helper
healthy living & prevention of early relapse

HEalthy Living and Prevention of Early Relapse

Healthy Living Stream- INTERACT

Training manual

Karina Lovell, Alison Wearden, Tim Bradshaw and Diane Escott


Inter Act
Intervention to encourage Activity,
improve diet and control weight gain

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Introduction to the Helper study

Firstly I would like to thank you so much for agreeing to deliver this intervention. Your help is invaluable in the delivery of this study. Much of what is covered in this manual is provided in the training; however this manual is for your reference throughout the study.

How to use this manual

This manual is for you to use in delivering a Healthy Living Intervention with participants from the early intervention service. The manual is divided into the following sections

Section 1 – What is this study about

Section 2 – Delivering the intervention

Section 3 – Supervision

Section 4 – Monitoring

Section 5 –Trial procedures

However if there is anything you do not understand or if you want to know more about the trial please contact us either by telephone or email

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What is this study about?

The study is funded for 5 years by the National Institute for Health Research (NIHR) and is led by Professor Max Marshall and the team includes Professor Shon Lewis, Professor Karina Lovell, Mr Jeff Warburton, Professor Graham Dunn, Professor Helen Lester, Professor Christine Barrowclough, Dr Richard Drake, Dr Linda Davies, Dr Fiona Lobban, Dr Nusrat Husain & Dr Alison Wearden. The overall aim of this study is to develop three phase specific interventions to prevent relapse of psychosis and or deterioration in physical health in people who are experiencing first episode psychosis. The three interventions which we are looking at are

- **Healthy Living intervention focussing on diet and exercise.**
- **Motivational Interviewing & CBT for substance misuse.**
- **Cognitive Remediation (CR) to improve insight & enhance CBT**

There are 3 streams of this research all with different teams and with different questions. This stream is concerned with the **Healthy Living intervention** and focussed on diet and exercise (if you would like more information on the other streams please do ask us).

Section 1

What is the Healthy Living Intervention about?

Let me introduce you to the trial team

Max

Professor Max Marshall. Max is a Professor of Community Psychiatry and is the principal investigator for Helper study and oversees all 3 streams.

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Karina

Karina Lovell leads the Healthy Living Stream and is a Professor of mental health at the University of Manchester. She is a mental health nurse by background, trained CBT therapist and provides low intensity interventions in the voluntary sector.

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Dr Alison Wearden is a Health psychologist with an interest in the management of chronic illness, and experience of carrying out exercise and lifestyle interventions

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Tim

Dr Tim Bradshaw is a senior researcher and lecturer in mental health nursing. At the university Tim works on a course which teaches multi-disciplinary groups of mental health professionals about psychosocial interventions

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Diane

Dr Diane Escot is a researcher is a research assistant to the Healthy Living Stream. She has a background in Psychology and works as a researcher in the School of Nursing, Midwifery and Social Work at the University of Manchester.

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Jeff

Jeff Warburton is the manager of the early intervention service and deputy Network director of the Camhs / EIS / SMS services for LCFT; he is a nurse by background with many years experience as a CPN and manager in AOT and EIS. His main role in the Helper program is to ensure the delivery of the research within the EIS whilst ensuring that effective care is delivered as usual to all service users, families and staff work to cooperate within the research.

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Nusrat

Dr Nusrat Husain is a psychiatrist and Senior Lecturer at the University of Manchester and an honorary consultant psychiatrist with Lancashire Early Intervention services. His area of research is mental health of ethnic minorities and developing culturally sensitive interventions. His role in this trial is to ensure that the interventions are culturally sensitive to the participants of South Asian origin

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What is the Healthy Living Intervention study about?

The main aim of the study is to develop and test evidence based, acceptable and feasible healthy living intervention for people with first episode psychosis.

Rationale for the study

The life expectancy of adults with schizophrenia is reduced by about 15 years when compared with the general population (Hennekens et al 2005), and while some of this premature mortality is accounted for by suicide, approximately 62% of all deaths are attributable to natural causes (Harris and Barraclough, 1998). Adults with a diagnosis of psychosis are twice as likely as members of the general population to suffer from ischaemic heart disease, stroke, hypertension, epilepsy or diabetes by the age of 55 years (Hippisley-Cox & Pringle, 2005).

This poor physical health may be explained both by the side effects of antipsychotic medication (Marder et al, 2004) and by the unhealthy lifestyles that many individuals with psychosis lead (Brown et al, 1999). People with psychosis have been shown to take less exercise (McCreadie, 2003), eat poorer diets (McCreadie et al, 1998) and to be significantly more likely to smoke (Brown et al, 1999) than members of the general population. They are more likely to be obese (Homel et al, 2002) and show a higher prevalence of metabolic syndrome (Sacks, 2004) and diabetes mellitus (Bushe and Holt, 2004). Patients taking second-generation antipsychotics, which are frequently prescribed to control symptoms of psychosis, are at particular risk of weight gain (Green et al., 2000). The risk of antipsychotic induced weight gain may be even higher among young people experiencing a first episode of psychosis (Zipursky et al., 2005). Despite these findings a systematic review published by Bradshaw and colleagues in 2005 was only able to identify sixteen studies that had evaluated health education interventions for this client group and recent guidance from the Department of Health (2006) has highlighted the need to develop and evaluate health education programmes for this client group.

Despite the increasing evidence base, there remains ambiguity concerning the exact nature of the components of a healthy living intervention for people experiencing first episode psychosis including the specific content of the intervention, the delivery style, where the intervention should take place and the skills and expertise required to deliver the intervention. In addition to these components it is also important to develop an intervention that is acceptable

to those receiving the intervention and those who are delivering the intervention.

The study

Our overall aim is to develop and evaluate an evidence based, acceptable and feasible healthy living intervention for people in the early intervention service. There are two phases to our study.

Phase 1: Development of an evidence based, acceptable, feasible and culturally sensitive healthy living intervention by identifying key components

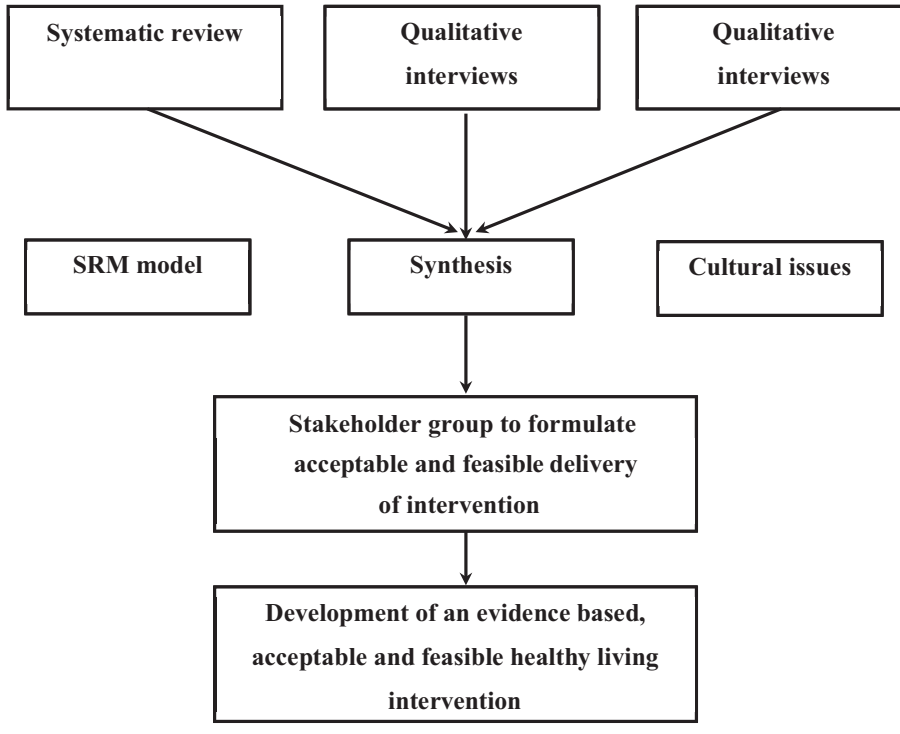
Phase 2: To test the intervention using an exploratory randomised control trial (RCT)

Phase 1 and 2

We completed 5 pieces of work to achieve our aim of producing a 'top down' 'bottom up' approach to develop an evidenced based, feasible and acceptable intervention (Figure 1)which included the following studies 1) a systematic review and meta regression 2) qualitative interviews with users experiencing first episode psychosis 3) focus groups/ interviews with health professionals 4) core dimensions of the Self Regulatory model which is the theoretical model underpinning the entire HELPER programme 5) core components of culturally sensitive intervention. We then held a one day synthesis day where we put all this information together and developed the intervention. To make sure that we had done this correctly we then asked carers, health professionals and users what they thought of our proposed intervention.

We then wrote the intervention, prepared the training materials and trained the people delivering the intervention. We then wrote the protocol for testing the intervention. The results of the development work and the trial protocol will be explained in the training but if you would like more details of the aims, methods and results of this work then it is available in the Helper (phase 1 report which any of the trial team will let you have).

Figure 1: Development of the Healthy Living intervention



Section 2 – Delivery of the intervention

Your role

Your role in the trial is to deliver the Healthy Living Intervention.

In terms of the research trial we will be asking you to record all (or as many as possible treatment sessions), keep detailed records of session length, number of sessions and content, and to participate in supervision.

Our role (Karina, Alison, Tim, Max, Diane, Jeff and Nusrat)

Our role is to execute the trial using the most rigorous methods possible, and ensure ethics and research governance procedures are adhered too. We will be conducting all of the assessments (by this I mean eligibility for the study and outcome measures,) and providing you with support and supervision.

What is the intervention?

The Healthy Living intervention will comprise of 8 individual sessions over a 12 month period with an emphasis on facilitating participatory exercise and dietary change through the development and implementation of patient led action plans. These sessions will be delivered by a STR worker who will be trained in the delivery of the intervention. To facilitate implementation of exercise and dietary change a range of optional active group sessions will be offered by the STR worker for those who prefer a group based activity. To optimise engagement, choice and self management a booklet will be given to all participants providing educational advice, action plans, goals, details of the group sessions, healthy eating recipes on a budget etc. A strong emphasis will be placed on maximising carer/family engagement. The duration of sessions will range from between 30 minutes to an hour depending on individual need.

Delivering the intervention

This is a step by step guide to help you in delivering the intervention. Brief details of what should be included in each session are described in the ‘session review box’ and are followed by a more detailed explanation.

Session 1 – Introduction to the intervention and identification of health beliefs

Session 1 overview:

Orientation to the session

Orientation to the intervention (including participant's role, your role, the patient book & the role of family and friends)

Assess lifestyle and elicit health beliefs

Identify and agree individualised goals

Offer choice and options of the scheduled groups

Ending: Feedback on session – final questions – next appointment

To help you with this session a crib sheet (interview guide) has been devised by the team to help you with this session and can be found in Section 6.

Orientation to the session

Introduce self, role (i.e. I am a Support Time Recovery or STR worker for short which means that my role is to work in partnership with you in helping you to maintain a healthy lifestyle. Confirm the patients full name, identify the purpose of the interview, and approximate duration of the interview, and re check consent for the interview to be recorded. The extent of confidentiality should be explained.

Orientation to the intervention

- Role of the STR worker
- Role of the client
- Role of the book
- Role of friends and family

Role of the STR worker: You need to explain your role i.e. STR working on this research study. Your role is work in partnership to help to develop a healthier lifestyle by looking at and making agreed changes particularly in relation to diet and exercise. Emphasise that the key role is to support and monitor participants to implement real changes in their life style and to help people incorporate such changes into their everyday routine. It is also to emphasise that the participant is the 'agent of change' (i.e. they are in charge of their treatment). A way of explaining this to patients might be to use an analogy of a personal fitness trainer. You might introduce this by saying that a way of explaining your role is similar to a personal fitness trainer- *"If you go down the gym or play sports, fitness trainers don't do the actual physical work of getting you fit. That's up to the individual. However, the trainer helps you to devise a fitness plan, monitor your progress and keep encouraging you when the going gets tough. I will act in the same way. I am there to support, advise, encourage and monitor your progress".* You will see participants for 8 sessions over a 12 month period, 5 sessions in the first 3 months, 2 sessions in months 4 and 6 and a final session in months 10 to 12.

Role of the participant: Explain the role of the participant – ie that it is a collaborative intervention, where they will work in partnership with you to try to make changes to improve their health through dietary and exercise changes. It is important to emphasise that the participant is the 'lead' in their intervention.

The Book

Introduce the book ensuring you tell the participant how to use it and what it contains. The book provides information on recommended diet and exercise, information about local activities which you may want to join, it provides information on some optional groups we are running and it also provides some practical information on 'healthy living on a budget' and a range of healthy recipes which you and or your family may want to try.

Your friends and family

We know how important friends and family are to people and we would very much like to include a member of your family or a friend to help you with making improvements into your life style. We will only do this with your permission but if you would like to bring a family member or a friend with you we would welcome this. Alternatively if you would like us to speak with a

member of your family or a friend on the telephone then we can do this as well. If you do not want anybody involved then just let us know.

Assess lifestyle and elicit health and cultural beliefs

It is important to conduct a patient centred assessment to elicit the participant's health and cultural beliefs to ensure that their healthy living intervention is individualised and tailored to the participant's life.

Introduce the assessment with an opening statement – e.g. *"What would be helpful now is for me to understand more about you and your current and past life style?"* Try to use general open questions, specific open and closed questions to funnel the information into a clear formulation.

The interview should be flexible and responsive to the participant's answers but sample questions which you may want to use are below.

Elicit expectations

Explore participant's expectations of the intervention. For example *"Tell me why you are you interested in healthy living?* (This may because they recognise that they are leading an unhealthy life style – or that they have put on weight due to medication, or it might be that previous exercise and dietary regimes have decreased since a relapse or it might be that they want to help other people – what ever the reason(s) this is a good lead in question to assess individuals own motivation and expectations of what they are seeking from the intervention.

Eliciting and working with beliefs about weight gain

The aim is to find out what the service user thinks about the whole issue of weight gain. By understanding what the service user thinks, you can start to see what is motivating his or her behaviour (or lack of behaviour!). Sometimes people's beliefs may be based on lack of knowledge or misunderstandings, sometimes they may simply be unhelpful with respect to the behavioural goals. By discussing what the service user believes with him or her, you can encourage him/her to consider different ways of looking at the issues, which might be more helpful in the long run.

You can elicit these sorts of beliefs by

- Using a simple questionnaire such as an adapted version of the Brief Illness Perception Questionnaire (which we will provide)
- Asking specific questions, like “Why do you think you have put on this weight – what has caused the weight gain?”
- Asking people to talk about their experiences of trying to control their weight (for example) and then picking up on beliefs as they emerge, and discussing them (this needs a bit of practice)

The self-regulatory model says that people’s beliefs about a health threat (in this case weight gain) come from a variety of sources including their own experience, what they see happening with others (e.g. family members), what they pick up from the media, and what medical practitioners tell them. So when trying to understand a person’s beliefs about weight gain, it is important to consider these beliefs in the whole social context – ie what are the other people in his/her family like, does s/he have a history of dieting etc.

We know from research that there are a number of different aspects (or dimensions) of people’s beliefs about risks to their health. A very important one is **cause**. You need to know what the service user thinks causes people to gain weight in general, and what causes him or her to gain or lose weight. Why does she weigh what she does right now?

Examples of things that people may believe about their weight include:

- Everyone in my family is fat, it is all genetically determined;
- I have a particularly inefficient metabolism;
- I am overweight because I eat too much junk food;
- I am naturally very thin because my body burns up food more efficiently than other people’s.

Try to get a discussion going about the possible causes of weight gain, and take the opportunity to gently correct any misunderstandings, by suggesting alternative ideas.

Of course, we can’t pretend to have a perfect understanding of what determines a person’s weight – but a very good rule of thumb is that it is the result of the balance between energy in (food) and energy out (activity). When a person’s weight is stable, this is because they are managing to achieve a

balance between what they eat and what they do. It's actually amazing how well most people achieve this balance, without thinking about it, by using a combination of bodily cues (feeling hungry or feeling full up after eating, wanting to get out and do something, or the feeling of needing to rest) and external cues (having a habitual portion size for your morning cereal; knowing how much to prepare for a family meal; playing football on a Friday night with your mates).

When a person is putting on weight this is because they are taking in more energy than they are using up. Obviously just keeping our bodies going uses up energy, and the amount of energy we need for this basal body function can vary according to a number of factors like body composition, age and stage of life, and other factors, possibly including the influence of drugs like antipsychotic medication. But even if there are differences in "metabolism" between people (and most experts think that these differences are likely to be much smaller than many people think), there is still scope to do something about the energy in/energy out equation. It is the voluntary activity part of activity that we can do something about – ie how much we move around. Or we can limit the amount of energy we take in by eating less, or eating less energy-dense food.

On the issue of genetic determination of weight, there is a lot of evidence that a tendency to be overweight or even obese, and a tendency to be thin, runs in families. But this doesn't mean that there is nothing we can do about weight gain, because part of what is inherited is the tendency towards certain types of behaviour. The tendency to find the sensation of hunger particularly acute and tendency not to know when you are feeling full (or not to stop eating when you are feeling full) may be inherited. Similarly, there is some evidence that the tendency to be active is genetically determined – not only on the level of playing sport or not, but also for more mundane everyday activity, like fidgeting, getting up and walking about, wanting to move around etc. So, it may be harder for some people to control their weight than others, and some people might need to be more mindful of the "energy in/energy out" equation than others, but the same basic principles apply to everyone.

Another important aspect of beliefs about weight gain is a set of beliefs about the **consequences** of weight gain. It might be important to explore a number of different sorts of consequences – e.g. health consequences, social consequences, consequences for role, work or leisure activities.

Examples of the sorts of beliefs which people might hold could include:

- I see a lot of people who are fatter than I am, so it must be all right;
- I don't know anyone who has died of being overweight, so I don't believe that stuff about obesity causing cancer;
- My risk of developing diabetes or heart disease is lower than most people's because (there is none in my family/ I used to play football/ I eat a lot of vegetables)
- Being overweight doesn't stop me doing anything around the house
- It doesn't matter if I am fat because I walk the kids to school and back every day
- I don't feel any different at 13 stone than I did at 10.

Once again, we can't pretend to know everything about the consequences of being overweight. Health promotion advice might include statements like "a third of cancers are caused by obesity" and "most heart disease could be avoided if people had a better diet" but these general statements actually summarise a whole mass of research and evidence, some of it contradictory, some of it flawed. On the other hand, we can be very confident that the general advice to keep weight within the BMI of 20-24 range is good advice, and that achieving this would certainly help a lot of people to lead healthier, longer and more fulfilling lives.

In the general population, being overweight is correlated with being unfit. It is difficult for overweight people to get fit for a whole range of reasons, but any increase in fitness will benefit an overweight person. Preferably, this increase in fitness will be accompanied by a loss of weight, but an increase in fitness without weight loss is definitely better than nothing.

Beliefs in this category will need to be discussed very sensitively. In our society there is a stigma attached to being overweight, with many members of the public erroneously believing that people who are overweight are morally defective, lazy or stupid. In fact, being overweight is a condition that invokes a huge amount of judgement and prejudice. Most of us can't help but be touched by these prejudices, and there is evidence that being overweight can have a tangible effect on people's lives – e.g. overweight people do less well when being interviewed for jobs.

A third important category of beliefs **is beliefs about controllability** of weight gain. Clearly, these beliefs are closely related to beliefs about the causes of weight gain – for example, if a person believes that she has put on weight because she has eaten too much carbohydrate rich food, she is likely to attempt to control future weight gain by trying to cut down on carbohydrates. Or in another example, if a person believes that her metabolism is responsible for her being overweight, she might not believe that there is anything she can do about it.

So beliefs about the causes of weight gain and its potential controllability are generally related in a coherent model of the problem (weight gain). It probably therefore makes sense to refer back to people's causal beliefs when discussing the controllability of weight gain.

But other, more individual, factors are important too. A person may believe that the best way for him to control his weight would be to do more strenuous exercise, but may not believe that he it is within his power to do that exercise. He may lack confidence in his ability to carry out exercise behaviour (have low self-efficacy) or he may perceive numerous barriers to carrying out exercise (no suitable trainers, no-one to do it with, can't afford gym fees etc.).

A person's beliefs about the controllability of weight gain (or weight in general) are therefore determined not only what she believes about how bodies regulate their weight, but also what she believes about how well she can regulate her behaviour. The beliefs about weight gain/control provide the motivation and the intention to behave differently, but beliefs about self-control will determine (in part) whether the intended behaviour is carried out or not. Beliefs about self-control might be described in terms of habits, will-power, resisting temptation, etc. It is because it is not always easy to translate good intentions into good behaviour that we encourage people to develop specific action plans. Hopefully you can now see how these action plans need to incorporate behaviours that match up with the person's beliefs, but the action plans also need to specify what the person will do when he or she encounters barriers, problems, temptations etc.

Finally, we need to look at a category of responses to weight gain called "**emotional representations**" in the literature. This is a rather complex construct, encompassing not only people's emotional reactions to being overweight but their beliefs about those emotions. However, for our purposes,

what we need to do is to gauge how the service user feels about his weight. For example, does he feel angry that he's gained weight, does he feel sad at the loss of the body he used to have, is he worried about the possible future consequences, or is he afraid of losing the approval of his family?

According to the self-regulatory model, when people are faced with a health threat (like the threat of weight gain) they do two things – they try to deal with the threat in more or less adaptive ways (as we have been discussing above), and they try to deal with the emotions engendered by the threat. So a person who has put on weight and feels really worried about it might do things to try to reduce the worry. They might talk to friends to seek reassurance, they might distract themselves by playing the Play Station, they might try to tell themselves that they don't care. These are all strategies that people use to make themselves feel better, but they don't necessarily tackle the problem itself. Problem-focused strategies (such as all the different strategies that people could use to try to lose weight) may have the additional effect of making people feel better about the problem, partly because they feel that they are addressing the problem, and partly because the problem-solving approach may actually have emotion-regulation benefits (e.g. doing more exercise can improve mood).

On the next few pages are three case studies which you can use as stimulus material for role plays or personal exercises on the use of beliefs about weight gain. The case studies give you a place to start, but to use them, you will need to think about the possible beliefs that each of these three individuals may have.

When using the case studies, you might like to keep in mind the following points:

People's beliefs about weight control and models of weight-related illnesses are derived from a number of sources of information.

- Has the person any direct evidence about weight control of their own to draw on? What has happened when they have tried to lose/increase weight before, and how has this impacted on their beliefs?

- Are members of the family overweight/underweight? What are their eating/exercise habits?

- What have healthcare professionals told the person about the effects of medication, about diet and exercise?

- Is there any history of possibly weight related illness in the family or among friends (diabetes, heart disease)

- How does the person feel about his/her weight?

- What barriers are there likely to be to changes in eating or activity?

In addition explore barriers and facilitators of healthy living (eg family, their own mental health in terms of mood, lack of sleep, working, isolation, lack of knowledge. Elicit cultural beliefs (a session on cultural sensitivity including a presentation and information will be given during the 3 training days) and the role of their family/friends in maintaining life style. Three case studies which will be used in the training can be found at the end of this manual.

Summary

Using the patient centred assessment summarise the information and seek feedback that the summary is correct. For example *"John you have told me that you first became ill about 2 years ago, but have felt well for the past 12 months. You live with your family who are very supportive and work part-time in JJB sports. Prior to your illness you were played rugby regularly. You don't play anymore and the reason you gave was that you felt your friends whom you played rugby with thought you were a 'crackpot' after you developed your illness. Although you wanted to continue to play you felt that your friends were talking about you and you stopped going and have not played since. You have told me that you put on a lot of weight, about 3 stones after starting medication and you think the weight gain is to do with both the medication and the lack of exercise. You would like to do something to help you lose weight but don't want to play rugby again – you would like to swim but feel too self conscious about your weight to go. You eat a reasonable diet mainly because your Mum cooks for you but you recognise that you drink too much coke (about 3 cans a day). You have also told me that you were interested in being part of this study because you want to try to lose weight and lead a more healthy life……. Is this correct and I have I missed anything out.*

Identify individualised goals

Work in partnership with the client to establish specific goals which they want to work on. Use the information that you have gathered to do this – for example *"to summarise you have said that you want to lose some weight and would like to do more exercise but you have found it difficult to be consistent with this. You have said that you find it difficult to be with lots of people and want to do something on your own and that you have a friend who will help you- have I understood this correctly". I am wondering if we can turn this into a few specific goals that we can work towards, are you happy to do this.*

Explain what goals are and why we write them down. Emphasise the following about goals

1) only take 2- 3 goals at the most
2) They must be focussed on a change
3) They must be patient centred (ie developed by the client)
4) They must be specific
5) They must be stated positively
6) They must be realistic and feasible
7) They must be measurable
8) They must be behaviours that can be incorporated into a persons lifestyle

An example would be:

To go swimming twice a week with a friend

To eat a healthier diet by ensuring that I eat at least 5 portions of fruit and vegetables daily

To be able to reach a target weight of 10 stone in 3 months

To be able to plan a weekly menu to ensure I eat healthily

To walk to and from work 4 times a week

Use the scale below to write down the goals and rate them

My healthy living Goals

Today's date……

Goal number 1

……

……

……

I can do this now (circle a number):

0	1	2	3	4	5	6
Not at all		Occasionally		Often		Anytime

Goal number 2

……

……

……

I can do this now (circle a number):

0	1	2	3	4	5	6
Not at all		Occasionally		Often		Anytime

Goal number 3

……

……

……

I can do this now (circle a number):

0	1	2	3	4	5	6
Not at all		Occasionally		Often		Anytime

Below is an example of a sheet which you may want to print out for the client to read prior to setting goals.

What are your goals? We have provided some sheets for you to write them down. Your worker will help you with this if you want. Working with too many goals can be confusing. We would advise you to work with between one and three goals. Here is some advice for setting your goals:

- *Ask yourself what you want to be able to do*
- *Be as specific as you can by stating how often you want to do something*
- *Set realistic goals, things you want to do in the future or used to do in the past*
- *State goals positively, start with 'to be able …' rather than 'to stop ……' e.g. 'to be able to to eat 5 portions of fruit and vey daily stay awake in the day' rather than 'to stop eating junk food every day'*

Goals are things to aim for. Pick things that will help you to achieve a healthier lifestyle. So that you know how you are doing, we have written down a simple scale underneath each goal. Circle one of the numbers for each one. This will tell you how difficult you find each goal.

At the moment, you should choose goals that you want to aim for. As you do work with this programme the goals will become easier to achieve. Re-rating them every now and then using the same scale is an excellent way to monitor your own personal progress. Aim to do this at least monthly with your worker.

Introducing the book

The healthy living book should be introduced to all participants. Introduce it as a book with lots of information on healthy living which they may find useful, eg local gyms and fitness/exercise classes, governmental guidelines for diet and exercise, information on how to eat more healthily, shopping and cooking healthily on a budget and a range of healthy recipes. Explain that the book is available in Urdu as well for participants and their families. For example *"The book is something we have written to help you to make improvements to your life style including government recommendations for healthy living, exercises, healthy eating recipes, and written exercises that you can do to help you put your plans into action). You can take it away with you today and have a look through and we will work through some sections of the book over the next few sessions".*

Ensure that you check literacy levels in a non stigmatising way, for example *"is there anything that would prevent you from looking at the book, ie visual, hearing, literacy or concentration difficulties. If there are difficulties then I would be happy to go through the book with you or I could audio tape sections if you would like me to.*

Ensure that you ask if you think a friend or family may find a copy of the book useful.

Ending

Recap the session, decide next steps which might include asking a family member/friend to attend the next session, to have a read of sections of the book and see what they think, or it might be working on their goals if you have been unable to complete them in the session. Ask for feedback from the session and ask if they have any final questions. Arrange next appointment.

Session 2

Session 2 overview:

Review

Review goals

Develop a feasible and acceptable action plan (identifying barriers and facilitators to implementation)

Collaboratively plan intervention and next steps of the intervention

Ending: Feedback on session – final questions – next appointment

Review

Welcome patient, orientate to purpose and duration of session (30-40 minutes). Review, summarise (and re state the goals that were established) and seek feedback from session 1 – ie what they liked about the session what they would have liked differently. Ask if they have read any parts of the book and what they thought of it. Ask if there is anything that they want you to go through again. Ask participant if there are any issues regarding healthy living which they want to address in the session. Clearly state that the purpose of this session is to look at ways of translating goals into reality by devising an action plan to help look at the steps that are needed to move from a goal statement to enacting this.

Identify action plan for implementation

This is a key element of the intervention and must be emphasised. This is the transition phase from putting participant's clear goals into practice. Firstly it is

important to establish with the participant how these goals will be implemented ie –an introduction to this could be something like the following

"Thank you for all the information that you have given me so far and I think you have done an excellent job in terms of identifying clear goals with which you want to work with. What I want to do is to support and help you in achieving these goals, and what would be useful at this point is to look carefully how we can achieve and implement these goals. It is also useful to think even at this early stage how we can incorporate these changes to become part of your regular routine. Can we first look at the steps that both you and I need to do to implement your goals?"

Using the participants goal (eg "*you have stated that you want to go swimming at least 3 time a week, lets look at how this can happen"* Then ask a series of related questions such as who do you want to go with (alone, friend/family), if wants to go accompanied how is this going to happen (ie has the friend or relative been asked, do they want you as the STR worker to accompany them the first couple of times) is there a swimming baths which is accessible, how much is it and is it affordable, is there any mileage in looking at discounts, 3 times may be a lot to start off with so breaking this down may be important in starting of with once a week and building up, identify with the participant which days they want to go, when and with whom and for how long). It is also important to ask if there are any other barriers or facilitators (ie things that will help and things that would stop them) to implementing their action plan- key issues may be motivation or if and when their mental health problems are worse- this might be simple actions for example you saying that you will give the participant a ring on the days that they going swimming for the first couple of weeks or writing out a timetable with them, or talking to a family member or friend. If there are major barriers, then plans should be made for overcoming them e.g. If I have difficulty getting out of bed in time to go swimming before work, I will…etc

With the participant write out the actions that need to be completed between the first few sessions similar to the example below. It should be emphasised that writing things down as in the action plan are important as we know (as with all of us) that if we write something down it is more likely to be achieved than if we hadn't. The action plan should be seen as a working document and participants should be encouraged to bring it with them to every session and you should keep a photocopy for your own records and to remind you of any actions you need to do.

My Action Plan	Actions and by whom
To go swimming 3 times per week	Identify the cost and distance of the local swimming pool (STR worker will do on Monday as well as seeing if there are any discounts that I am entitled to and tell me at my next session) **(STR worker)** Ask my friend (Tom) if he will come with me on a regular basis) I will ring him tonight **(Me)** I don't have any swimming trunks that fit me (I am fairly sure that my mum will buy me them but I need to check) **(Me)** My best time to go swimming is around lunchtime (before I go to work) STR worker to find out specific opening times of the pool to make sure it fits in with work **(STR worker)**

Offer the option of the schedule groups

Ensure you offer the participant to attend the scheduled groups. The groups are completely optional and they are simply a method to help participants implement healthy living changes. The groups may or may not fit into the individual's action plans but all participants must be given the option. If the groups are to be part of the participant's healthy living intervention then they should be included in the action plans.

Ending

Recap the session, and reiterate next steps of the action plan i.e. who is doing what actions. Ask for feedback from the session and ask if they have any final questions. Arrange next appointment.

Session (3 - 5) Implementation of the action plan

Session 3 – 5 overview:

Review

Review progress on action plan and implementation steps

Collaboratively plan next steps for implementation and implement action plan

Monitoring progress

Ending: Feedback on session – final questions – next appointment

Review

Welcome participant, orientate to purpose and duration of session (30-40 minutes). Review, summarise (and re state the goals that were established) and seek feedback from session 2– ie what they liked about the session what they would have liked differently. Ask if they have read any parts of the book and what they thought of it. Ask if there is anything that they want you to go through again. Ask participant if there are any issues regarding healthy living which they want to address in the session.

Review Progress on action plan and next implementation steps

Review what actions have been completed and which ones have not – use problem solving strategies to resolve barriers to implementation. The main purpose of these sessions is to actually implement the action plan into routine life. There is a large amount of flexibility within these sessions to meet

individuals' needs. To implement the plan may require a number of options and it is for you and the participant to collaboratively decide how to do this and make best use of the time that you have. For example it may be necessary or helpful to attend a swimming, exercise session with the participant, or to accompany them to one of the scheduled groups you are running. Alternatively it might involve a session with a family member in a session of changing or modifying the family diet - or it might be doing a live shopping and cooking session on an individual basis.

Ending

Recap the session, next steps of the intervention, ask them to read or listen to the intervention selected and reiterate what they have agreed to do before the next session. Ask for feedback from the session and ask if they have any final question. Arrange next appointment.

Session 6 & 7

Session 6- 7 overview:

Review

Review progress (measure progress towards goals)

Review action plan

Ending: Feedback on session – final questions –closure of the session – next steps

Review

Welcome participant, orientate to purpose and duration of session (30-40 minutes). Complete a general review on wellbeing over the past few months. Ask participant if there are any issues regarding healthy living which they want to address in the session.

Review Progress on Intervention

Review and rate progress on achievement of goals and if life style changes have been incorporated into the participant's routine life. With the use of the action plan and participant information collaboratively identify what further steps need to be taken to achieve original goals. Collaboratively problem solve 'stuck points' and barriers. Actively seek participant feedback on other benefits or limitations resulting from the healthy living programme. Re-rate original goals.

Review action plan

Review action plan – have a focussed discussion on any changes or amendments to the action plan which the participant wants to make. For example their changes in the participants life, work or leisure may mean that part of the plan is difficult.

Ending

Recap the session, next steps of the intervention, ask them to read or listen to the intervention selected and reiterate what they have agreed to do before the next session. Ask for feedback from the session and ask if they have any final questions. Arrange next appointment.

Session 8 (months 10-12)

Session 10

Review

Review goals

Review progress and plan next steps

Plan next steps

Ending: Feedback on intervention

Review

Welcome participant, orientate to purpose and duration of session (30-40 minutes). Review, summarise (and re state the goals that were established) and seek feedback from session 2– ie what they liked about the session what they would have liked differently. Ask if they have read any parts of the book and what they thought of it. Ask if there is anything that they want you to go through again. Ask participant if there are any issues regarding healthy living which they want to address in the session.

Review and rate goals

Re rate original goals and review progress.

Review progress

Have a focussed discussion on further plans, for example if the participant has incorporated change into life style- explore how this can be maintained, and identify barriers and facilitators to maintenance and strategies that the participant can put into place to help maintenance. If not incorporated into life, or there have been changes which have prevented changes into their life style collaboratively problem solve.

Feedback

Discus with the participant their views of the healthy living intervention- explore timing, duration of sessions, what was helpful, what was not helpful, what changes could be made to the intervention, explore views on the book, optional groups if they used them.

Ending

Recap the session, next steps of the intervention, ask them to read or listen to the intervention selected and reiterate what they have agreed to do before the next session. Ask for feedback from the session and ask if they have any final questions. Arrange next appointment.

Section 3 – Audio taping and supervision

Audio taping

You will be asked to audio tape all your sessions with participants – you will be supplied with audio equipment. Participants will be asked to consent to this by the researchers and if any patients refuse then the researchers will inform you. For participants that have consented please confirm their agreement at each session. Sometimes participants are reluctant to tell you information with the tape on – please ensure that you tell participants that it is confidential and that the purpose of the tapes is to listen to what the STR worker is doing rather than what the patient is saying. Ensure that the patient knows that if there is anything that they want to discuss with the tape off then they can do this. If there are sessions where you are accompanying a participant to an activity it is not necessary to tape the session.

Supervision

All workers delivering the intervention will receive supervision on a fortnightly basis – trial supervision does not preclude any other supervision sessions that you may have. Supervision will be on a fortnightly basis with Tim Bradshaw with input from Karina Lovell and Alison Wearden. Supervision will be conducted over the telephone or face to face dependent on your preference and availability.

Section 4 - Monitoring

You will be keeping your own notes for the clients you are seeing. We will ask you to keep a monitoring sheet for each patient (see patient contact sheet at the end of this manual) and the groups you run. This information is very important to us as it will tell us how many sessions patients attended, and what specific interventions they used. The participant contact sheet requires you to complete the participant study number (not the patient's name), session number, session length and brief details of the content of the session. In the group participation sheet it would help us if you completed these on any group you ran, and include details of date, the number of participants you invited the number attended and brief details of the type of group (e.g. walking, demonstration etc).

Section 5 – Trial procedures

Audio taping of sessions

Patients sign a separate consent to the taping of sessions ie patients can opt for inclusion into the trial but can refuse consent for taping of sessions. If a patient refuses consent to taping therapists will be informed when allocated patients. For patients who have given signed consent - therapists should ask at every session that consent for taping remains. All audio tapes should be labelled with pt initials, pt ID number, date and session number. All audio tapes should be stored in a lockable cabinet and will be hand delivered to the trial team.

Patient notes

Patient notes should be kept in individual files labelled with patient name, patient ID and kept in a lockable cabinet. Therapists will keep a log of each patient session (in therapist manual) with date, time and details. Patient logs will be hand delivered to the trial team.

Supervision

Supervision will occur every 2 weeks on an individual basis with Tim. A supervision log will be kept by supervisors.

Section 5 - HELPER first interview guide for STR workers (Crib sheet)

Instructions about how to use the interview

This guide has been provided to assist STR workers to conduct the first health education session with participants in the HELPER InterACT study. The interview should be conducted in a relaxed and conversational manner in order to develop a good rapport with the patient. The questions can be followed flexibly and it is not essential to ask all questions if you think an answer has already been provided. In some instances it may seem appropriate to conduct the interview over the first two healthy living sessions. Whilst conducting the interview STR workers should remember the importance of listening attentively to what the person is saying and making brief summaries to ensure they have an accurate understanding of what the person has told them.

Introduction and orientattion, for example:

"my name is …….. and I am a Support Time Recovery Worker employed to help deliver the healthy living intervention being evaluated by the HELPER InterACT study. Thank you for agreeing to participate in the study and for seeing me today. The aim of today's session is for us to get to know one another and for me to find out more about your current health and lifestyle. How does that sound to you? Is there anything specifically that you wanted to get from today's session?

Lifestyle

"I'd like to start by asking you some questions about your lifestyle and how it has changed since you first started to receive treatment for your mental health problems?"

- *So tell me if you think there have been any changes to your lifestyle since you first developed mental health problems?*

- *What sort of things do you think are important to maintaining a healthy lifestyle?*

- *What do you do at the moment to stay fit and healthy?*

- *Tell me about the types of things you eat in a typical day? (probe – how many portions of fruit and vegetables, how much fried food, sugary drinks, type of bread preferred etc.)*

- *Tell me about what types of physical activities you participate in? (for each activity probe – frequency, duration, intensity of activity etc.)*

- *Would you like to make any changes to your current lifestyle in order to make it healthier?*

Eliciting beliefs about weight gain

"Now I would like to ask you some questions about your current weight and how you feel about it? How does that sound?"

- *How would you describe your weight at the moment? (probe – do they consider themselves to be of normal weight, overweight or obese)*

- *Has your weight changed since you started treatment for your mental health problems? Probe – amount they think they gained or lost and timescale)*

- *What do you think are the reasons for your weight gain/loss? (probe – beliefs e.g. change in appetite etc. and source of information)*

- *What do you think are the consequences for you from gaining/losing weight? (probe – worries about health, appearance, functioning etc.)*

- *How much control do you feel that you have over weight? (probe – what sorts of things the person does to control their weight)*

- *Would you like to make any changes to your weight? (probe – if they want to loose weight how much?)*

Summary

"Alright can I just check that I have understood what you have told me correctly **(**summarise key points about lifestyle issues and weight including beliefs about causation, control and desire to change) ***does that sound about right so far is there anything important that I have missed?"***

Barriers and facilitators

"Now I would like to ask you about what factors you think will help you to make changes to your lifestyle and/or loose weight and also about what factors you think might make this difficult to achieve"

"Okay so you have told me that the things you would most like to achieve is/are (list what they want to change below)*:*

1. _____

2._____

3._____

"What factors do you think will help you to make this/ these changes? *(*record all ideas expressed and use prompts below when necessary)

Prompts

- access to exercise facilities
- encouragement from family member / friend
- Having a clear plan
- Sharing goals with others

"Now tell me what factors might make it difficult for you to change your lifestyle and/or loose weight or might get in the way of success*"?* (again list all suggestions made but use prompts below when appropriate)

Prompts

- low energy
- poor motivation
- lack of resources
- lack of support
- poor self confidence

Collaboratively agree goals (using goal sheets)

Ending

Section 6 – Case studies

Case study 1

Yasser aged 22

Yasser lives at home with his parents and 16 year old sister. Two brothers (one older, one younger than Yasser) live away from home. Since leaving school, Yasser has worked in the restaurant trade, mainly as a waiter in local restaurants, although he has also done kitchen work. He first started to be ill about two years ago, and has not now worked for twenty months, although he is hoping to return to part-time work soon. Yasser had been engaged to get married, but when he became ill, the engagement was called off and he rarely sees his ex-girl friend.

Although he is rather shy, Yasser has always been quite active, playing cricket and football at school and he has played with various parks football teams over recent years. He stopped playing when he became ill, and would like to start up again, but has lost touch with a lot of the friends he used to play with. Yasser is six foot tall, a good-looking boy, and has never had any problems with his weight, but since starting to take Olanzapine, he has gained 6 kg (almost 1 stone), which upsets him. Yasser's parents both suffer from Type 2 diabetes for which they take tablets. They have also received advice on diet and exercise, and have recently got into the habit of taking a half hour brisk walk at 6.30 each morning. Yasser has thought about going out with them, but has not yet managed to get up in time.

Yasser's mother prepares the food in his house, and the diet predominantly reflects her origins in Pakistan, with lots of home-made vegetable and daal

curry dishes, chapattis and yoghurt, but Yasser and his sister also enjoy meals like egg, chips and baked beans, and shepherds pie with peas, washed down with diet coke. No-one in the family eats any pork products, and Yasser's parents eat a predominantly vegetarian diet.

Case study 2

Christopher aged 21

Chris was half way through a degree in politics when he suddenly became acutely ill and was hospitalised. On his discharge from hospital, he left his course in Nottingham to return to live with his mother in East Lancs, but the arrangement broke down when his mum became depressed and could no longer cope with Chris's changed behaviour (particularly his excessive sleeping and his smoking). After an unsettled spell of living with various friends, and with his grandma, Chris was found a place in supported accommodation, where he now lives with two other young men recovering from mental health problems. He is not currently working, but is doing an online Spanish language course, and plans to go back to university one day.

Chris was always a very skinny young man, in spite of the fact that he ate whatever he wanted and drank whatever he wanted too, including a large amount of strong bottled beer. The most exercise he ever got was playing his drums in a band which he set up with several friends from school. During his teenage years, Chris's Mum despaired of his diet which seemed to her to consist of sausages, bagels, orange juice and beer, with very little variety. Chris's Mum, a social worker, lives on her own now (his Dad remarried and moved down South many years ago). She is a bit of a fitness freak, goes running, biking and walking, and she eats a pretty healthy, mainly vegetarian diet. She too has always been thin, although she has put on a little weight recently, which annoys her. Chris sees his Mum several times a week and they are getting on much better now that they don't live together.

Chris was prescribed olanzapine while he was in hospital, and is still taking it. He has been having regular health checks, and although he has put on some

weight (about 3kg) he is happy with this, as he thinks he was too thin before, and he is still pretty thin. He doesn't think he could ever get fat because he's just not that body type. Chris's doctor has told him that he needs to do some exercise, but Chris hasn't done anything about this. Chris is aware that both of his uncles (his Dad's brothers) have had heart attacks, but as he never sees them, he never thinks about this.

Case study 3

Sarah aged 26

Sarah is 26. She lives on her own in a council flat. Her six year old daughter, Hayley, is currently living with her Mum. Sarah is on good terms with her Mum and sees her regularly. She takes Hayley to school a couple of days a week and sees her most evenings. Sarah was working in a factory before she became ill, but has been unable to get a job recently, and is currently unemployed. She spends her day watching daytime TV, doing her shopping and housework, and doing word puzzles.

Sarah was overweight as a teenager and has gained even more weight since becoming ill two years ago. Her BMI is now getting seriously high, at 31.5. Sarah's Mum and her older sister, are also quite overweight, and the teachers at Hayley's school are now starting to say that Hayley is overweight too. This really upsets Sarah. In fact Sarah feels pretty fed up about her weight. Hardly any of her clothes fit her, and she is embarrassed when she has to sit next to someone on the bus, because she seems to take up most of the space.

Sarah has been on more diets than she can count, but never seems to be able to stick to them for more than about a week. She has been advised to take up exercise, and wants to do some, but the only exercise she likes is swimming and the nearest swimming pool is a mile and a half away. She can't afford the bus fares to go regularly, and secretly is too ashamed to put on a swimming costume anyway (and she hasn't got one that fits). Sarah's friend, who is much thinner, said she would go jogging in the park with her, but Sarah thinks that they would look like Laurel and Hardy, and is just too embarrassed to go.

Sarah isn't even hungry a lot of the time, but she eats because she is bored or upset. She doesn't really have any regular mealtimes. Her favourite food is pizza, and she has been known to eat a whole packet of biscuits in one sitting. Sarah doesn't really drink alcohol, except maybe at Christmas, but she smokes 30 a day. Whenever she tries to stop smoking, she puts on even more weight. Since being on her medication, Sarah has gained 4kg, and she now has pains in her hips, which means that she walks with a bit of a limp.

HELPER first interview guide for STR workers

Instructions about how to use the interview

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- *What sort of things do you think are important to maintaining a healthy lifestyle?*

- *What do you do at the moment to stay fit and healthy?*

- *Tell me about the types of things you eat in a typical day? (probe – how many portions of fruit and vegetables, how much fried food, sugary drinks, type of bread preferred etc.)*

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- *How much control do you feel that you have over weight? (probe – what sorts of things the person does to control their weight)*

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Barriers and facilitators

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"Okay so you have told me that the things you would most like to achieve is/are (list what they want to change below)*:*

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_____

2._____

3._____

"What factors do you think will help you to make this/ these changes? *(*record all ideas expressed and use prompts below when necessary)

Prompts

- access to exercise facilities
- encouragement from family member / friend
- Having a clear plan
- Sharing goals with others

"Now tell me what factors might make it difficult for you to change your lifestyle and/or loose weight or might get in the way of success*"?* (again list all suggestions made but use prompts below when appropriate)

Prompts

- low energy
- poor motivation
- lack of resources
- lack of support
- poor self confidence

Participant Contact Sheet

Participant ID number……

Date	Session Number	Duration of session (minutes)	Brief details of the session – ie goal setting, action planning, meeting family/friends, accompanied session to group or activity

Group Contact Sheet

Patient name……

Date	Invited to the group	Attended the group	Brief details of the group – what was the aim of the group – who was the group aimed at, who ran the group, where was the group