibus baseline data

	TOP BOX - % VERY ABLE			
	Omnibus baseline	IW Pre-training delivery	IW Post training delivery	
Total Empowerment	**40**	**57.7%**	**74.9%**	**+17.2%**
Speak up for your own rights	51	30.8%	69.2 %	+34.4%
Speak up for others' rights	50	46.2 %	71.4%	+25.2%
Say no/stand up to person treating you unfairly	46	38.5%	35.7%	-2.8 %
Talk about mental health within your community/area	31	76.9%	84.6%	+7.7%
Talk about mental health outside your community/area	27	69.2%	92.3%	+23.1%
+Talk about mental health at work/school/college	29	53.8%	76.9%	+23.1%
Talk about mental health with friends/family	50	61.5%	84.6%	+23.1 %
Speak more openly about your mental health	36	76.9%	84.6%	+ 7.7%
Total Social Capital	**36**	**38.4%**	**50.5 %**	**+12.1 %**
Seek work or maintain employment	45	46.2%	64.3%	+ 18.1 %
Get involved in new activities	38	46.2%	53.8%	+7.7%
Be involved with local action groups	24	46.2%	53.8%	+7.7%
Make friends	44	53.8%	53.8%	0%
Get support when you need it	39	15.3%	30.8 %	+15.3%
Give help if needed	52	61.5%	61.5%	0%
Feel confident about the future	32	38.5%	38.5%	0%
Feel confident in your daily life	37	30.8%	38.5%	+ 7.7%
Become involved in community/local events	30	38.5%	61.5%	+23.1%
Become involved in volunteering	34	15.3%	61.5%	+46.2%
Trust people who are like you	36	38.5%	61.5%	+23.1%
Trust people who are not like you	15	15.3%	15.3%	0%
*Use the facilities in your area	42	53.8%	61.5%	+7.7%

Summary of: Comparison with Omnibus baseline

- **There were several areas where the IWs significantly improved compared to the Omnibus baseline**
- **These areas included 'speaking up for self and others', 'getting the support when it is needed' and 'feeling confident in one's daily life'**

Element 4:Qualitative Findings

The Involvement Workers were asked to complete two open-ended qualitative questions at the end of the project. Fourteen IWs gave a response. The questions focused on:

- The IWs' experience of delivering the face to face training to primary care staff
- The skills that the IWs developed through being in involved in delivering the training that were of value in other parts of their life

Experiences of delivering the face to face training

IWs experiences of delivering the training fell broadly into four categories, which are outlined in the table below:

Theme	Narrative
A positive experience *'It was far more positive than I thought. A very valuable experience.'* *'I enjoyed doing it.'*	All of the IWs described a positive experience of delivering the training. Many of them described feelings of being uncomfortable and nervous in the beginning, but their confidence grew over time. On the whole they found it rewarding and valuable.
Empowering and confidence building *'It gave me the confidence to realise that I could speak to professionals, just like I speak to everybody else.'* *'Very empowering, particularly watching staff's excitement about the training.'*	Some IWs found it empowering, rewarding and challenging. It gave them a lot of confidence in one to one situations. They described the experience of being able to talk to professionals as empowering and enlightening. This seemed to stem from the realisation that they were able to successfully converse with professionals, even if they though this previously to be difficult. The support from the project's paid staff was also highlighted to be very important to the success of the project
The value of a two way conversation with primary care professionals *'My biggest fear was feeling not hear or rejected – I didn't experience this.'* *'I found that all people were interested and willing to listen.'*	IWs felt that being able to have a dialogue with primary care professionals was really positive. They especially highlighted the value of being able to meet with busy GPs and to hear their perspective on mental health. Being heard and listened to by primary care staff were identified as valuable outcomes for the IWs.

Understanding pressures in primary care *'Enlightening in realising the many pressures.'* *'Great to reach GPs as their time is very protected.'*	Being able to talk with primary care staff during the training raised the awareness of IWs regarding the pressures that practices experience. This was described as enlightening. Hearing the GPs point of view and understanding the issues and concerns was very positive. GPs were seen as a very hard to reach group and being able to spend time with them was invaluable.
Mental health problems are common, even in professionals *'It amazed me how common mental health problems are, with several people I've trained saying they are directly or indirectly involved with mental health issues.'*	IWs were surprised at how many professionals they spoke to had mental health experience of their own. They felt that many professionals wanted the time to talk about their own or relative's experience. This was considered to be 'encouraging', when the IWs realised that professionals wanted to know more and were willing to open up about their own concerns.

Transferable skills for the future

The findings in this area produced three specific themes that were considered to be transferable for the future:

Practical Skills	Intrapersonal skills	Interpersonal skills
Speaking skills	Confidence	Communication
Listening skills	Clarity of purpose	Facilitation
Presentation	Leadership	Support to others
Timing	Flexibility	Team Work
Preparation	Structuring personal stories	To be 'Person Centred'
Organisational skills	Develop resilience to criticism	

Summary of: Qualitative Analysis

- **Involvement workers found delivering the training a positive experience which was empowering and confidence-building**
- **There was positive value in a 2 way conversation with primary care professionals and an increase in understanding the pressures that primary care professionals face**
- **Involvement Workers developed transferable skills from taking part in delivering the training**

Secondary analysis of qualitative data from 2 day Involvement Worker training event

Prior to the commencement of the primary care education project, the Involvement Workers received a 2 day training to prepare them to deliver the face to face training in primary care practice, and to enable them to shape the way that the training was delivered. An initial evaluation was undertaken by Rethink regarding the experiences of the 2 days training. As part of the overall evaluation of the project, a brief secondary analysis of the data has been undertaken. This secondary analysis has focused on the empowerment, social capital and transferable skills elements of the IWs evaluation, using these as a guide to identify themes emerging in the 2 day training data. Eight IWs responded to the post 2 day training evaluation.

Many of the themes emerging in the data read across to the themes outlined above and to specific areas in the Empowerment and Social Capital survey findings. They are outlined in the table below:

Theme	Narrative
Concerns about confidence and ability to deliver *'I was not feeling very confident because I wasn't sure how I was going to present my experiences with GPs.'* *'Apprehensive about fitting everything in.'* *'Having to pluck up courage and 'do your bit' in front of the camera was difficult but extremely helpful.'*	The IWs reported varying amounts of apprehension and levels of confidence around being able to deliver their personal story within timescales, and so that it did their story justice. These concerns about confidence and ability to deliver were echoed in the post training delivery findings for the IWs. However, there is a positive move forward for the IWs, as they describe their confidence as increasing and their fears being reduced, as there fear are dispelled by their good experiences in the primary care practices.
Team work and team ethos *'Support and encouragement from all at the training helped increase my confidence.'* *'I felt part of the team, involved in the whole package.'* *'Felt like a valued member of the team.'*	IWs referred to the importance of working as a team and creating a team ethos. Having this approach was said to help increase levels of confidence. Feeling part of the team involved in the shaping and delivering the package was felt to be valuable. This also came across in the themes emerging from the post training delivery evaluation as a transferable interpersonal skill.
Shaping the project and empowerment *'It was a very empowering process…designing, planning delivering, preparing and rehearsing the delivery of a tailor made training package. I found the process highly informative and enjoyable.'*	Rehearsing the delivery of the training and being able to develop a bespoke training package, based around IWs personal stories came across strongly in the feedback. Some IWs found this level of ownership and involvement to be an empowering process. Some IWs identified that being able to go a step

'I would have liked…in the future with regards to co-designing a training package.'	further and co-design training in the future would be beneficial.
Feeling valued *'It gave us ownership.'* *'The ability to make key points.'* *'Our views were taken very seriously…'*	Many of the IWs reflected that they had felt valued in being involved in shaping the training and being a member of the team. This theme ties in with the findings in the post training delivery evaluation, as an important aspect in being involved in delivering personal stories and being valued in both primary care practices, and as part of the delivery team. One IW indicated that the role and title did not reflect the work that they were doing as it appeared vague. The skills that they used to design and facilitate the training were seen as being unique and they wanted this to be recognised.
The challenge of not being listened to *'Doctor not at all interested, or says s/he's very good at dealing with mental health patients.'* *'GP being dismissive or appearing not interested.'*	This theme also emerged strongly in the findings of the post-training delivery survey. IWs showed concern about not being listened to and saw this as being a major challenge. However, their experience of delivering training in the practices proved to be highly positive and they were surprised by the level of interest in mental health issues and their stories.
Great opportunity to influence *'A great opportunity to influence GPs and make them more aware of mental illness.'*	Being able to influence the way that mental health services were designed and deliver came across as inspiring and a key motivator for some of the IWs. Being able to bring a focus on mental health to a GP practice was seen to be a great opportunity to influence practice.

Summary of: Secondary Analysis of Data from IW Training Event

- **The confidence of the Involvement Workers increased around their ability to deliver the training**
- **The team work and team ethos was important and the opportunity to shape the training programme was empowering and confidence-building**
- **IWs were concerned about not being listened to when delivering the training but this wasn't borne about by their experience**
- **IWs found it a great opportunity to influence the practice in primary care**

Discussion

Overall for Element 1 of the evaluation, there was a good response rate at T1 and T2 (84%). 242 people received the training. 209 completed the T1 survey and 203 completed the T2 survey. We were able to analyse 201 matched pairs of questionnaires. For T1b and T3 there was insufficient data returned to allow for analysis of the impact of the online training materials. Therefore, this evaluation necessarily concentrates on the evaluation of the face-to-face training. It is unclear why there were few responses to the T1b and T3 surveys as it is evident from Google analytics that people did visit the website. One of the issues might have been the short data capture period as it was discovered that a few people were still visiting the survey after the end of the data capture period. From the T3 data and Google analytics we were unable to determine how many had actually finished the online training - 1 person finished the survey. The findings from the case study interviews show that not having the time was the main reason for not having completed the online materials. We have considered whether registration to the site, which takes time, was a barrier for some people, as the primary care practitioners did emphasise the time pressure that they experience.

When considering at the results of the questionnaires at T1 and T2, we found that face to face training does make a difference overall and that it made a statistically significant impact primarily in the areas of changing knowledge. The effect on changing attitudes was also positive, but not as strong as in the areas of knowledge. The key questions where the training had made a difference were in the areas of knowledge e.g. recognising signs of mental illness. In the case study an increase in the awareness of mental health problems and the needs of people who had mental health problems was the biggest impact.

According to the questionnaire results, there was little difference in the questions that had an affective/emotional component. These questions focused on talking about their own mental health or discovering other people had mental health problems (Qs 9, 10 and 11). However, in the case study we did find that participants were emotionally engaged in the stories that had been shared as part of the training. Some had reflected on their own mental health or that of friends and family about what it is like to live with a mental health problem and what adjustments might be made to their practice, suggesting an improvement in attitudes. It is however possible that these participants, as demonstrated by the T1 questionnaire, may have had positive attitudes to start with, as most participants did.

The training reinforced a lot of what primary care professionals knew already about mental health but it also made people think about how they might change their behaviour or how the Practice might respond. There was very little specific information about changes in the individual's behaviour. Participants were at the stage of reflecting on their training experience and there were lots of intentions to change practice within the Practice, these mostly were in the areas of providing information to patients and listening more.

For the Involvement Workers, delivering the training was a positive experience which made them feel empowered and built their confidence. They appreciated being able to talk to primary care professionals on an equal footing. They developed transferable skills in three main areas – practical,

intrapersonal and interpersonal. It was found that the Involvement Workers (IWs) already had high levels of empowerment (E) and social capital (SC) before they were involved in the training delivery. Post-training an improvement was seen in both of these areas for IWs although it is difficult to say it is statistically significant due to the small sample size. However, we can say that having the opportunity to deliver the training has made a difference to the IW in both areas (SC and E). The case study showed that the personal qualities, style and experiences of the trainers/IWs was key to the success of the training having an impact. Participants felt able to ask questions and make changes to their practice. Sharing the personal experiences of the IW made the training feel more effective interesting and enjoyable to trainees. Those participants who had one particular trainer had started to think about the mental health needs of young people, so the specific experiences of the trainer could make the outcomes of the training different.

There was improvement in every area of social capital for IWs although 'trusting people not like you', became the lowest scoring area at T2 (i.e. other areas of social capital come out higher at T2) – this is interesting as they had by then spent a lot of time talking to others about their own mental health. Due to the minimal numbers in the study, it is hard to reflect how significant this is. 'Talking about their own mental health' did not change following the delivery of the training project. It could be that they are quite comfortable to start with, which might be why they were chosen/volunteered to do this.

IWs were also enabled to understand the pressures faced by primary care professionals and they seemed surprised by the number of mental health problems amongst primary care professionals. This perhaps made the IWs realise that when they feel they are being treated differently this may actually to be to do with the pressures that the primary care professionals are under, rather than because of their mental health problems. GPs, in the survey questionnaire undertaken with trainees, did not show a significant improvement in Q6 ('the care of people with mental health problems is too time-consuming to deal with in the practice') but they were at the positive end to start with.

Overall, it seems that the training had a two-way benefit. The IWs gained a lot of insight about the pressures faced by primary care professionals, and that primary care professional face mental health issues too, and the primary care professionals heard what it's like to be a patient with mental health problems coming into a primary care setting. This new perspective helps each to develop empathy with the other.

Recommendations

Recommendations for the face-to-face training

Participants liked the fact that the training was delivered in 10 minute bite-sized segments. The training should be kept to 10-15 minutes per person, to fit in with busy primary care workloads and schedules.

The delivery of the training should continue to be led by people with lived experience of mental health problems as this was found to be valuable in communicating the reality of support needed in primary care practices, and enabled trainees to connect on an emotional level.

The evaluation indicates that need for the whole staff group in the practice to have the training on the same day. This allows for discussion within the practice following the training, and will encourage systemic and sustainable change within the practice.

Encourage staff in the practices to have a follow-up meeting after the training to plan how they might respond to the issues raised by the training. This follow-up meeting could be facilitated by staff and Involvement Workers from the MYPMHF project.

The training bag reminded people to focus on mental health. It might be useful to have a poster or some specific leaflets that could be used with patients or in the practice. A link to somewhere purchase these materials was also identified as important in the findings, as time pressure that practitioners are under can impact on their capacity to seek out materials.

Recommendations for follow-up to the face-to-face training

Develop a feedback loop to all GP practices to share good practice and the learning and skills that have been developed as a result of the training. One way might be to share the themes developed by the thematic analysis of the postcard promises with all practices that have taken part, in order to reinforce what people's intentions and share new ideas for making positive change.

Contact each practice about the postcard promises to follow-up activity in each practice.

Build upon the memory jog/reminder served by the training bag and chocolates by offering facilitated follow-up sessions.

Develop a criteria and standards for Practices to be accredited as a 'mental health friendly practice' and make this a service user review and award.

Develop and gather materials for GPs to continue to empower their patients to manage their own mental health and put them in an accessible place, either the online training page or in the training bags.

The method of delivering the training was successful and effective. A follow-up session should be designed and be based around specific mental health topics and how to have conversations about mental health.

Recommendations for the online training

Explore options for incentives that will encourage take up of the online training, such as a certificate for Continuing Professional Development (CPD) once completed, or a certificate of being a 'mental health friendly practice' once a certain number of staff in a practice have completed it.

Streamline the online process. This might be achieved by taking off the registration requirement or moving it to the end in order to receive a CPD certificate.

Monitor the visits to the online training materials to identity the on-going uptake of this training.

Recommendations for Involvement Workers (IWs)

The IWs valued the opportunity to shape the training programme. Continue to involve the Involvement Workers in the shaping and delivery of the programme.

If this programme is continued, adequate support in the form of supervision should be in place for the Involvement Workers, as they often had to deal with the issues raised by trainees about their own or their family's mental health.

Ensure that there is follow-up with the Involvement Workers to enable them to shape their skills to employment prospects through a formalised offer to them, for example, a set of coaching sessions to enable them to plan for the future. This would help them to develop their learning into future assets.

Recommendations for follow-up with Primary Care Practices that participated in the training

Within the Primary Care Practices, people may have either been nominated, or nominated themselves to follow-up on this training, thereby becoming local leaders and champions of making practices mental health friendly. Maximise the opportunities that have been created through the local leadership that has emerged and the energy that has been generated from this training by offering opportunities for further focus on mental health issues. This might take the form of letting practice staff know what they might do when they have 5 or 10 minutes to think about mental health, as outlined in the box below:

If you have 5 minutes to focus on mental health, you could:	If you have 10 minutes to focus on mental health, you could:	If you have an hour to focus on mental health, you could:
Make a personal pledge to talk about mental health on the Time to Change website.	Talk to your colleagues about making a practice-wide pledge with Time to Change.	Complete the online training materials.
Look at the postcards contained within the training bag.	Share the contents of the training bag and your thoughts about it with a colleague.	Have a facilitated discussion about the training in a practice meeting.
Have a look around the surgery and see what information about mental health there is.	Put up a poster about mental health in the waiting room.	Explore online information that is available about mental health and order some.
Check the information around the practice is up to date.	Find out about one local mental health service.	Organise for the Mental Health training team to do a 'booster' session in the practice.

These suggestions could be sent at regular intervals, along with newsletters, such as the Rethink magazine, to practices to act as regular reminders of the need to think about mental health.

General Recommendations

Send the postcard promises to the local Clinical Commissioning Groups (CCG) so that they are aware that the training has taken place, and aware of the changes that people intend to make. Ask the CCG to support the training and ask them to make a promise about what they are going to do to make practices mental health friendly at a strategic level.

Should further funding be available, a cost-benefit analysis of the training should be conducted. This could explore the costs and potential savings in the areas of the use of local services and prescription costs.

Hearing the IWs personal story was very powerful in this training. Explore the use of story-telling in other mental health training. It may be useful to make a booklet of personal stories, which could be shared with Practices, so that they can hear a variety of experiences.

The Evaluation Team

Dr Fiona Warner-Gale (FWG) is Co-Director of Associate Development Solutions. She holds a PhD, an MA in Management and an MA in Research Methodology, and has a wide experience of designing managing research and evaluation projects on a national scale. She has a specific interest in research related to tacking the stigma and discrimination related to mental health. She is also a Registered Mental Health Nurse, a qualified Executive Coach and a Lean Consultant practitioner. With over 25 years' experience in mental health, she was a Regional Development Worker with National CAMHS Support Service (NCSS) for 7 years, where she was also National Lead for Advanced CAMHS Education, coordinating HEIs delivering postgraduate CAMHS training across England. She was also the National Lead for Tackling Stigma in Children and Young People during this time. She is an Honorary Visiting Fellow in Children's Mental Health at Northampton University and the Expert Advisor for Children and Young People to the Time to Change Programme Advisory Board.

Jane Sedgewick (JS) is Co-Director of Associate Development Solutions Ltd. JS is a qualified mental health nurse, with a degree in Health Care Research and is completing an MSc in Leadership and Management in Health and Social Care. She is a qualified Executive Coach and a Managing Successful Programmes practitioner. JS has over 20 years' experience in child and adolescent mental health (CAMHS) and was a Regional Development Worker (RDW) with National CAMHS Support Service (NCSS) and National Project Manager for CAMHS Workforce Development and led nationally for NCSS on training for universal services. JS has collaborated with the University of York to develop *SCAMHP*, the short child and adolescent mental health programme.

Dr Dina Gojkovic (DG) is an Associate Research Consultant of Associate Development Solutions Ltd. She has substantial experience in research and evaluation from both and quantitative and

qualitative perspective. She is fluent in several languages and has researched children's mental health both nationally and internationally. Her research on the stigma surrounding learning disability in Serbia has influenced the UNICEF project 'Leave No Child Out'. She also has expertise in the mental health of young offenders and works in an advisory capacity to an initiative led by the Global Initiative in Psychiatry (GIP), Netherlands, to improve conditions for prisoners and consults on a newly set-up scheme for rehabilitating and resettling offenders in Northern Thailand. She has held positions at Lincoln University and the University of Southampton.

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