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Evaluation of Cognitive Therapy Awareness Training

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*turning complex problems
into simple solutions*

1 Introduction	2
1.1 Executive Summary	2
1.2 Background	7
1.3 The Evaluation	8
2 The Context	10
2.1 Incidence of Mental Health	10
2.2 Mental Health Policy Context	11
2.3 Cognitive Therapy	13
2.4 Mental Health Provision in C.A.W.T. Area	16
3 The Project	18
3.1 Background	18
3.2 The C.T. Awareness Training - Key Aims	19
3.3 Programme Structure & Content	20
3.4 Programme Activity	22
4 Key Outcomes	27
4.1 Participant satisfaction	27
4.2 Improved Skills	29
4.3 Impacts on Service Provision in C.A.W.T. area	33
4.4 Relevance to Peace II funding	43
4.5 Value for money	46
5 Conclusions and Recommendations	47
5.1 Conclusions	47
5.2 Recommendations	52
6 Appendices	56
6.1 Policies and Strategies	56
6.2 N.I.C.E. Guidelines - Mental Health	56
6.3 Recommendations - Training	58

1 Introduction

1.1 Executive Summary

1.1.1 Co-operation and Working Together (C.A.W.T.) was established under the Ballyconnell Agreement in 1992. C.A.W.T. covers an area which has a population of 1 million people and incorporates the S.H.S.S.B. and W.H.S.S.B. in N.I. and the H.S.E. N.W and H.S.E. N.E. in R.o.I. Its overall aim is to co-operate on improving the health and social well-being of their resident population. The Cognitive Therapy Awareness Training programme was one of a number of projects delivered through the C.A.W.T. structure. It was delivered over a two year period (2003-2005) and aimed to enhance the skills and competence of front line Mental Health staff in dealing with psychological problems. This independent evaluation of the Cognitive Therapy Awareness Training Programme was commissioned to assess the impacts of the programme and to make recommendations on next steps.

1.1.2 In terms of the context in which the project was delivered:

- ◆ Research and statistics would indicate that approximately 150,000 in the C.A.W.T. area suffer from a mental health problem and approximately 6,000 suffer from a psychotic illness.
- ◆ Mental Health policies are currently being established in N.I. and R.o.I. and are likely to incorporate many elements of the National Services Framework (N.S.F.) for mental health in England and Wales. The N.S.F. in turn recommends following N.I.C.E. guidelines relating to the treatment and care of a range of mental health problems. These guidelines strongly recommend the use of therapeutic interventions, and in particular, Cognitive Therapy (based on widespread evidence-based research highlighting its benefits).
- ◆ Mental health provision in both N.I. and R.o.I. has recently undergone radical change. Cognitive Therapy is one element of treatment and support offered within mental health provision and its provision varies within the C.A.W.T. region. Long waiting lists for C.T. were noted.

1.1.3 In view of the above issues, the key staff within the four Board areas of C.A.W.T. recognised the need to promote awareness of Cognitive Therapy with a view to ensuring better use of resources in the long term. To this end:

- ◆ a Cognitive Therapy Awareness Project Management Group was established
- ◆ £292,000 funding was obtained under Measure 5.2 of Peace II funding to deliver a Cognitive Awareness Training Programme.
- ◆ The training was delivered, by experienced professionals, through 8 programmes over a two year period and targeted front line staff from each of the H.S.S.B.s/H.S.E.s within the C.A.W.T. area.
- ◆ 339 front-line staff registered an interest in the 160 available places
- ◆ 137 staff participated on the programme, representing 85% capacity. 8 did not attend any classes and 14 cancelled without time for a placement to be acquired. (The programme received further Interreg funding which enabled a further 60 places to be made available (this falls outside the evaluation remit, however).
- ◆ Each H.S.S.B./H.S.E. used 85-90% of their allocated places, except the S.H.S.S.B. which only used 73%.
 - One Trust area noted difficulties in releasing staff for training
 - one Trust area was less supportive of Cognitive Therapy as a therapeutic intervention than the other areas
- ◆ To a certain extent the structure of mental health provision dictated the background of participants however, overall, 36% were hospital based, 23% community based and 41% from other settings (addictions, elderly care, etc.).
- ◆ Attendance levels were very high, with an average attendance rate of 94%.
- ◆ The management of the programme, and course delivery were considered excellent (some participants citing it as the best training they have ever had)

- ◆ Training content was considered appropriate and relevant. In particular, participants highlighted role play, involvement of all participants and tutor support as key elements.
- ◆ Most participants indicated that they had expected to gain a greater understanding of C.T. and how it could be used in their work environment. 94% indicated that their expectations of the course had been met (the remainder did not reply to the question).
- ◆ A huge increase in knowledge and skills was noted post training, in particular, in relation to awareness of the benefits of C.T., identifying who could benefit from C.T. and knowing when and how to refer patients to C.T. practitioners. Some can now use the techniques at a basic level within everyday work. None indicated that they would or could practice C.T. formally, recognising the need for further training to do this. Many indicated that the course has increased their interest in C.T. and that they would like to progress further (70%)
- ◆ In terms of impacts on service provision, it would be unfair to expect a course of this nature and size to have a significant impact on delivery, structures and policies surrounding mental health service provision, as there are a range of other factors which impact to a greater degree. However it has had impacts at operational level in terms of staff awareness of the benefits of C.T., ability to put some elements into practice in everyday work, triggering an interest among colleagues of those who participated, and informal networking among participants in different areas and settings. Most acknowledged that, for C.T. to be formally adopted within service provision, strategic and operational management support is required, as is an appropriate level of resources.
- ◆ All indicated that it was useful to undertake training with staff from other units, departments, H.S.S.T.s and H.S.E.s. Joint learning provided an opportunity to gain an insight into how services are provided in other areas.
- ◆ Overall the project provided a foundation upon which further work could continue in terms of increasing awareness and use of C.T. and in terms of promoting networking and co-operative working within the C.A.W.T. area.
- ◆ The project was relevant to Peace II funding objectives and horizontal principles and demonstrated good value for money in terms of the level of expertise required of trainers and quality of course materials used.

1.1.4 Clearly the programme was very well delivered and, not only were participants enthused about how it was delivered and about what they have learned, many have indicated that it has impacted on their skills, ability and to some extent work environment. However, although participants felt they learned from other participants from other areas through joint training of this kind, the extent to which it has resulted in increased formal networking and co-operation has been limited. To be fair, this depends on a range of other issues beyond the scope of a programme of this kind.

1.1.5 In terms of building on the work undertaken so far through this project and in line with findings relating to the role of Cognitive Therapy in mental health provision it is recommended that

- ◆ at a wider strategic level:
 - An economic case for C.T. is demonstrated
 - The appropriate level of Cognitive Therapy provision and structure needs to be assessed
 - The level of training required to ensure this level of provision needs to be established.
 - A forum within which professionals, managers and planners can discuss how best to share Cognitive Therapy Resources needs to be established
 - The Cognitive Awareness Project Management Group and the Mental Health sub group within C.A.W.T. have a role in lobbying D.H.S.S.P.S and D.o.H.C. to ensure that appropriate levels of funding are provided to meet the need for C.T., for C.T. training and for fostering more collaborative working which in turn can result in better use of resources.
 - The Cognitive Awareness Project Management Group and the Mental Health Sub group within C.A.W.T. should be involved in any lobbying which may be required to encourage the incorporation of therapeutic intervention awareness training into mainstream formal training for mental health professionals (and other professionals who are likely to work with people with mental health problems) so that future staff will have at least basic.

- ◆ At an operational level:
 - The Cognitive Awareness Project Management Group should develop and facilitate the delivery of a certificate level course (which fits within the U.K. skills and competencies framework) which will enable participants to build on their skills and deliver C.T. at a basic level to those suffering mild mental illness conditions - particularly those with caseloads of mental health patients, those within the primary care setting and a sample of those in other settings.
 - The Cognitive Awareness Project Management Group should continue to facilitate the delivery of Awareness Training to capture all staff working with mental health patients
 - The Cognitive Awareness Project Management Group should identify demand for and provision of training for those who wish to become Cognitive Therapists (and specialised Cognitive Therapists) and consider how best to meet any identified gaps/needs
 - The facilitation of such training will require fund-raising to enable the purchase of training and will also require quality assuring training providers
 - Training should be targeted to ensure:
 - fit with overall plans to establish a strong C.T. infrastructure with agreed numbers of staff trained to deliver at different levels
 - that where appropriate and possible resources can be shared across geographical areas and delivery settings
 - appropriate geographical area and delivery setting representation.
 - that levels of mental illness, mental health staffing levels and existence of other similar training are taken into consideration.
 - Training should build in resources required for supervision and on the ground training
 - Training should be delivered to allow staff from different areas/settings to train together
 - Managers, commissioners and staff should be made aware of how training fits within wider strategic plans for C.T. with a view to encouraging adoption of C.T. and networking and co-operation

1.2 Background

1.2.1 The Cognitive Therapy Awareness Training programme was delivered over a two year period (2003-2005) through Co-operation and Working Together (C.A.W.T.) C.A.W.T. was established in July 1992 when the (then) North Eastern and North Western Health Boards in the Republic of Ireland and the W.H.S.S.B. and S.H.S.S.B. in N. Ireland entered into a formal partnership agreement to co-operate on improving the health and social well-being of their resident populations. This was known as the Ballyconnell Agreement. C.A.W.T's main objectives are:

- ◆ to improve the health and social well-being of its resident population.
- ◆ to identify opportunities for co-operation in the planning and provision of services
- ◆ to assist border areas to overcome the special development problems arising from their relative isolation in national economies and within the E.U. as a whole
- ◆ to involve other public sector bodies in joint initiatives where this would help fulfil common primary objectives
- ◆ to exploit opportunities for joint working or sharing where these would be of mutual advantage

1.2.2 The area covered by C.A.W.T. comprises a population of approximately 1 million people and includes:

- ◆ the W.H.S.S.B. area in N.I. - incorporating the areas covered by Foyle H.S.S.T., and Sperrin and Lakeland H.S.C.T. (Limavady, Strabane, Omagh, Fermanagh Council areas)
- ◆ the S.H.S.S.B. area in N.I. - incorporating the areas covered by Armagh and Dungannon H.S.S.T., Craigavon and Banbridge H.S.S.T., and Newry and Mourne H.S.S.T. (Newry and Mourne, Armagh, Dungannon, Craigavon, Banbridge Council areas)

- ◆ the Health Service Executive North East area in R.o.I. (Counties Cavan, Louth, Meath, Monaghan)
- ◆ the Health Service Executive North West area in R.o.I. (Counties Donegal, Sligo, Leitrim)

1.2.3 Through the Cognitive Awareness Training Programme 160 training places were offered to front line Mental Health staff to enhance their skills and competence in dealing with psychological problems. A specific element focused on the inclusion of activities which may lead to a greater understanding of trauma related issues.

1.3 The Evaluation

1.3.1 This independent evaluation of the Cognitive Therapy Awareness Training Programme was commissioned with a view to identifying further training needs in relation to the current course content and other types of linked courses and workshops. The terms of reference indicated that the evaluation should consider.

- ◆ participants' views/experiences
- ◆ project outcomes:
 - extent to which skills have improved
 - extent to which new strategies/networks have developed
 - numbers receiving treatment from the programme
 - increased co-operation/collaboration
 - improvements in the range of services
 - greater equality in service delivery
 - improvements in health and social gain
- ◆ extent of increased co-operation and networking (including cross border)
- ◆ extent to which horizontal principles of the Peace and Reconciliation Initiative have been addressed

- ◆ extent to which use of resources has been maximised and elements of the work have been mainstreamed to ensure sustainability
- ◆ lessons learned
- ◆ identification of future needs

1.3.2 The methodology for undertaking the evaluation included:

- ◆ Assessment of project fit within context
 - consideration of information on the use and benefits of Cognitive Therapy from a range of recommended sources
 - consideration of relevant strategies and policies
 - feedback from key stakeholders
- ◆ consultation with participants
 - questionnaires
 - focus groups
- ◆ consideration of relevant programme information/statistics
- ◆ consultation with key stakeholders - relevant health professionals
- ◆ consideration of fit with P&R requirements
- ◆ assessment of value for money and other economic impacts

2 The Context

2.1 Incidence of Mental Health

- 2.1.1** The N.S.F. (see below) and the N.I. Promoting Mental Health Strategy and Action Plan highlight that at any one time around one in six people of working age have a mental health problem, most often anxiety or depression. One person in 250 will have a psychotic illness such as schizophrenia or bipolar affective disorder (manic depression). Generally, for every one hundred people who consult their G.P. with a mental health problem, 9 will be referred to specialist services for assessment, advice or treatment.
- 2.1.2** The R.o.I. Health Strategy “Quality and Fairness” indicates that more than 1 in 4 adults will suffer from mental illness at some point during their lives. It estimates that the numbers of people presenting to mental health services for treatment are likely to increase due to the modernisation of the services and the reduction in stigma associated with using mental health services.
- 2.1.3** These statistics would suggest that in the C.A.W.T. region, (population 1 million) at any given time, approximately 150,000 people suffer from mental health problems and approximately 6,000 will suffer from a psychotic illness such as Schizophrenia or Bipolar Affective Disorder.
- 2.1.4** Key strategy and policy documents indicate that mental health problems can result from a range of adverse factors which include:
- ◆ Poverty and unemployment (The N.S.F. indicates that unemployed people are twice as likely to have depression and children in poorer households are three times more likely to have mental health problems).
 - ◆ Social isolation - the N.I. Promoting Mental Health strategy indicates that rurality exacerbates problems of isolation

- ◆ Other personal circumstances - drug/alcohol misuse, physical illness (twice as likely to have mental health problems), people who have been abused or are victims of domestic violence, carers, neglect/bullying/abuse of children, older people
- ◆ Family or community conflict. The impact of the conflict in N.I. was acknowledged in the report “Living with the Trauma of the Troubles”. There is a clear link between poor mental health and living in neighbourhoods which are both economically disadvantaged and which have experienced greater exposure to the troubles. The N.I. Victims Strategy “Reshape, Rebuild, Achieve” also acknowledges the difficulties faced by victims of the conflict.
- ◆ The N.I. Promoting Mental Health Strategy and Action plan indicates that there is evidence that people who are economically or socially disadvantaged may not readily report mental health complaints.

2.1.5 The C.A.W.T. area suffers from many of the factors which can negatively impact on mental health. The area has been disadvantaged on account of low levels of economic activity, rurality, geographical location, isolation and the impacts of the 30 years of troubles in N.I. This itself results in higher than average health needs.

2.2 Mental Health Policy Context

2.2.1 In the relatively recent past there has been an increased awareness, acceptance and understanding of mental health problems. This has resulted in a shift in policy away from treating and caring for people with mental health problems within psychiatric hospitals/wards, to helping them understand and manage their illness in a community setting. Alongside this has been the increasing evidence based research highlighting the importance and benefits of psychological interventions (particularly C.T.) in treating people with mental health problems, in helping them understand and manage their illness and in ultimately reducing their need for support from the health service. This in turn has shaped (and continues to shape) policy relating to the provision of mental health services.

2.2.2 A National Service Framework (N.S.F.) for Mental Health has been established in England and Wales. The purpose of the N.S.F. is to raise quality and reduce variations in provision. It was developed with the advice of an External Reference Group with representation from health and social care professionals, service users, carers, health and social service managers and partner agencies. It sets national standards and defines service models for promoting mental health and treating mental illness. It puts in place underpinning programmes to support local delivery and establishes milestones and performance indicators against which to measure progress. It covers health promotion, assessment and diagnosis, treatment, rehabilitation and care and encompasses primary and specialist care and the roles of partner agencies.

The N.S.F. recommends that people with mental health problems should have access to psychological therapies and quotes the N.I.C.E. guidelines (see below) in terms of advocating best practice. Indeed one of the key performance indicators within the N.S.F. is “access to psychological therapies”. The N.S.F. also highlights the importance of workforce planning, education and training and support.

2.2.3 The D.H.S.S.P.S. in N.I. commissioned a draft Mental Health Strategy for N.I. (following a review of mental health and learning disability) which, it is anticipated, will refer to the N.S.F. (above). One of the key recommendations is likely to include the need for a Cognitive Therapy Strategy, in acknowledgement of the important role of C.T. in treating and managing people with mental health problems. Mental health is also highlighted in a number of other key policies and strategies in N.I. (see Appendices).

2.2.4 In the Republic of Ireland the Health Strategy “Quality and Fairness” highlights the need to update policy and objectives for mental health to take account of legislative reform (Mental Health Act 2001) and concerns about using only the traditional “medical” model of care for mental illness rather than considering psychotherapy or psychological treatments. A new policy for Mental Health was very recently launched “Vision for Change”. Based on the Mental Health Act 2001, this policy if focuses on more community based care and the widespread evidence based research on the effectiveness of C.T. has resulted in it being strongly considered within the new policy.

2.3 Cognitive Therapy

2.3.1 Cognitive Therapy, or Cognitive Behavioural Therapy, is based on the fact that the way we feel is partly dependent on the way we think about events. It also stresses the importance of behaving in ways which challenge negative thoughts. It is a discrete, time limited, structured psychological intervention in which the patient:

- ◆ works collaboratively with a therapist to identify the types and effects of thoughts, beliefs and interpretations on current symptoms, feelings, states and/or problem areas
- ◆ develops skills to identify, monitor and then counteract problematic thoughts, beliefs and interpretations related to the target symptoms/problems
- ◆ learns a repertoire of coping skills appropriate to the target thoughts, beliefs and/or problem areas

2.3.2 Much research has been undertaken by relevant professionals on Cognitive Therapy (C.T.) and as a result it has become the recommended, and often preferred, treatment for a range of conditions such as depression, anxiety, panic attacks, phobias, Obsessive Compulsive Disorder, Post Traumatic Stress Disorder, eating disorders, sleep problems, substance abuse, and dealing with a range of personal circumstances. Cognitive Therapy is often combined with psychiatric medication. It has been shown to be as effective as medication in treating depression and anxiety and better than medication in avoiding treatment failures and in preventing relapse after the end of treatment (medication, unlike C.T., does not encourage the development of valuable coping and emotional management skills).

2.3.3 Ideally, Cognitive Therapy is provided as and when needed and the frequency of input depends on the condition. Most C.T. treatments are brief interventions (weekly sessions over a few months) however, more complex problems require more frequent and/or lengthy input.

- 2.3.4** The National Institute for Health and Clinical Excellence (N.I.C.E.) is the independent organisation responsible for providing national guidance on the promotion of good health and the prevention and treatment of ill health. N.I.C.E. produces a range of guidelines which provide recommendations on the appropriate treatment and care of people with specific diseases and conditions. The guidelines are adopted by the N.H.S. in England and Wales and are based on the best available evidence (validated by a wide range of professionals). N.I.C.E. has produced guidelines on a range of Mental Health conditions including Anxiety, Depression, Depression in Children and Young People, Eating Disorders, Obsessive-Compulsive Disorder, Post Traumatic Stress Disorder, Schizophrenia and Self Harm. Each of these guidelines recommends the use of Cognitive Therapy as a well researched, evidence based treatment (see Appendices). In all cases, the N.I.C.E. guidelines recommend that C.T. should only be delivered by suitably trained and experienced staff.
- 2.3.5** A report “Psychological Therapy Services - A Strategy for R.o.I.” was prepared with input from key professionals in R.o.I. and N.I. The document highlights that psychotherapy can improve therapeutic outcomes and treatment adherence, reduce the length of inpatient stay and readmission rates and reduce repeated demands of challenging patients on other parts of the health service (e.g. G.P.s, A&E, medical specialities). It recommended that a full range of psychotherapies should be provided at all levels of primary and mental health care services. This included Cognitive Therapy. The report also highlighted the need for additional staffing and training in this area to ensure that these recommendations could be realised.
- 2.3.6** Cognitive Therapy is developing on an ongoing basis and increasingly being used by mental health professionals to treat a wide range of mental health illnesses. It is also being adopted within other areas of health and in other fields. The Department of Health guidelines “Organising and Delivering Psychological Therapies (2004)” indicates that therapists from all professional backgrounds can make a valuable contribution to the provision of effective psychological therapies. These include psychiatrists, psychologists, psychotherapists, nurses, social workers, occupational therapists, counsellors, arts and drama therapists, child psychotherapists and family therapists.

The document also indicated that staff involved in the delivery of psychological therapies need to be trained and well supported and supervised. Further consultation with relevant professionals as part of this evaluation has highlighted that, in order to practice C.T. effectively, relevant professionals must receive professional training and supervision as follows:

- ◆ Supervision is required for approximately 2 hours per month for a C.T. therapist (peer and senior supervision)
- ◆ Certificate level accreditation helps relevant health care staff to get a deeper appreciation of how C.T. can be used to address mental health problems and helps develop good questioning and listening skills for those working with mental health patients.
- ◆ Diploma level accreditation enables relevant health care staff to practice C.T. in most circumstances and to provide supervision to other Cognitive Therapists. (Diploma level training is sometimes incorporated as an element of a relevant Degree course, or as a separate stand alone certification for those who have already completed a relevant degree course).
- ◆ Masters level accreditation enables relevant health care staff to undertake more research, practice higher level C.T., supervise and teach. In general, approximately 1-2 out of every 100 practitioners might undertake a Masters degree in C.T.

2.4 Mental Health Provision in C.A.W.T. Area

2.4.1 In N.I. mental health services are delivered through Health and Social Services Trusts. As noted above there are 5 H.S.S.T.s in the N.I. C.A.W.T. region. In R.o.I. mental health services are delivered through the Health Services Executives. As noted above, there are 2 H.S.E.s in the R.o.I. C.A.W.T. region. Both N.I. and R.o.I. have seen significant strategic changes in health commissioning and delivery structures over the past few years. In R.o.I. these have yet to fully bed in. In N.I. there are more changes expected in line with the recent Review of Public Administration. However, in both cases, in line with developing policies and strategies relating to mental health provision (as above) H.S.S.B.s and H.S.E.s are working towards a model whereby people with mental health problems can live as normal a life as possible within their home/community setting. This will seek to ensure that they have access to the support they need, when they need it, from the most appropriate professionally trained staff. (Obviously the level of support needed depends on the complexity of illness and there are times when it would be inappropriate for some patients to be treated within a community setting (e.g., on a temporary basis during acute episodes, or in forensic or some elderly cases)).

2.4.2 In relation to mental health provision H.S.S.T.s and H.S.E.s are focusing on:

- ◆ Developing community based mental health services with the aim of reducing the number of long term and **acute** beds in psychiatric hospitals/wards. In fact, where possible and appropriate, H.S.S.T.s aim to provide the hospital care required by people with mental health problems in psychiatric wards in a general hospital setting, rather than in separate psychiatric hospitals.
- ◆ Developing a multi-disciplinary approach to providing mental health services which involves a range of disciplines such as psychiatrists, psychiatric nurses (community and hospital based), psychologists, occupational therapists, G.P.s, social workers, etc.

2.4.3 Although H.S.S.T.s and H.S.E.s are moving in the direction outlined above each provides and/or has access to both hospital and community based services. Mental health

structures currently differ and mental health services are at different stages of development.

- ◆ Some have developed specific services such as 24 hour helplines, Rapid Response teams, intensive home based treatment and support services
- ◆ Some share the more specialist services
- ◆ Some provide better access to psychological interventions.

2.4.4 How, and the extent to which, structures and services have developed to date appears to depend on a number of factors. These include availability of resources and, to a certain extent, the attitudes of key personnel. However, newly developed policies and strategies for mental health provision (currently being developed in N.I. and R.o.I.) should ensure a more consistent approach to provision in the long term, particularly by improving access to services, adopting a multi-disciplinary approach to treatment and care and ensuring access to psychological interventions, in particular Cognitive Therapy.

3 The Project

3.1 Background

3.1.1 Since its inception C.A.W.T. has evolved into a more formal structure and now comprises:

- ◆ a Management Board with representation from each of the H.S.S.B.s and H.S.E.s in the area covered. The Management Board takes overall responsibility for the strategic direction of C.A.W.T.
- ◆ A Development Centre which provides support to, and co-ordinates the work of, C.A.W.T. and takes responsibility for overall management of the projects funded under Interreg and Peace monies and for communications and I.C.T.
- ◆ 13 subgroups spanning the complete health and social care spectrum, each of which has developed Service Development Proposals for a range of projects. The subgroups include Health Promotion, Older People, Social and Community Care, Primary Care, Learning Disability, Acute Services, Public Health, Family and Childcare, Mental Health, Support Services, Management Development, Communications and I.C.T. Project Boards are created for each project to oversee its management and implementation.
- ◆ A Secretariat which serves as a link between the Management Board and the Sub Groups

3.1.2 In early 2002 the D.H.S.S.P.S. in N.I. and the Department of Health and Children in R.o.I. appointed C.A.W.T. as the delivery agent for Priority 3 Measure 2 of the Interreg IIIA Programme, Health and Social Well-being. Through this measure a total of 10.455m euro (£7.2m) became available to implement the C.A.W.T. Strategic Plan for 2001-2004 and its 2002-2006 Business Plan. 35 individual projects were funded, as was the C.A.W.T. Development Centre. Some elements of the C.A.W.T. business plan are being implemented with funding of 1 million euro (£690,000) from the Peace II Programme.

3.2 The C.T. Awareness Training - Key Aims

3.2.1 A Cognitive Awareness Project Management Group (made up of key representatives from each of the C.A.W.T. areas) developed an application for funding for a Cognitive Therapy Awareness Training Programme under Priority 5, Measure 2 of Peace and Reconciliation funding. The application was made in recognition of the need to raise awareness of Cognitive Therapy among front line staff dealing with people with mental health problems. This was in response to:

- ◆ the acknowledgement that the area covered by C.A.W.T. is an area which has suffered throughout the 30 years of troubles and that this itself has had implications for the resident population in terms of the need for support in dealing with the impacts of trauma.
- ◆ the growing acceptance of Cognitive Therapy as an evidence based good practice approach to supporting people with mental health problems and the adoption of such an approach in the key regional and local mental health strategies impacting on the C.A.W.T. area
- ◆ the lack of training in Cognitive Therapy Awareness in the area
- ◆ the fact that budgetary constraints and difficulties associated with freeing large numbers of staff to attend such training rendered it unlikely that such training would be delivered by H.S.S.B.s and H.S.E.s, unless additional funding was acquired through the opportunities offered by “Peace funding”.

3.2.2 The application was successful and funding was awarded to deliver the Cognitive Therapy Awareness Training over a 2 year period (2003 - 2005). The overall aim of the project was to offer Cognitive Therapy Awareness Training to 160 front line mental health staff (multidisciplinary and cross border). In line with the ethos of C.A.W.T. it was anticipated that the project would also:

- ◆ offer opportunities for the development of cross cultural understanding of the adverse influences of the conflict on the mental health of people in the border areas

- ◆ offer the opportunity for mental health staff from different H.S.S.B.s and H.S.E.s to learn together
- ◆ empower workers to deliver a more effective response to those who have suffered psychologically as a result of the troubles
- ◆ create additional opportunities for greater numbers of patients to benefit from the Cognitive Therapy approach
- ◆ stimulate further interest in, and provide knowledge about, the C.T. approach
- ◆ help ensure that the border is no longer an obstacle in delivering health and social care services
 - help ensure further collaboration and co-operation between health personnel within the C.A.W.T. region (at all levels)
 - help facilitate economies of scale and reduction of duplication in terms of providing and accessing services
 - enhance understanding and pooling of ideals and information on a cross border basis
 - harmonise policies and protocols

3.3 Programme Structure & Content

3.3.1 A Project Manager was appointed in September 2003. The Manager also had responsibility for the delivery of other relevant training in the field of mental health. Following open tender, the N.I. Centre for Trauma and Transformation (N.I.C.T.T.) was appointed to deliver the training. The training programme was derived from other similar training undertaken in Newcastle (England) which was considered to be best practice. All trainers had extensive experience in both Cognitive Therapy and dealing with the impacts of trauma. The content of the course was developed on the basis that Cognitive Therapy is a proven treatment of choice for a host of psychological problems and that to practice Cognitive Therapy effectively requires a combination of knowledge and skills. The training had an emphasis on providing mental health staff with knowledge of what Cognitive Therapy is and when it can be used to effectively support people with mental health problems, rather than enabling them to practice Cognitive Therapy (this

requires more detailed study at Certificate or Diploma level). The training was designed primarily for health practitioners who have significant input into the emotional or mental health care of patients. For course participants, the aims of the course were:

- ◆ develop C.T. skills
- ◆ increase understanding of the skills used in the practice of C.T.
- ◆ develop a more collaborative approach to working with clients and become more problem focused and task oriented.

3.3.2 The training was geared to introduce clinicians to ways of thinking about patients and their difficulties in terms of the cognitive theory of psychological problems, the core means of communication common to cognitive approaches and some of the methods used to conceptualise and help address clients' problems. A broad overview of the topics covered is noted below:

Day 1	Introduction and negotiation of goals Introduction to the general principles of C.T. Inductive questioning Problem identification Socialisation (understanding the problem from a cognitive perspective)
Day 2	Identifying Negative Automatic Thoughts
Day 3	Introducing Cognitive Change Techniques- structuring a session, use of the dysfunctional thought record
Day 4	Facilitating Change - behavioural experiments
Day 5	Consolidation Formulation - conceptualising problems Supervision issues The future
Day 6	Troubleshooting - review and feedback of skills acquired, repeat some techniques, more practice, case material

3.3.3 Course delivery included conveyance of essential information, skills demonstration (live or using video), role play with active coaching from trainers and group reflection on learning. Participants were active experiential learners. Participants were provided with a very extensive training package which

covered all the above areas. The course was not formally assessed.

3.4 Programme Activity

- 3.4.1** From January 2004 until June 2005, 8 courses were delivered, each lasting 6 -7 weeks on one day per week. (The first 3 courses lasted 7 weeks and the last 5 courses lasted 6 weeks). Each course had 20 places, with 5 places reserved for each of the H.S.S.B. and H.S.E. areas. The Project Administrator advertised and raised awareness of the course to relevant staff within each H.S.S.B. and H.S.E. area and the 5 places for each area for each course were allocated on a first come, first served, basis. Courses were provided free of charge to H.S.S.B.s and H.S.E.s and the project covered the cost of providing replacement staff (bank staff) whilst participants attended the Cognitive Therapy Awareness training. All of the training was undertaken at the Cognitive Therapy Centre in Omagh.
- 3.4.2** The Board met on a quarterly basis throughout the delivery of the project. The Programme Manager prepared quarterly project reports for the Board in addition to facilitating end of training evaluations, preparation of course materials for trainers, project planning, project advertising and initiating and maintaining contact with relevant stakeholders and participants.
- 3.4.3** In total 339 people registered an interest in participating in the programme. 70-80% of these were Psychiatric Nursing staff and others included Doctors, Social Workers, Health Visitors and other professionals involved in supporting people with mental health problems. The table below provides a breakdown in terms of H.S.S.B. and H.S.E. area. Interest was particularly high from the W.H.S.S.B. and the H.S.E. N.W. Additional Interreg funding (not included in this evaluation) was able to facilitate an extra 3 courses, providing a further 60 places, of which 57 were used.

Registry of Interest

	Nos. registering interest	Interreg funded places
W.H.S.S.B.	104	17
S.H.S.S.B.	55	13
H.S.E. N.E.	102	15
H.S.E. N.W.	78	12
Total	339	57

3.4.4 In total 137 people participated on the 8 courses. The number of participants from each area who attended each of the 8 courses is noted in the table below. As noted above, the Project Manager had endeavoured to ensure that each H.S.S.B. and H.S.E. area was allocated 5 places on each course, on a first come first serve basis. However, not all places were filled. Some participants cancelled their involvement on the course and where this was the case, it is noted in the table below (e.g. 2 people from W.H.S.S.B. cancelled their place on Course 4, leaving a total of 4 participants on that course from W.H.S.S.B. instead of 6). Where possible the Project Manager tried to award cancelled places to others who had registered an interest in the course. However, this was not always possible at the last minute (due to difficulties in releasing staff, etc.). Some participants did not attend any of the training days for the courses in which they were allocated places and where this was the case they are marked as Absent or Did not Attend in the table below (e.g. 3 participants from H.S.E.N.W. were absent from course 2 leaving 2 participants from H.S.E.N.W. on course 2 instead of 5). The last column indicates the % capacity uptake (e.g. 75% of places in course 3 were used and overall 85% of places were used) .

Participant Backgrounds in terms of H.S.E./ H.S.S.B. area

	Total places	W.H.S.S.B.	S.H.S.S.B.	H.S.E.N.E	H.S.E.N.W	Other	Total	% capacity
Course 1	20	6	5	5	5	-	21	105%
Course 2	20	5	5	5	2 (3 Absent)	-	17	85%
Course 3	20	4 (1 Absent)	3 (1 Cancelled 1 Absent))	5	3 (2 cancelled)	-	15	75%
Course 4	20	4 (2 Cancelled)	3 (2 cancelled)	3 (2 cancelled)	4 (1 cancelled)	-	14	70%
Course 5	20	5 (2 cancelled)	2	5	6	-	18	90%
Course 6	20	2	3 (2 Did not att.)	5	4	-	14	70%
Course 7	20	3	5	4 (1 did not att.)	5	2	19	95%
Course 8	20	5	3 (2 cancelled)	4	5	2	19	95%
Total	160	34	29	36	34	4	137	85%

As noted, each H.S.S.B. and H.S.E. was offered a total of 40 places (5 places on each of the 8 courses).

- ◆ W.H.S.S.B. took up 34 of its places in total (85%)
- ◆ S.H.S.S.B. took up 29 places (72.5%). There was a view that one of the Trusts in the area had difficulty in releasing staff for training and that in another Trust Cognitive Therapy did not have the backing of key staff as the main therapeutic intervention
- ◆ H.S.E. N.E. took up 36 places (90%)
- ◆ H.S.E. N.W. took up 34 places (85%).

Interest in the course was noted from other areas and in courses 7 and 8 the N.H.S.S.B. was offered 2 places, as there was spare capacity to do so.

- 3.4.5** The following table provides an overview of participant backgrounds in terms of the environment in which they work, i.e. hospital based, community based, specialised team.

Participant Backgrounds - work environment

	W.H.S.S.B	S.H.S.S.B.	H.S.E. N.E.	H.S.E. N.W.	Other	Total
Hospital based	12	8	18	11		49
Community Mental Health	5	5	5	1		16
Respite/Rehab/Residential/Day Centre	5		1	9		15
Addictions Unit		6	4			10
Community Addiction		1				1
Elderly Care	1	1	3	1		6
Other Disciplines	5	3		3		11
Unknown	6	5	5	9	4	29
Total	34	29	36	34	4	137

Other disciplines include clinical psychologist (1), Disability Nurse (2), Learning Disability (1), O.T. (1), Health and Disability Nurse (1), Surestart (1), Brain Injury Team (3), Manager (1).

To a certain extent, the structure of mental health provision in each area dictates participant backgrounds in terms of their work environment. However, overall, 36% of participants were hospital based, 23% community based (including community rehabilitation and respite care, etc.), 8% Addictions, 4% Elderly Care and 8% other disciplines.

- 3.4.6** Participant attendance rates are noted in the table below and are represented as a percentage of the maximum training days per course. *Maximum training days are based on the number of training days per course (7 training days for courses 1 - 3 and 6 training days for courses 4 - 8) times the number of participants from each area. For example, there were 6 participants from the W.H.S.S.B. at course 1 which had 7 training days. Therefore the maximum training days would be 42. In total, the 6 participants attended 38 training days between them representing an attendance of 90%. Overall, 137 participants attended a total of 823 training days (out of a possible 875), representing an overall attendance rate of 94% and an average of 6 days per participant.*

Participant attendance rates

	W.H.S.S.B.	S.H.S.S.B.	H.S.E.N.E.	H.S.E.N.W	Other (NHSSB)	Total
Course 1	90%	94%	88%	85%	-	90%
Course 2	94%	86%	100%	71%	-	90%
Course 3	100%	95%	88%	81%	-	91%
Course 4	87.5%	100%	89%	79%	-	88%
Course 5	100%	100%	100%	100%	-	100%
Course 6	100%	88%	100%	100%	-	98%
Course 7	100%	87%	100%	97%	100%	96%
Course 8	100%	100%	100%	100%	100%	100%
Total	95%	92%	95%	91%	100%	94%

(Should the analysis be based on the number of training places available overall (i.e. accounting for the fact that cancelled places, absentees and do not attends are included) then a percentage of 80% of the total possible training days was achieved).

4 Key Outcomes

4.1 Participant satisfaction

4.1.1 As part of the evaluation, course participants were asked why they participated on the course, what they expected to gain from participation and to comment on their satisfaction with course content and delivery. 15 participants attended focus groups as part of this evaluation and 86 out of 137 participants returned questionnaires forming part of this evaluation.

4.1.2 Reasons for participation and expectations are summarised below (some indicated more than one of the following expectations).

- ◆ approximately 60% indicated that they wanted to improve their understanding of the application of C.T., and to gain awareness, insight and practical knowledge of C.T.
- ◆ 9% indicated that they had an interest in C.T. which they thought the course could help them pursue.
- ◆ 16% indicated that they wanted to further develop their skills.
- ◆ 22% indicated that they thought that C.T. may be useful within their work context and wanted to see if it could improve the treatment available to their clients

4.1.3 There was a very high level of satisfaction with the training programme. Questionnaire returns indicated that 94% felt that their expectations were met (the remainder did not comment). Feedback, from both focus groups and questionnaires forming part of this independent evaluation, indicated that.

- ◆ the training programme was considered to be very relevant with excellent content and was both interesting and enjoyable

- ◆ the training programme was well structured and planned and was delivered and managed in a highly professional manner. In particular participants highlighted the effectiveness of:
 - role play as a good learning method
 - having a good mix of participants
 - adopting a practical approach relevant to work
 - involving all participants in practical learning experiences
 - excellent support from tutors and group members
- ◆ 3 participants indicated that it was one of the best courses they had ever attended/most beneficial training ever achieved - “in my 30 years of working, this was one of the best courses I have attended and the content and expertise of trainers was excellent”
- ◆ although some indicated that they would have liked more application within their field of work, they also recognised that such a niche area would not have been appropriate for others.

4.1.4 Within the questionnaires, participants were asked to rate their satisfaction with the training and support provided through the C.T. Awareness Training Programme on a scale of 1 - 5 (5 being the highest/best score). Findings are highlighted in the table below.

Satisfaction with course content

	% scored 1 (v. poor)	% scored 2 (poor)	% scored 3 (average)	% scored 4 (good)	% scored 5 (v. good)	Ave. Score
Content of course & relevance to work	0%	0%	11%	41%	48%	4.4
Locations/times	1%	6%	25%	32%	36%	3.97
Delivery methods	0%	0%	1%	38%	61%	4.6
Support provided by trainers	0%	0%	2%	30%	68%	4.7

4.1.5 Feedback highlighted a very high level of satisfaction with the way the course was delivered, with 98 - 99% scoring 4/5 in relation to delivery methods and support provided by trainers. 89% scored 4/5 in terms of course content and relevance. Fewer scored 4/5 in terms of locations/times however, given the distances travelled by many of the participants throughout the C.A.W.T. area, this was quite high and on balance most

considered Omagh as central a location as possible for such a diverse group.

4.2 Improved Skills

4.2.1 The training aimed to provide awareness of Cognitive Therapy among front-line staff working with people with mental health problems. The training programme was devised by professionals in the field of psychotherapeutic interventions and trauma. It was based on training provided in Newcastle upon Tyne and covers the key elements of Cognitive Therapy, including when its use is considered appropriate. The training sought to help course participants gain an awareness of Cognitive Therapy, its benefits, when it could be used and to provide some basic C.T. skills. However, participants were not being trained to act as Cognitive Therapists as this requires much more intense training over a longer time period.

4.2.2 Feedback gained from focus group consultation and evaluation questionnaires showed that, prior to the training, most participants had a basic perception of what Cognitive Therapy was. Most did not know much about the practice of C.T. and very few had used C.T. approaches within their work environment. A lack of opportunity to learn about C.T. (even at awareness level) prior to this course, was highlighted, as was the limited number of places on courses delivering professional C.T. training (most of which have waiting lists). This has made it difficult for many to progress in this.

4.2.3 Following the training:

- ◆ All indicated that they were now aware of the benefits of Cognitive Therapy and of when it can be used and have a basic knowledge of C.T. techniques.
- ◆ Many indicated that they are now in a better position to explain Cognitive Therapy to their patients as a potential treatment option and to assess when it is appropriate to refer patients to a trained C.T. practitioner. (However, the lack of Cognitive Therapy practitioners in all areas was highlighted and there were concerns about the ability to meet current demand, never mind future demand for C.T.)

- ◆ Some indicated that they can now use the techniques at a basic level within their everyday work
- ◆ None indicated that they would, or could, practice C.T. formally. All recognised the need for further training in order for them to become therapists. For some, this course provided a good deal of realism in terms of what is expected of C.T. and what is required to be able to practice C.T. within their work environment.
- ◆ Many indicated that the course had increased their interest in C.T. and that they would like to progress further, with some indicating that they would like to undertake further training at a level between “Awareness” and “Diploma” training.

4.2.4 As part of the independent evaluation, participants were asked to rate their knowledge and use of C.T., pre and post training, on a scale of 1 to 5 (5 being the highest/best score). The tables below indicates the percentage of participants who scored 1 - 5 for each question and the last column indicates the average score. The first table highlights scores pre training, the second table highlights scores post training and the third table provides an overview of the difference between the average scores pre and post training. *(average scores are calculated by multiplying the score by the number of participants who indicated that score, divided by the total number of participants)*

C.T. Skills/Usage Scores - Pre Training

	% scored 1	% scored 2	% scored 3	% scored 4	% scored 5	Ave Score
Knowledge of who would benefit from C.T.	17%	37%	31%	10%	3%	2.4
Knowledge of when to use C.T.	20%	44%	26%	8%	2%	2.3
Knowledge of benefits of C.T.	15%	31%	33%	17%	3%	2.63
Extent of use of C.T. with patients	33%	43%	12%	10%	2%	2

C.T. Skills/Usage Scores - Post Training

	% scored 1	% scored 2	% scored 3	% scored 4	% scored 5	Ave Score
Can identify who would benefit from C.T.	0%	2%	10%	52%	35%	4.2
Know when & how to refer patients to C.T. practitioners	0%	8%	8%	36%	48%	4.2
Aware of benefits of C.T.	0%	0%	3%	56%	41%	4.4
Can use basic C.T. skills with patients	2%	7%	24%	42%	25%	3.8

Difference between average scores pre and post training

	Ave. score Pre training	Ave. score Post training
Knowledge of who would benefit from C.T.	2.4	
Can identify who would benefit from C.T.		4.2
Knowledge of when to use C.T.	2.3	
Know when & how to refer patients to C.T. practitioners		4.2
Knowledge of benefits of C.T.	2.63	
Aware of benefits of C.T.		4.4
Extent of use of C.T. with patients	2	
Can use basic C.T. skills with patients		3.8

In summary:

- ◆ 13% scored 4/5 in terms of considering themselves to have a knowledge of who would benefit from C.T. prior to the training, compared to 87% scoring themselves 4/5 in terms of being able to identify who could benefit from C.T. after they received the training. The average score moved from 2.4 - 4.2.

- ◆ 10% scored 4/5 in terms of considering themselves to have a knowledge of when to use C.T. prior to the training, compared to 84% scoring themselves 4/5 in terms of knowing when and how to refer patients to C.T. practitioners post training. The average score moved from 2.3 - 4.2.
- ◆ 20% score 4/5 in terms of knowledge of the benefits of C.T. prior to the training, compared with 97% scoring themselves 4/5 in terms of awareness of the benefits of C.T. The average score rose from 2.6 - 4.4.
- ◆ 12% scored themselves 4/5 in terms of the extent to which they used C.T. prior to the training. 67% scored themselves 4/5 in terms of ability to use C.T. skills with patients. However, it must be noted that none of the participants would consider themselves to be Cognitive Therapists (recognising that this requires further intensive training) and the extent to which they use skills is based on using questioning/listening skills at a very basic level.

4.2.5 The findings would indicate that the course has had a positive impact in terms of increasing participants' knowledge about the benefits of C.T., who would benefit from C.T., when/how C.T. can be used and when/how to refer to C.T. practitioners. In these cases the average scores rose from 2.3/2.6 pre training to 4.2/4.4 out of 5 post training. In terms of using C.T. skills with patients, it must be noted that the course was not designed to create Cognitive Therapists and therefore an outcome whereby participants would be using C.T. with their patients would be unlikely and inappropriate. However, participants have indicated that they can use certain aspects of what they have learned in their work and adopt questioning and listening skills at an appropriate level.

4.2.6 At the start and end of each course, participants were asked to indicate their strengths in terms of knowledge and skills associated with C.T., by giving themselves a score between 1 (weak) and 7 (strong). 113 participants completed scores at the start of the training and 86 completed scores at the end of the training. The table below provides an overview of the average scores for each question pre and post course.

	Pre Course average score	Post course average score	Difference (Post score - Pre score)
Knowledge of C.B.T.	2.33	5.03	2.7
Skill in using C.B.T.	1.91	3.89	1.98
Ability to use Socratic/Inductive approaches	1.51	4.31	2.8
Ability to set an agenda	2.92	4.79	1.87
Ability to work to produce a problem list	3.27	4.85	1.58
Skill at socialising a client to the cognitive model	2.11	4.64	2.53
Skill in using thought records	1.96	4.72	2.76
Skill in using pie charts	2.38	4.38	2
Skill in using continual assessment	1.58	4.01	2.43
Skill in designing behavioural experiments	1.92	4.16	2.24
Skill in setting up homework tasks	2.52	4.61	2.09

Comments included on the evaluation forms indicated that the main areas where participants now felt proficient included: questioning and listening; behavioural techniques; socialising and structure; and setting agendas. The main areas where participants envisaged difficulties included: putting what was learned into practice; needing more practice; getting the opportunity to gain experience; and getting supervision/back up. Most of these issues relate to the extent to which their work environment contributes towards their putting their learning into practice (within the limitations of what the training sought to achieve).

4.3 Impacts on Service Provision in C.A.W.T. area

4.3.1 The terms of reference for the evaluation sought to establish the extent to which the project has impacted on service delivery in the C.A.W.T. area, particularly in relation to promoting health and social gain and co-operation within and between H.S.S.B. and H.S.E. areas, in terms of providing effective support for mental health patients and effective use of resources.

4.3.2 It must be reaffirmed at this point that the Programme was a "C.T. Awareness Training Programme" designed to raise awareness among front-line staff about C.T., its benefits and how and when it should be practised. None of the participants would be in a position to practice C.T. after the training and,

since most were front-line staff, their ability to influence service delivery at a strategic level would be limited. It would therefore be unfair to expect that a course of this nature and size alone could have immediate and significant impacts on the delivery, structures and policies surrounding service provision for mental health patients. This is not to say that some of these staff, so influenced, would not have an important influence on policies and strategies at a later stage in their career. Consultation feedback and research forming part of this evaluation has highlighted a range of other factors which influence how mental health services are provided and structured:

- ◆ The wider strategic and policy context
 - in N.I. and R.o.I. mental health provision has undergone radical changes in the recent past with respect to both delivery and administrative structures, some of which have yet to fully bed in. (establishments of H.S.S.T.s and H.S.E.s and increasing emphasis on provision in the community setting). In N.I. such changes are likely to continue within the context of the Review of Public Administration.
 - there are no definitive strategies and policies relating to C.T. within mental health provision (or indeed relating to mental health provision as a whole) in N.I. and R.o.I. However, both are developing new Mental Health Policies and Strategies and these are likely to incorporate C.T. approaches, based on the overwhelming evidence based researching highlighting C.T. as the preferred intervention for many mental health conditions. References are likely to be made to the N.S.F. (in England and Wales) which in turn refer to N.I.C.E. guidelines. However, realistically it may be a number of years before these are in place.
- ◆ The extent to which key staff in each H.S.S.B./H.S.E. adopt, promote and advocate C.T. approaches
- ◆ The availability of resources to deliver C.T.

4.3.3 The C.T. Training Programme and the way in which it was delivered has had a degree of influence on service delivery and it is reasonable to expect that, through highlighting these impacts, a longer term strategy for C.T. within the C.A.W.T. area (which takes account of regional policies and strategies, or perhaps influences these) could be developed. These impacts are noted below and relate to feedback and views on:

- ◆ Impact on mental health patients
 - how patients could benefit from C.T.
 - opportunities participants have had to use the skills acquired through the training
 - referrals to C.T. practitioners as a result of training
- ◆ Recognition of C.T. within H.S.S.B.s and H.S.E.s as a result of training
- ◆ Increased networking and co-operation as a result of training

Impact on mental health patients

- 4.3.4** Feedback suggested a view that C.T. can have a positive impact on mental health patients to help them better deal with their illness, helping them to manage everyday life and, where appropriate, helping them to deal with the impacts of “the troubles”. There is also a view that C.T. can lead to reduced dependence on health services (both in helping people better manage their illnesses and in preventing illness from becoming worse). This view mirrors that found through research upon which key Government guidelines are based (N.I.C.E.). Provision of C.T. is therefore thought to help H.S.S.B.s and H.S.E.s meet their ultimate objectives of best meeting the needs of their resident populations and making best use of resources.

As part of this independent evaluation’s questionnaire, participants were asked to indicate how they thought patients would benefit from C.T. approaches on a scale of 1 - 5 (5 being the highest/best score). Findings are noted in the table below.

Impact of C.T. on Patients

	% scored 1	% scored 2	% scored 3	% scored 4	% scored 5	Ave Score
Better able to deal with their illness	0%	4%	21%	49%	27%	4
More socially included	0%	3%	37%	44%	16%	3.75
Less episodes of care required (on average)	0%	8%	37%	41%	15%	3.63
More able to deal with everyday life	0%	0%	21%	47%	33%	4.12
Better able to deal with the impacts of the Troubles	1%	1%	19%	50%	29%	4

An average score of 4 or more in terms of helping patients better deal with their illness, helping patients to better manage with everyday life and helping patients to better to deal with the impacts of the troubles indicates a view that C.T. can have very positive impacts in this regard. However, it was noted that, whilst raising awareness of C.T. is a useful exercise, its benefits cannot be fully realised if the means by which C.T. can be delivered are inadequate. In order for the benefits of C.T. to be fully maximised:

- ◆ patients must be willing and ready to engage
- ◆ there needs to be an adequate number of professionally trained therapists who can provide C.T. (at present waiting lists for C.T. are presenting a problem for many patients whose condition can deteriorate whilst awaiting support)
- ◆ C.T. should be provided as early as possible, at the appropriate level to prevent mental health problems becoming more serious and requiring more intensive support in the long term.
- ◆ referrals to C.T. should be filtered to ensure that resources are used effectively (e.g. to ensure that the most highly qualified and experienced Cognitive Therapists are generally dealing with the most complex cases and that those who require C.T. have access to C.T. at the appropriate level).
- ◆ there needs to be an adequate level of supervision and ongoing training/updating for those practising C.T.

- 4.3.5** Feedback has indicated that participants are very aware of the fact that they are not trained to deliver C.T. However, most did indicate that they have been able to put into practice the skills that they learned at a very basic level within their everyday work. This generally involves using listening and questioning techniques at a very basic level. In total, 65 participants who responded to the relevant question within the independent evaluation questionnaire indicated that they collectively had approximately 750 opportunities to use the skills acquired since training (at the level to which they were trained). This represents an average of 11 opportunities per participant. Extrapolation of this figure would suggest that the programme as a whole has generated approximately 1,500 opportunities for front-line staff to use C.T. skills (at a basic level) at work. Only 8% of participants were unable to use C.T. directly.

Opportunities to use skills

Number of opportunities	No. of respondents	% respondents
None	7	8%
2-5	22	26%
6-10	11	13%
11-20	8	9%
21-30	15	17%
50	2	2%
Did not answer	21	24%

- 4.3.6** As noted in previous sections, participants felt that the training helped them become more aware of who could benefit from C.T. and have indicated that they are now in a better position to make appropriate referrals to C.T. practitioners. However, the limited number of Cognitive Therapists and the vicious circle of lengthy waiting lists for C.T. was frequently highlighted. The effect that this has on patients' health, the resulting need for more intensive support in the long term and in turn the increasing demands on the limited number of Cognitive Therapists were noted. In order to address such problems it was suggested that each mental health team/ward should have access to Cognitive Therapists and that referrals should be filtered to ensure the appropriate level of support, based on the complexity of need (e.g. most complex cases should be referred to Therapists with most experience and training). 67 participants who responded to the question indicated that collectively they referred 171 patients to a C.T. practitioner. This represents an average of 2.5 patients per participant. Extrapolation of this figure would indicate that the

programme as a whole has generated 350 referrals to C.T. practitioners, however we do not know how many of these referrals might have taken place without the training.

Number of patients referred to C.T. practitioners

Number of opportunities	No. of respondents	No. patients referred
None	31	
1	3	3
2	9	18
3	6	18
4	4	16
5	5	25
6	2	12
8	1	8
10	4	40
11	1	11
20	1	20
Did not answer	19	
Total	86	171

Increased recognition of C.T. within H.S.S.B./H.S.E.

4.3.7 Feedback has indicated that the training has resulted in an increased recognition of C.T. within H.S.S.B.s and H.S.E.s to some degree:

- ◆ Participation on the course has generally triggered an interest in C.T. among other staff in the area, some of whom were able to participate on the programme at a later date. This has been enhanced because of the positive feedback about content and delivery methods.
- ◆ Some participants have indicated that they have discussed C.T. further on a formal basis with their line managers following the course, while others have noted little opportunity to do so formally, although have done so informally with other colleagues. As above, this in turn has generated interest among other colleagues.
- ◆ Participation in the course has led to many staff wishing to pursue further training in C.T. to enable them to practice within their workplace. However, all those who responded noted the limitations of training availability and difficulties in obtaining a place and/or funding for the training. Some also highlighted the difficulties that release for training would pose for their managers, teams, wards and colleagues.

- ◆ Feedback indicates that the course has highlighted the benefits of C.T. and the need for this to be accessible to all mental health patients when they need it. Participants believed that it should be possible for patients to be referred for C.T. treatment as opposed to being referred to a waiting list (during which time the condition may deteriorate and the need for more intensive treatment increase). All respondents acknowledged that there was a current shortage of Cognitive Therapists and that only those trained to a certain level can practice C.T. A relatively high percentage of participants indicated that they would like to develop their skills further in order to be able to practice C.T. within their workplace, thus reducing the demand on existing Cognitive Therapists. Not all have indicated a desire to train to Diploma level and some wished to know whether training at a level between “awareness” and “diploma” level could be introduced to enable them to provide basic levels of C.T. support to their patients.
- ◆ Feedback also highlighted views about the level at which C.T. could and should be practised within the workplace. (This in turn would have implications for the extent to which staff training should be provided at diploma, certificate and awareness level).
 - There appeared to be a view that all staff with a caseload of mental health patients should be able to practice C.T. as, at any given time, they are likely to have patients who would benefit from such support. Some highlighted the problems this would present in terms of resources and, while it may not be possible to train all such staff to this level, each team should have at least 1-2 Cognitive Therapists who can provide support as and when needed.
 - It was also thought that C.T. should be made available at primary care level so that “new” patients would be able to access such support as and when needed (especially those with mild to moderate conditions). This in turn would serve to address problems as they arise and ultimately reduce the extent to which mental health issues become complex and require more intensive support. In theory, this temporary increase in resource requirement should ultimately produce a reduction in resources needed. However, this argument probably holds true for most areas of health care!
 - Most of those consulted indicated that C.T. awareness training should be made available to all staff working with mental health patients (even beyond mental health services) as, even if C.T. approaches cannot be easily adopted within their place of work, knowledge of C.T. and an ability to explain its benefits to clients

and to generate referrals are key elements of providing a good service for mental health patients.

- There was also a view that all mental health staff should participate on training at a slightly higher level than “awareness” training to enable them to at least practice C.T. at a basic level within their workplace
 - Overall, the impending mental health strategies and policies should incorporate a needs assessment in terms of the numbers of staff who should be trained at each level, based on a practical structure and level of C.T. provision.
- ◆ Most highlighted the need for, and importance of, support and supervision for those providing C.T. This issue was highlighted within the training and it was acknowledged that, while it would be useful to train staff to deliver C.T. (perhaps at a range of different levels), this would be pointless if the necessary support and supervision structures were not incorporated into delivery structures.

4.3.8 As part of the independent evaluation, participants were asked to rate the extent to which they believed the training has increased recognition of C.T. within their workplace and has resulted in an increase in C.T. provision. They were also asked to rate the extent to which the programme produced a better understanding of provision in their own area.

	% scored 1	% scored 2	% scored 3	% scored 4	% scored 5	Ave. Score
Resulted in C.T. being recognised as a valuable intervention	5%	17%	33%	32%	12%	3.3
Resulted in an increase of C.T. provision/services	21%	26%	31%	16%	6%	2.6
Better understanding of provision in own area	0%	16%	33%	28%	23%	3.66

- ◆ 44% indicated a score of 4/5 in terms of C.T. being recognised as a valuable intervention
- ◆ 22% indicated a score of 4/5 in terms of increased provision of C.T., perhaps reinforcing the view that the training could not substantially increase availability of Cognitive Therapy.

- ◆ 52% indicated a score of 4/5 in terms of a better understanding of provision in their own area

As noted above, there are other factors beyond the scope of the project which impact on the extent to which C.T. has been promoted within the workplace. Some indicated that the use, and promotion, of C.T. can depend on the views of the key consultant in an area and their preference for medical or other psychological models of intervention. Some believed that some consultants see C.T. as a treatment of last resort, rather than a preventive approach or one part of a holistic care package. Some indicated that other structural issues, such as shift patterns, can have an impact on the future delivery of C.T. (e.g. limiting continuity of care).

- 4.3.9** As part of the evaluation participants were asked to indicate the extent to which the training resulted in the identification of the need for C.T. awareness training for other staff, the need for further training for themselves and the need for further support in C.T. for themselves. Again, they were asked to rate this on a scale of 1 - 5 (5 being the best/highest score).

	% scored 1	% scored 2	% scored 3	% scored 4	% scored 5	Ave Score
Need for awareness training for other staff	2%	13%	27%	35%	23%	3.6
Need for further C.T. training for participant	2%	5%	25%	37%	31%	3.9
Need for further support with C.T. for participant	5%	10%	32%	24%	29%	3.6

- ◆ 58% indicated a need for awareness training for other staff. .
- ◆ 68% indicated a need for further training in C.T. for themselves.
- ◆ 53% indicated a need for further support with C.T. for themselves

Increased Networking and Co-operation

- 4.3.10** The extent to which the programme has led to increased co-operation and networking within, and between, H.S.S.B.s and H.S.E.s would seem to be relatively limited. However, as noted above, the course was aimed at front-line operational staff (managers/policy makers are generally better positioned to promote networking and co-operation) and there are a range of factors within the wide context which come into play and which are outside of the scope of this project.
- 4.3.11** Consultation has highlighted that there was little evidence of cross border or inter area co-operation among participants prior to the training (Some did note involvement in joint projects between the voluntary sector and H.S.S.B. and involvement in cross border networks, while some indicated that their H.S.E. has begun more liaison with other bodies). There has been some informal networking between participants since the training, however there is no evidence of any further structured development. In fairness, formal networking and co-operation also needs a management lead and this programme was aimed at front-line staff. However, most participants have indicated that it was useful to train with similar staff from other areas or who are working within different settings and that by doing so they had an opportunity to learn about other perspectives and approaches. All indicated that the North South dimension was good and that joint training provided a good insight into how services are provided in other areas. Although not necessarily resulting in changes in provision, some participants indicated that this has resulted in minor adaptations in smaller operational issues. Some also indicated that they can now discuss issues with staff from other areas more easily. Undoubtedly, the shared experience has started to address stereotypical views and misconceptions about each other and has paved the way for future co-operation.
- 4.3.12** In the independent evaluation questionnaire, participants were asked to rate the extent to which there was increased joint working within their own H.S.S.B./H.S.E. area and with other H.S.S.B./H.S.E. areas. Again, they were asked to rate this on a scale of 1 - 5 (5 being the best/highest score). They were also asked to rate the extent to which the training resulted in better understanding of mental health provision in other

H.S.S.B./H.S.E. areas. Again they were asked to rate between 1-5 (5 being the highest/best score)

	% scored 1	% scored 2	% scored 3	% scored 4	% scored 5	Ave Score
Increased co-operative work within own H.S.S.B./H.S.E. area	42%	14%	23%	9%	11%	2.33
Increased co-operative work with other H.S.S.B./H.S.E. areas	77%	13%	5%	1%	3%	1.38
Better understanding of provision in other H.S.S.B./H.S.E. areas	7%	19%	33%	25%	15%	3.2

- ◆ 20% noted increased co-operation within their own H.S.S.B./H.S.E. as a result of the training
- ◆ 4% noted increased co-operation with other H.S.S.B./H.S.E.s as a result of the training
- ◆ 40% indicated a better understanding of provision in other H.S.S.B./H.S.E.s as a result of the training

4.4 Relevance to Peace II funding

4.4.1 The project was funded under Priority 5, Measure 2 of Peace II funding “Improving cross border public sector co-operation”. The funding aims to provide support to cross border co-operation initiatives and projects between public bodies and ensure co-ordinated approaches to common problems through the delivery of public services, which will make a positive impact on the improvement of services, and a contribution to peace building and reconciliation.

4.4.2 The project builds on what C.A.W.T. is aiming to achieve in terms of encouraging cross border co-operation at all levels in the provision of services which improve the health and well-being of the resident population. The project is also aiming to address issues arising from the legacy of the “Troubles”, that is, it is taking steps to improve services and support available for people with mental health problems. Research, as noted above and in the Appendices, has indicated that conflict is one of the factors that contributes towards mental health problems. The Troubles have heavily

impacted on the border areas covered within the C.A.W.T. region. Therefore, taking steps towards improving mental health services and support available to those in the C.A.W.T. area, helps address the impacts of the Troubles. Those who have been affected by the Troubles, and who require support within mental health services as a result, can come into contact with mental health services at any time and through a range of mechanisms. Many of those affected are considered “hidden victims” and, for many, the impacts of the Troubles can surface at any time and be triggered by a range of other life events and circumstances. C.T. is recognised as an appropriate treatment option for those suffering mental health problems (including those affected by the trauma/conflict). The course included an element dealing specifically with trauma. Therefore, raising awareness of the benefits of C.T., its appropriateness and how it can be accessed, among a wide range of staff is an appropriate step to take towards supporting those who have been affected by the Troubles in the C.A.W.T. area.

- 4.4.3** However, as noted before, this project is a “step” towards improving cross border co-operation between H.S.S.B.s and H.S.E.s and towards improving mental health services to those in the C.A.W.T. area (including victims of the troubles). There are a range of other factors outside of its scope which also need to be addressed. These include availability of resources, strategic and policy directives and staff attitudes.
- 4.4.4** The project has been successful in raising awareness of C.T. among front-line staff and initiating small changes in service delivery and co-operation at operational level. It has also fostered an interest to pursue further development of C.T. skills among staff working within mental health provision in the C.A.W.T. area. It has been very successful at achieving what it set out to achieve in this regard and it has highlighted the need to address the issue at a wider level. There is a general view that the work to date needs to be further built upon to ensure further development of C.T. skills and to ensure further cross-border and inter H.S.S.B./H.S.E. working (and perhaps this should be targeted at management level).
- 4.4.5** In terms of meeting the horizontal principles, the Cognitive Therapy Awareness training has sought to follow these in a number of ways:

- ◆ Accountability - The project is managed by Steering Group within the mental health sub group of the C.A.W.T. structure and is therefore accountable through this to the main health structures in the area.
- ◆ Balanced Intervention/Equal Opportunities - The project is open to all mental health staff with allocations split evenly between each H.S.S.B. and H.S.E. area
- ◆ New Targeting Social Need - C.T. Awareness Training is targeted at staff dealing with mental health patients. Factors contributing to mental health problems include poverty, unemployment and isolation and therefore those who are most disadvantaged receive greater benefit.
- ◆ Economic and Social Stability - The project aims to support people with mental health problems and thus promote social stability and employability and fits with government's wider agendas about increasingly the percentage of economically active.
- ◆ Partnership - based on partnership approach within a wider C.A.W.T. partnership structure and at delivery level
- ◆ Inclusive Delivery Mechanisms - representation from all areas on steering group and participants targeted from all areas
- ◆ Publicity/Transparency - well advertised in a timely manner to all potential participants. Organisational skills of project manager ensured transparency within the areas targeted
- ◆ Co-ordination - managed by steering group made up of representatives from all areas. Well co-ordinated at delivery level by project manager
- ◆ Environmental/Sustainability - no detrimental environmental impacts, except perhaps for increasing travel requirements which was unavoidable

4.5 Value for money

4.5.1 The table below provides an overview of the programme costs for the period September 2003 - September 2005 (24 months).

Element	Amount (£s)
Fixtures and Fittings	3,000
Salaries	44,000
Travel and Subsistence	8,000
Heat, light, phone	3,000
Audit, Accountancy, I.C.T.	8,605
Professional fees	3,000
Marketing, printing, stationery, publicity	3,500
Nurse replacement costs	150,542
Trainers	65,200
Graduation	3,000
Total	291,847

4.5.2 In total this represents a cost of £2,130 per participant and £355 per participant per day. If we exclude the nurse replacement costs this works out at £1,031 per participant and £172 per participant per day. Nurse replacement costs are approximately £1,100 per participant (£183 per day). In training cost terms, the course represents good value for money, based on the level of training provided and the need for specifically trained and experienced course tutors.

5 Conclusions and Recommendations

5.1 Conclusions

- 5.1.1** The C.A.W.T. area suffers some of the factors which can negatively impact on mental health such as social isolation, impact of conflict and unemployment. At any given time approximately 150,000 people in the area suffer from mental health problems.
- 5.1.2** Mental Health services in both N.I. and R.o.I. have undergone periods of change and new mental health strategies are being developed which are likely to highlight the importance of multidisciplinary approaches to care and therapeutic interventions. In particular, Cognitive Therapy which, due to much evidence based research, is widely recommended for dealing with a range of mental health problems. The recognised benefits of Cognitive Therapy include helping patients understand and manage their illness and ultimately reduce levels of dependence on the health services.
- 5.1.3** Although it is likely that future N.I. and R.o.I. strategies will consider a more strategic approach to developing and delivering C.T. within mental health services, there is currently no strategic, structured or formal approach to provision. Cognitive Therapy is currently provided at the discretion of individual H.S.S.T.s/H.S.Es./units/departments and largely depends on management attitudes to developing C.T. and on the resources available. At present the level of cognitive therapy provision in the C.A.W.T. area, and in fact in all areas, is inconsistent and does not meet demand or need. Feedback has indicated that there are long waiting lists for cognitive therapists in all areas and this itself results in a vicious circle of demand, whereby patients who would have benefited from a moderate level of support at an early stage in their illness deteriorate and require more intensive support in the long term. Feedback also indicates that, in general, there are no mechanisms to filter referrals to ensure efficient and effective use of resources.

5.1.4 Demand for therapeutic interventions, and in particular cognitive therapy, has been growing and is likely to continue to grow. This is due to increased understanding of mental health problems and increased awareness of the potential benefits of therapeutic interventions, in particular Cognitive Therapy. Feedback indicates a hope that therapeutic interventions, particularly C.T., would be seamlessly incorporated into all mental health provision and not be viewed as a separate, additional service. In fact, one of the pioneers of Cognitive Therapy, A.T. Beck, indicated that the future of C.T. would be for it not to exist!!

5.1.5 To ensure best use of Cognitive Therapy resources future provision structures should ensure that:

- ◆ a larger number of therapists are trained to deal with mild/moderate conditions and be appropriately spread across geographical areas and delivery settings (hospital, community, primary care)
- ◆ a smaller number of specialist therapists are trained and would serve a wider geographical area and delivery settings.
- ◆ Supervision, networking and collaboration within and between all levels of provision is encouraged to ensure appropriate quality and information sharing.

Of course, the success of the future of therapeutic interventions, including C.T., within mental health provision will depend on the extent to which it has been incorporated into relevant regional strategies and policies, the extent to which it is supported by mental health managers and planners and the resources available to ensure effective development.

5.1.6 To date there has been no structured or formal approach to C.T. training as a whole within the C.A.W.T. region or elsewhere. Although many staff are becoming aware of what C.T. is, they are not necessarily aware of when/how it can/should be practised and at present opportunities for those interested in developing C.T. skills to enable them to practice as therapists are limited.

- ◆ Therapeutic interventions are not as a rule covered in formal professional training (although this is now recommended by the Royal College of Psychiatrists).

- ◆ In order to practice as Cognitive Therapists staff need to undertake training to at least diploma level. This involves one day per week formal training for a year, and practising C.T. in the workplace under the supervision of a suitably trained C.T. therapist. (Supervision can be provided by those who have already obtained the diploma and have appropriate levels of experience). Staff can also train to Certificate level (also one day per week per year with workplace supervision) which enables them to practice C.T. at a lower level within the workplace.
- ◆ At present there are a small number of reputable organisations offering this type of training (within N.I. and C.A.W.T. region of R.o.I.), offering approximately 70 places per year. Participation on such courses generally depends on H.S.S.T./H.S.E./unit/department ability to release staff who have an interest in developing C.T. skills. Although some H.S.S.T./H.S.E./unit/departments are willing to cover the cost of the training for staff who have secured a place this is not always the case. Resource constraints (in terms of course costs and covering staff absences) generally make it difficult for mental health providers to release staff for training.
- ◆ Demand for training places is high and all have waiting lists.

Although the issue of C.T. training is likely to be considered within future mental health strategies and as a result be adopted by strategic and operational managers within mental health provision, there is as yet no guarantee of additional resources or funding for training and it will take time to develop and implement any recommendations regarding future provision.

5.1.7 Prior to the development of the Cognitive Awareness Training Programme there was no such training available within the C.A.W.T. region. However the funding obtained by the Cognitive Awareness Project Management Group facilitated the delivery of 8 programmes over a two year period by professional and experience training providers.

- ◆ 339 front-line staff across the C.A.W.T. region registered an interest in the 160 available places which were equitably allocated across the H.S.S.B.s and H.S.E.s in the C.A.W.T. area.
- ◆ 137 staff participated on the programme (with a further availing due to additional funding through Interreg). Each H.S.S.B./H.S.E. used 85-90% of their allocated places, except the S.H.S.S.B. which used

73% (problems in releasing staff and views that C.T. received less support from key staff in some areas were highlighted). Participants came from a range of settings. 36% were hospital based, 23% community based and 41% from other settings (addictions, elderly care, etc.). Attendance levels were very high with an average attendance rate of 94%.

- ◆ The management of the programme, and course content and delivery were considered appropriate and excellent (some participants citing it as the best training they have ever had) and 94% indicated that their expectations of the course had been met.

5.1.8 The following impacts of the Cognitive Awareness Training Programme were highlighted through the evaluation:

- ◆ Improvements in participants' knowledge and skills post training with participants indicating that they are now much more aware of the benefits of C.T. and of when it can be used and have a basic knowledge of C.T. techniques. None indicated that they would or could practice C.T. formally. All recognise the need for further training in order for them to become therapists and for some this course provided a good deal of realism in terms of what is expected of C.T. and what is required to be able to practice C.T. within their work environment. The course was not designed to create Cognitive Therapists and therefore an outcome whereby participants would be using C.T. with their patients would be unlikely and inappropriate. 70% of participants indicated that the course has increased their interest in C.T. and that they would like to progress further.
- ◆ It would be unfair to expect a course of this nature and size to have a significant impact on delivery, structures and policies surrounding mental health service provision as there are a range of other factors which impact to a greater degree such as strategic/policy guidance, attitudes of management at all levels and availability of resources. However it has had a number of impacts at a more operational level:
 - staff are aware of the benefits of C.T. for their patients and how/when it can be used and this in turn helps towards ensuring best care for the resident population. However, all raised concerns about waiting lists for C.T. practitioners.
 - although the training does not enable staff to practice as therapists, most indicated that they can put some elements of what they have learned into practice within their own work environment at an appropriate level.

- participation on the course has triggered an interest among other staff, some of whom were able to participate on the programme at a later date. Participants generally thought that all mental health staff should have the opportunity to undertake awareness training of this kind and may have indicated a desire to undertake further training themselves although they noted the limited opportunities to do so and the constraints facing their managers (finances and staff cover).
- most acknowledged that, for C.T. to be formally adopted, strategic and operational management support is required, as is an appropriate level of resources.
- it was useful to undertake training with staff from other units, departments, H.S.S.T.s and H.S.E.s. Joint learning provided an opportunity to gain an insight into how services are provided in other areas.
- there has been some form of informal networking between participants since the training.
- Evaluation feedback indicated that 44% felt that their participation on the training has resulted in C.T. being recognised as a valuable intervention within their place of work.
- Evaluation feedback indicated that 22% felt that the training resulted in increased provision/services
- Evaluation feedback indicated that 51% felt that training resulted in a better understanding of provision in their own area

5.1.9 The programme demonstrated good value for money with a cost of £2,130 per participant and £355 per participant per day. (This included nurse replacement costs which made up just over 50% of costs). It also fits with the funding objectives, criteria and horizontal principles.

5.1.10 Clearly the programme was very well delivered and, not only were participants enthusiastic about how it was delivered and about what they had learned, many have indicated that it has impacted on their skills, ability and to some extent work environment. However, although participants felt they learned from other participants from other areas through joint training of this kind, the extent to which it has resulted in increased formal networking and co-operation has been limited and to be fair depends on a range of other issues beyond the scope of a programme of this kind.

5.2 Recommendations

5.2.1 Most mental health professionals take the view that therapeutic interventions, and in particular, Cognitive Therapy, can produce improvements in mental health which have resulting reductions in the need for mental health care in the long term. This in turn is likely to result in long term reductions in the cost of mental health care.

5.2.2 Much research has been undertaken in relation to Cognitive Therapy and it is the recommended, and in some cases preferred, therapeutic intervention for many mental health conditions (often in conjunction with other support and medication). It is apparent that the need for therapeutic interventions such as Cognitive Therapy is much greater than current levels of provision. The Cognitive Therapy Awareness Training delivered through C.A.W.T. has played a major part in raising awareness of C.T. in the C.A.W.T. area, however it has further demonstrated the gap between the level of need and the level of provision. It is acknowledged that resources are in short supply at present and it is unlikely that any further resources which may be made available at a more strategic level in line with pending mental health policies and strategies in N.I. and R.o.I. will fully meet the need to develop this area of mental health provision.

5.2.3 It is with these issues in mind that the following recommendations are made.

5.2.4 Strategic Level Recommendations

5.2.5 At a strategic level the Cognitive Awareness Project Management Group and the C.A.W.T. Mental Health Sub Group should consider to the following (in most cases in conjunction with D.H.S.S.P.S. (N.I.) and D.o.H.C. (R.o.I.)) :

- ◆ **Making the Economic Case for C.T.** - An economic case for C.T. needs to be demonstrated, whereby existing studies on C.T. are examined with a view to demonstrating the extent to which the provision of C.T. impacts on the long term demand for mental health

provision (e.g., can it be demonstrated that provision of an appropriate level of C.T. at the right time can result in a reduction in the need for mental health services in the long term?). This is something which should probably be done in conjunction with D.H.S.S.P.S. and D.o.H.C. It is acknowledged that work has already been undertaken in this regard by members of the Cognitive Therapy Awareness Project Management Team.

- ◆ **Assessing Level of Provision** - the appropriate level of Cognitive Therapy provision needs to be assessed and appropriate Cognitive Therapy delivery structure established - e.g., how many staff should be able to provide each level of Cognitive Therapy and what areas/settings should they cover?
- ◆ **Agreeing the Scale of Training Required** - The amount and level of training required to provide adequate supply of C.T. needs to be established. In terms of facilitating networking and shared learning between operational staff involved mental health provision in the C.A.W.T. area, consideration should be given to bringing staff from different areas/settings together (as was the case in the Cognitive Therapy Awareness Training).
- ◆ **Maximising the C.T. Resource (Cross Border)** - In terms of facilitating networking, co-operation and collaboration between H.S.S.B.s and H.S.E.s in the C.A.W.T. area, consideration needs to be given to establishing a forum within which professionals, managers and planners can discuss how to share Cognitive Therapy Resources to best meet the needs of the resident population
- ◆ **Getting More Resources** - lobbying to ensure that appropriate levels of funding are provided to meet the need for C.T., for C.T. training and for fostering more collaborative working which in turn can result in better use of resources. An important tool in lobbying will be the economic/business case already mentioned. This will ensure that increased resource can reduce the long term financial burden.
- ◆ Encouraging the incorporation of therapeutic intervention awareness training into mainstream formal training for mental health professionals (and other professionals who are likely to work with people with mental health problems) so that future staff will have at least basic awareness and this type of training will no longer be required

5.2.6 Suggestions relating to the proposed structure and training are included in the Appendices.

5.2.7 Operational Level

5.2.8 At an operational level the Cognitive Awareness Project Management Group should

- ◆ develop and facilitate the delivery of a certificate level course (which fits within the U.K. skills and competencies framework) which will enable participants to build on their skills and deliver C.T. at a basic level to those suffering mild mental illness conditions - particularly those with caseloads of mental health patients, those within the primary care setting and a sample of those in other settings.
- ◆ continue to facilitate the delivery of Awareness Training to capture all staff working with mental health patients
- ◆ identify demand for and provision of training for those who wish to become Cognitive Therapists (and specialised Cognitive Therapists) and consider how best to meet any identified gaps/needs. Should it transpire that there are currently fewer places than meets demand/need, consideration should be given to developing appropriate training in this area (e.g. Diploma level and/or diploma level with specialisms). This training should be targeted to ensure appropriate numbers of participants per geographical area and delivery setting. At this level, consideration needs to be given to sharing resources across areas/boundaries (e.g. training specialists to ultimately deliver across a wider area and/or number of delivery settings)

5.2.9 The facilitation of such training will require fund-raising to enable the purchase of training and will also require quality assuring training providers

5.2.10 The number of training places offered should be in line with the recommended number of cognitive therapists at each level per mental health patients/staff.

5.2.11 Training should be targeted to ensure:

- ◆ fit with overall plans to establish a strong C.T. infrastructure with agreed numbers of staff trained to deliver at different levels. It may be worth ensuring that a certain proportion of those undertaking this training (in each geographical area and delivery setting) should have a desire to develop their skills even further once they have finished their certificate. This could lead to the development of the future structure of fully trained Cognitive Therapists throughout the C.A.W.T. area.
- ◆ that where appropriate and possible resources can be shared across geographical areas and delivery settings
- ◆ appropriate representation from each geographical area and delivery setting. In particular this type of training would be relevant and should perhaps be targeted towards:
 - those working within the community setting who carry a caseload of mental health patients who may require basic C.T. at various times throughout their contact with mental health teams.
 - those working at a primary care level who are likely to come into contact with those suffering anxiety/mild depression (and perhaps be referred from G.P.s).
- ◆ that levels of mental illness, mental health staffing levels and existence of and demand for other similar training are taken into consideration.

5.2.12 Training should build in resources required for supervision and on the ground training needs of participants**5.2.13** Training should be delivered to allow staff from different areas/settings to train together where possible as this results in good networking/learning opportunities.**5.2.14** Managers, commissioners and staff should be made aware of how training fits within wider strategic plans for C.T. with a view to encouraging adoption of C.T. and networking and co-operation.

6 Appendices

6.1 Policies and Strategies

- ◆ R.o.I. Mental Health Strategy “Vision for Change”
- ◆ Programme for Government/Priorities and Budget - one of the priorities of the Programme for Government is to work for a healthier nation and within this priority it recommends taking measures to promote mental and emotional health.
- ◆ The Investing for Health strategy provides the framework for addressing ill health and health inequalities and one of its priorities is mental health with a target of “reducing the proportion of people with a potential psychiatric disorder by a tenth by 2010”.
- ◆ The Promoting Mental Health Strategy for N.I. 2003 - 2008 outlines an integrated approach addressing the wider determinants of mental health. It focuses on promoting good mental health, preventing mental ill health and ensuring early intervention when mental health problems occur. It recommends addressing mental health promotion at three levels, one of which is “strengthening individuals” which involves increasing emotional resilience through interventions to promote self esteem, life and coping skills (e.g. communicating).
- ◆ The Victims Strategy “Reshape, Rebuild, Achieve” was developed following the Belfast Agreement 1998 where the need to acknowledge and address the suffering of victims was noted. The Strategy sets out how the N.I. administration will deliver practical help and services to those affected by the Troubles. One of the aims of the strategy is “to promote and facilitate an improvement in the standard of services being provided to victims and to seek to address any identified gaps in service provision” and within this the role of C.T. is acknowledged..

6.2 N.I.C.E. Guidelines - Mental Health

- ◆ Management of Anxiety - C.T. is the preferred psychological therapy in primary care and should be delivered by suitably trained and supervised staff for approximately 1-2 hours per week over a period of around 4 months (will vary with degree of complexity).

C.T. is also recommended as further treatment for those who require more specialised support.

- ◆ Management of Depression (mild, moderate, severe and severe with psychotic symptoms) - C.T. is the preferred short term intervention for mild to moderate depression (6-8 sessions), for moderate to severe depression (16-20 sessions), for chronic depression, for older adults with depression, and for recurrent depression . It should often be delivered in conjunction with other treatments such as medication and treatments for co-morbidities. It is recommended for those with moderate to severe depression who have not responded to other treatments.
- ◆ Treatment and Management of Eating Disorders - C.T. is recommended for the treatment of anorexia nervosa (6 months), bulimia nervosa (a specifically adapted form of C.B.T. - C.B.T. B.N. (C.B.T. Bulimia Nervosa)- offered for 16-20 sessions), for binge eating disorder (a specifically adapted form of C.B.T. - C.B.T. B.E.D. (C.B.T. - Binge Eating Disorder)).
- ◆ Management of Obsessive-compulsive Disorder (O.C.D.) and Body Dysmorphic Disorder (B.D.D) - it is recommended that treatment should include C.T. (including Exposure and Response Prevention - E.P.R.) for approximately 10 hours. This can be increased for those who need it. This can be provided in the individual or group setting. For children and young people, family and carers should be involved .
- ◆ Management of Post Traumatic Stress Disorder - it is recommended that all people with P.T.S.D. should be offered a course of trauma focused C.T. on an individual basis where possible within the first month (approximately 5 sessions). However 8-12 sessions may be necessary for those treated later. More sessions may be required as assessed by health professionals.
- ◆ Treatment and Management of Schizophrenia - C.T. should be available as a treatment option for all people with schizophrenia (particularly to those who are experiencing persisting psychotic symptoms) to prevent relapse, to reduce symptoms, to increase insight and to promote adherence to medication. Input depends on assessed needs however longer treatments are recommended rather than shorter (more than 10 treatment session for more than 6 months)

6.3 Recommendations - Training

6.3.1 In terms of working towards embedding therapeutic interventions (C.T.) in mental health provision the C.A.W.T. Mental Health Sub Group, in conjunction with D.H.S.S.P.S. and D.o.H.C., should ideally work towards:

- ◆ **ensuring access to basic awareness training** for all key health staff who are likely to interact with mental health patients during the course of their work, should be made aware of C.T. (and other therapies if deemed appropriate by N.I.C.E. guidelines) - benefits and when and how it could/should be used, and how to access relevant support for their patients when this is needed. Such staff include:
 - all mental health staff and managers (incorporated into foundation training below)
 - staff and managers in other units/departments where mental health patients are likely to be supported/treated
 - volunteers, staff and managers in the voluntary sector who deal with people who suffer mental health problems

- ◆ **providing foundation training** for mental health staff (to cover all geographical areas and mental health settings) perhaps at certificate level which builds on the awareness training (above), and incorporates the basics of C.T. which will ideally enable them to practice C.T. at a basic level within their work environment. Although it would be ideal for all mental health staff to benefit from this type of training, priorities would include those managing caseloads of mental health patients and those in contact with mental health patients over a sufficiently long period of time for C.T. to be effective. It would also be useful for specified number of staff in each mental health team setting (hospital, community, primary care) to acquire such skills to ensure patients in such settings have access to this support if and when they require it.

- ◆ **offering diploma level training** for mental health staff who have a desire to develop C.T. skills and practice as a Cognitive Therapist, dealing with patients who have been referred because they require more specialised input than can be provided elsewhere. At present it is difficult to ascertain how many such therapists would be required to meet demand. Presumably, if some patients can be dealt with by staff trained at Certificate level (above) this will reduce the demand for the support provided by more highly trained therapists. However,

more highly trained therapists would be dealing with more complex issues which require more intensive input. The priority would be that mental health patients have access to such a therapist when needed in whatever setting best suits them (in the primary care setting, community setting, and hospital settings).

- ◆ **ensuring specialised training** for mental health staff who have a desire to develop C.T. skills specific to certain illnesses or to enable them to deal with more complex needs. It is likely that there would be fewer therapists of this kind, covering a wider area (geographical area, hospital, community and primary care settings, etc.). The Mental Health Sub Group should work towards establishing the number of such therapists required.
- ◆ **ongoing training and updating** is provided for all staff at whatever level is appropriate to their original training. For those operating at below diploma level this could be provided by staff trained to diploma level in local settings. However, in terms of providing shared learning “networking training and updating” should be considered as this allows staff from different geographical areas and settings to meet and learn from each other as well as maintain contact. This also helps meet the aims of “joining up” services to ensure the most effective and efficient support for patients.
- ◆ **adequate supervision** - supervision is a vital element of all training and indeed provision and resources to ensure appropriate levels of supervision should be incorporated into any training plans.



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