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**Evaluation of the Health Education England working across the North West (HEE NW) Mental Health First Aid (MHFA) training programme**

# Executive summary

The Mental Health First Aid (MHFA) programme was commissioned by the north west team of Health Education England (HEE NW), previously known as Health Education North West, in response to a need to the increasing priority of mental health in healthcare. In 2015, the following organisations were selected to participate in the MHFA programme delivered by HEE NW: East Lancashire Hospitals NHS Trust; Pennine Acute Hospitals NHS Trust; Alderhey Children’s NHS Foundation Trust; Lancashire Care NHS Foundation Trust, and NHS Tameside and Glossop Clinical Commissioning Group.

A mixed method evaluation included both quantitative (surveys) and qualitative (interviews) components. The quantitative aspect of the evaluation involved (1): a survey designed to acquire feedback from staff (n = 12) who had undergone training in the delivery of the programme (2); a survey designed to assess the impact of the programme via pre and post measures. This assessed shifts in participants’ knowledge, attitude, behaviour, and general opinions of the programme before and immediately after completion (3); a survey designed to assess knowledge, attitude and confidence for longitudinal comparison. The qualitative component of the evaluation consisted of semi-structured telephone interviews conducted with participants following completion of the training.

Findings

*Staff who undertook MHFA instructor training*

12 frontline healthcare staff undertook MHFA training. Working in pairs, these staff each ran four cohorts of MHFA training with the target of 14 participants per course. The majority felt that their expectations had been met, with a good overall impression of the course. The training and resources gave staff confidence to deliver sessions. Several potential considerations for improvement were identified.

*Participants who undertook the MHFA programme*

Pre/post questionnaire: A survey was distributed to participants immediately following completion of the two day MHFA programme. This assessed what participants thought before the course and what they thought immediately after on a number of areas relating to mental health. 258 responses were received (female n = 84.1%, n = 217, mean age = 42, standard deviation = 12.1). A high proportion indicated that they felt there was a need for training in order to help staff communicate with people with mental health issues (98.4%, n = 254). Nearly all participants (98.8%, n = 255) stated that the training provided staff with the knowledge to help identify mental health issues, while 98.1% (n = 253) agreed that the MHFA training would help them in their job.

Follow up survey: 98 responses were received representing 35.3% of the original sample. The majority of participants were (female n = 90.1% n = 82, mean age = 44, standard deviation = 10.2). 84% indicated the training was either useful or very useful in the work place and 79% found the training useful or very useful in their everyday life. Participants felt the course provided confidence to communicate with people with mental health issues, and knowledge to identify people with potential mental health issues.

* Following the training (pre-post) there was a significant reported increase of **knowledge of mental health** issues from pre to post training, but a slight decrease at follow-up.
* Following the training (pre-post) there was a significant reported increase in participants’ **attitudes towards mental health** which was maintained at follow-up.
* Following the training (pre-post) there was a significant reported increase in participants’ **confidence to identify** mental health issues, but a slight decrease at follow-up.
* Following the training (pre-post) there was a significant increase in participants’ **confidence to advise** (e.g. signposting to local resources) those who have or may have a mental health issue which was maintained at follow-up.
* Following the training (pre-post) there was a significant reported increase in **participants’ confidence to advise carers** (e.g. signposting to local resources) of those with a mental health issue, but a slight decrease at follow-up.

The integration of survey data and interview data provided a composite account of participants’ overall experiences and perceptions. Four key themes emerged including knowledge & awareness, delivery style, and outcomes, and participant recommendations.

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| ***Knowledge & awareness**** Better informed, knowing how to help
* Helped understand what service users experience
* Look at mental health in a different way
* Normalising of mental health issues and confidence given around them
* Listen non-judgmentally
* How to communicate with suicidal service users
* Recognise signs and symptoms of mental health issues, signposting
 | ***Delivery style**** Clear information presented well
* Knowledge of trainers, update attitudes towards mental health
* Very engaging trainers, knowledgeable
* Sharing experience and knowledge with others
* Relaxed environment, discussion
* Practical aspects, revisiting conditions, space to think
* Case studies helped me think how I would act
* Good combination of presenters, videos, group work
 |
| ***Outcomes**** Helped increase confidence, comfortable asking questions about suicide
* Confident to speak to young people and families
* Confidence to use tools and strategies
* Confidence to challenge misconceptions
* Mindful of own wellbeing
* Relevant to work and personal life
* Confidence to communicate with friends and family
* Enhanced practice
* Empowered to support colleagues
 | ***Participant recommendations**** More specific examples of managing conditions in workplace
* More freedom for instructors to promote local MH services
* Chance to talk to mental health specialists about their experiences, more information about referral routes
 |

Recommendations

* To explore opportunities for commissioning the MHFA programme for those working in the health field and in particular those who are front line healthcare staff.
* Health professionals and those in other industries for example, education, should have access to mental health education training programmes, such as MHFA, which are incorporated into basic or mandatory training and supported with ongoing updates.
* For those attending the training who may be new to mental health or very inexperienced, a pre-programme information package might serve to convey a basic understanding of mental health in preparation for the main MHFA programme. This would potentially provide a richer learning experience as the potential for ‘overload’ would be reduced for these participants.
* An update to the facts and figures used within the MHFA presentation and handout materials in order to help maintain current levels of knowledge and provide engaging and relevant information.
* Provide more time for discussion during the training for a deeper exploration of mental health issues i.e. through case studies / role play, and additional videos, specific examples of managing conditions in the workplace, and an opportunity to talk with mental health specialists about their experiences and information on referral routes.
* Provide instructors delivering the MHFA training more freedom to promote local mental health services so participants are better informed of resources close by.

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# Evaluation Team

This evaluation was conducted by the following staff at the University of Gloucestershire:

* Dr Colin Baker (operational lead, project development, survey design, qualitative and quantitative data collection and analysis, report writing);
* Dr Elizabeth Loughren (data analysis, report writing);
* Professor Diane Crone (project development, report writing).

# Acknowledgments

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# 1.0 Background

## 1.1 Introduction

This evaluation report establishes evidence concerning the pilot of the Mental Health First Aid (MHFA) programme commissioned by the north west team of Health Education England (HEE NW), previously known as Health Education North West. MHFA is an educational course designed to teach people how to identify and understand individuals who may be experiencing mental health issues. The programme adopts a first aid approach by helping people to recognise the early signs and symptoms of mental health issues and assists with determining appropriate courses of action. This is consistent with the government’s desire to (Department of Health, 2013) ensure that all health professionals have an understanding of mental health conditions and the actions they can take to ensure that service users receive appropriate support.

The MHFA programme was commissioned by the North West team of Health Education England in response to a need to the increasing priority of mental health. In 2015 the East Lancashire Hospitals NHS Trust, Pennine Acute Hospitals NHS Trust, Alderhey Childrens NHS Foundation Trust, Lancashire Care NHS Foundation Trust, and NHS Tameside and Glossop Clinical Commissioning Group were selected to participate in the MHFA programme delivered by HEE NW. The aim was to train 12 front-line healthcare professionals to deliver, the MHFA programme. Working in pairs, these staff each ran 4 cohorts of the 2 day MHFA training programme, targeting 14 participants per programme (i.e. 6 x 4 x 14 = approximately 336 participants). This is part of a process to roll the training out to other members of staff across the organisation in order to increase responsiveness and effectiveness to service users and carers dealing with mental health issues.

Via a systematic evaluation approach, quantitative data were collected via a series of surveys in order to understand the immediate and long term impact of the training on staff attitudes, confidence and skills. Qualitative data were collected via one-to-one telephone interviews to explore participant perceptions regarding impact, areas for improvement and overall opinion of the programme.

## 1.2 Evidence for MHFA training need

### 1.2.1 Mental health and the burden of disease

The prevalence of mental ill health is clear, accounting for 23% of the total burden of disease with an estimated 400,000 adults of working age taking time off work with stress each year (ONS 2011; Royal College of Psychiatrists 2010). Common issues include depression, anxiety and substance abuse which represent an important risk factor for suicide (Hadlazky et al., 2014). In the UK, evidence suggests that people experiencing mental health issues tend to avoid seeking help from health experts for example, GPs and psychologists (Oliver et al., 2005). Providing information about mental illness and its treatment might increase the chances that people will seek help (Esters, Cooker & Ittenbach, 1998; Han et al., 2006; Jorm & Kelly, 2007), the ability to recognise symptoms and awareness of treatment options (Jorm et al., 2006).

### 1.2.2 Health professionals and mental health training

Health Education England (HEE) in its mandate for 2015/16 stresses that all health professionals need to have an understanding of mental health conditions. It is recognised that high quality education and training is required to achieve parity of esteem between mental and physical health and to ensure that service users presenting with a variety of issues are able to receive superior patient care (Department of Health, 2013). This is consistent with Public Health England’s priorities (Public Health England, 2013, p.6) which, among others, are concerned with ‘*Helping people to live longer and more healthy lives by reducing preventable deaths and the burden of ill health associated with smoking, high blood pressure, obesity, poor diet, poor mental health, insufficient exercise, and alcohol’.* While the World Health Organisation (WHO, 2007) identifies a need to improve the knowledge, skills and confidence to deal with mental health issues it is apparent that cost and time constraints, lack of interest and organisational support present barriers to successful mental health training (Brunero, Jeon, & Foster, 2012). Training to support healthcare professionals to deal with mental health issues can increase knowledge, empathy and person-centred care although impacts vary between individuals (Crowe & Averett, 2015).

### 1.2.3 Mental Health First Aid

Mental Health First Aid (MHFA) is an educational programme that was developed to address mental health issues and suicide by increasing mental health literacy, improving attitudes and initiating purposeful responses (Kitchener & Jorm, 2002). The five core elements of the training include: (1) assess the risk of suicide or harm; (2) listen in a non-judgement way; (3) give support and information; (4) encourage people to seek appropriate professional help, and (5) promote self-help strategies (Kitchener, Jorm, & Kelly, 2010). A further aim of the programme is to reduce the stigma surrounding mental health issues (Hadlazky et al., 2014). The training has been applied within the domain of healthcare professionals as a means of increasing basic mental health knowledge. Here it is recognised that health professionals need to be equipped with the skills to enable them to understand the mental health needs of people seeking help (Happell, Wilson, & McNamara, 2014). These aspects are also important in the workplace whereby a need to assess attitudes about mental illness is important for ensuring that compassion, fatigue and burnout are not affecting health professionals (Crowe & Everett, 2014).

Evidence suggests that participating in a MHFA programme can successfully lead to a reduction in negative attitudes toward individuals suffering from mental health issues although less is known about how MHFA actually improves the mental health in the general population (Hadlazky et al., 2014). The use of MHFA in the UK has shown positive results increasing knowledge and confidence across a range of populations including the public sector and black and other minority ethnic organisations (Brandling & McKenna, 2010; Khaliq, 2011). This might suggest that the programme has potential benefit in respect of supporting the mandated approach for ensuring parity between physical and mental health and increased understanding of mental health conditions together with appropriate actions health professionals can take (Department of Health, 2013; Public Health England, 2013). However, to date, the impact of MHFA on health professionals within the UK is not well understood and further research and evaluation is warranted in order to assess the efficacy of the MHFA training course in helping NHS front line staff to achieve greater resilience in communicating with people with mental health issues, and their carers.

# The evaluation

## 2.1 Evaluation design

The evaluation adopted a mixed methods approach incorporating a series of surveys and interviews to investigate the MHFA training for staff and trainers. The quantitative component (surveys) involved the development of two surveys.

The first survey was designed to acquire feedback from frontline healthcare staff (n = 12) who had undergone training in the delivery of the programme. This provided a means of understanding how well the training was received and possible areas which might be improved for future trainer training.

The second survey was designed to assess the impact of the programme via pre and post measures on the cohorts receiving the MHFA training programme. This assessed shifts in participant knowledge, attitude, behaviour, and general opinions of the training (1) before the training; (2) immediately after completion of the training.

The third survey assessed the same items as the second survey with respect to knowledge, attitude and confidence to provide a longitudinal comparison i.e. ‘follow up’. This was conducted at between 6 and 12 weeks following the completion of the training. The purpose of this was to investigate whether the effects of the training had been sustained after participants had returned to practice in the long term.

The qualitative component of the evaluation consisted of semi-structured telephone interviews conducted with participants following completion of the training (8 to 14 weeks after completion). The purpose of the interviews was to investigate attitudes, perceptions and opinions concerning the impact of the training longer term, after staff had returned to practice.

## 2.2 Participants

The participants in the evaluation were:

1. Healthcare professionals who had been trained in the delivery of the MHFA programme. Those who had been trained to deliver the programme to healthcare staff were sent a brief online questionnaire (Bristol Online Surveys) asking them to feedback on the training and its impact.
2. Healthcare professionals and other public sector staff who had enrolled on the MHFA programme rolled out by HEE NW. Those participating in the MHFA programme evaluation were asked to complete a paper-based questionnaire immediately after completion of the programme (Day 2).

The initial questionnaire was distributed by the programme trainers directly to each participant immediately following completion of the second day of the programme. The questionnaire assessed satisfaction, attitudes, confidence, and perceptions of its usefulness via a number of quantitative-type questions For example, responses to knowledge, attitudes, and confidence items were assessed on a 5-point Likert-type scale (1 = very low/not at all useful; 5 = very high/very useful). The questionnaire was designed to assess perceptions concerning the same measures before (pre) and after the programme (post).

1. Long term follow up. The same participants were contacted between 4 and 12 weeks following completion of the programme (follow up). Participants were sent a URL to access an online survey (Bristol Online Surveys) via direct emails using the addresses they had disclosed in the paper-based version of the questionnaire completed immediately after the programme.

## 2.3 Aim

The evaluation aim was:

To investigate the efficacy of the MHFA training course in helping NHS front line staff to achieve greater resilience in communicating with people with mental health issues, and their carers.

## 2.4 Evaluation objectives

To address the evaluation aim the following objectives were established:

1. To investigate trainers’ and participants’ experiences and perspectives, using a bespoke survey, on perceptions of learning from the MHFA training course for NHS front line staff.

2. To investigate the impact of the MHFA course for participants, through an online e-survey (approximately) 3 months post attendance, specifically investigating:

• changes in practice;

• reflection of the learning from the course and their day to day work;

• psychological resilience (both of themselves and for the people that they work with including colleagues and service users);

• how behaviour in the workplace has changed as a result of MHFA training.

3. To develop case studies, using telephone interviews, to further illustrate the impact of the MHFA training for front line staff.

# Data collection methods and procedures

## 3.1. Surveys (quantitative)

Three surveys were administered (Table 1). These were designed to establish feedback concerning the training provided to trainers (survey 1), and to provide comprehensive data concerning the efficacy of the programme for those undertaking the training (surveys 1 and 2).

**Table 1: Overview of quantitative surveys**

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| **Survey** | **Number of questions** | **Target audience** | **Key items** |
| 1. **Trainer feedback**
 | 8 | Newly trained trainers | Previous experiences, confidence to deliver MHFA, areas for improvement (open-ended) |
| 1. **Pre/post**
 | 18 | MHFA programme participants | Knowledge, attitudes, confidence, general opinions |
| 1. **Follow up**
 | 21 | MHFA programme participants | Knowledge, attitudes, confidence, changes, usefulness at work/everyday, general opinions |

### Procedure

Survey 1: The trainer feedback survey was designed in collaboration between the evaluation team and the north west team of Health Education England in order to establish a simple survey investigating prior experiences of mental health at work, how well the training was received, and areas for improvement (see Appendix 1). An e-survey was set up using the Bristol Online Surveys (BOS) platform. This provided a unique URL which was sent directly to all trainer course participants via email. Given the nature of the data, a simple descriptive approach was used to summarise trainer feedback.

Survey 2: The pre/post survey was developed by the evaluation team, building on a survey deployed in an evaluation of another MHFA programme (national level). In consultation with the north west team of Health Education England, items were amended and/or added in order to meet the needs of the evaluation (see Appendix 2). Information concerning the data collection process was provided to all trainers conducting the programme. This outlined the evaluation protocol and the role of the trainers in helping facilitate data collection. Included were instructions regarding the return of the paper-based surveys, via freepost, to the evaluation team.

The questionnaire included quantitative measures of course satisfaction, knowledge, confidence and attitudes. It also included demographic information (e.g., age, gender) and space for contact information at follow-up. The first set of paper questionnaires was completed in August 2015, the final questionnaires being completed in November 2015 following the final iteration of the programme. Questionnaires were sent to the evaluation team for collation and entry into a single evaluation database ready for analysis.

All participants were asked to complete the survey immediately after completing the two-day training programme and return to the trainer before leaving the venue. The survey required participants to provide their name, date of birth and email in order that unique identifiers could be set up to link data in the subsequent follow-up survey. Participants were invited to take Open ended responses concerning various aspects of the programme for example, what was learned, were explored using inductive content analysis (Waltz et al., 2010) to unpack participant feedback. This involved a process of coding ‘text units’ initially into basic themes, and into more detailed themes via systematic review.

Survey 3: For the follow up survey, an e-survey was set up using the BOS platform (see Appendix 3). This provided a unique URL which was sent directly to all course participants by the evaluation team via the email acquired in Survey 2. To encourage responses, 2 x £50 Amazon vouchers were included as an incentive for the completion of the follow-up survey, chosen at random following completion of data entry. The online questionnaire was live for from February 1st 2016 to March 11th, 2016.

The data were collated and entered into SPSS for analysis. For Surveys 2 and 3, quantitative analyses including descriptive and inferential statistics were used to analyse the data. Following all data entry, the data were matched by email address for comparative analysis, per and post survey. The evaluation team undertook pre-post-follow-up data analysis using repeated measures Multivariate Analyses of Variance (MANOVA), which is suited to quantifying the statistical significance of mean-level, within-person change across three time points.

### 3.1.2 Evaluation ethics

Ethical approval for all aspects of the present study was given by the University of Gloucestershire research ethics committee and the evaluation Commissioner (Ref: CBAKER3A2014-15). All appropriate ethical guidelines had been observed and taken into account to protect participants involved in the study. Participants’ anonymity and confidentiality were assured through adherence to University’s ICT security system protocols including password protected computer access. All written material was stored securely in a locked filing cabinet in a locked office.

## 3.2 Interviews (qualitative)

Qualitative interviews were used to explore the impact of the MHFA training for front line staff. For participants who had completed Survey 2 and 3, a purposive sample of participants (n = 15) was established based on ratings of perceived confidence, and to ensure a range of course locations were included. Due to an initial lack of uptake, the sample was expanded (n = 103) in order to increase the potential for individual interviews to take place. In total, 5 interviews were conducted with staff who had completed Surveys 2 and 3. Participants reflected a number of different backgrounds including front line healthcare, education, administration, research, and weight management services. Two participants were employed directly within a mental health setting. Participants had a variety of experience with identifying and dealing with people experiencing mental health issues either through working within a specific mental health role or more generally through their current and previous professional roles.

### 3.2.1 Procedure

Prior to an invitation being sent to participate in an interview the survey database (2 and 3) was checked to ensure that the participants had agreed to take part in a follow up interview. The evaluation team contacted each participant directly via email, inviting them to participate in the telephone interview. A participant information sheet and informed consent form were supplied (Appendices 4 and 5). Interviews were recorded and transcribed verbatim to ensure accuracy. Data were analysed using an inductive thematic approach to unpack the data. Participant data was anonymised prior to analysis in order to protect identities.

A standardized interview schedule was used which involved an identical set of questions for each participant (see Appendix 6). Participants were also asked whether there was anything else they would like to add following the completion of the interview.

The interviews, which ranged in duration from 15 and 35 minutes, were digitally recorded and transcribed verbatim. Transcripts were analyzed using deductive analysis based on themes that emerged via analysis of the survey data which took place prior to the qualitative interviews. This involved systematically coding sections of text via the predetermined themes and unpacking the data to identify sub themes where possible.

# Results

## 4.1 Survey – Trainer feedback

The trainer survey was designed to acquire feedback from staff who had undergone training in the delivery of the programme (n = 12). This provided a means of understanding how well the training was received and possible areas which might be improved for future training sessions.

An overview of the results is presented in Table 2. This draws together key points outlined in the responses.

## 4.2 Surveys – Participant knowledge, attitudes and confidence

This section presents the findings from the surveys which assessed participants’ knowledge, attitudes and confidence, in addition to other factors. An overview of the participant profile is presented from the first participant survey (pre/post) and the second survey (follow up), before attention is given to changes in knowledge, attitudes and behaviour.

### 4.2.1 Participant profile

1. *Pre/post survey*

In total, 258 responses were received to the survey. The majority of participants were female (84.1%, n = 217), with a mean[[1]](#footnote-1) age of 42 (standard deviation [SD[[2]](#footnote-2)] = 12.1). A variety of ways were indicated with respect to hearing about the course, 40.7% stating email, bulletin or newsletter/poster, 31% via a colleague or manager, and 23.6% other / not defined, including HEE NW, CCG, and Trust. As part of the survey, participants were asked to indicate their overall satisfaction with the course (Figure 1). Overall, 98% (n = 251) indicated ‘high’ or ‘very high’ satisfaction.

**Table 2: Trainer feedback**

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| **Question** | **Review of responses** |
| Describe your experiences of communicating with people with mental health issues (and their carers) prior to MHFA training: | There were large contrasts in experiences. Some participants had significant experience in professional capacities i.e. through training and / or their job roles. Others had limited experience communicating with people with mental health issues. For some, this had been as a result of the changes in professional role, or a lack of exposure during training. |
| Prior to training, how did you feel about communicating with people with mental health issues (and their carers)? | While no participants indicated low confidence, there was a range of responses whereby some felt “comfortable” and “confident and experienced”, while others felt slightly less confident; “I was ok but unsure what to say” and “apprehensive with regards to discussing suicide”.  |
| Having completed the training, how do you now feel with respect to delivering the course to other NHS members of staff? | There was a mixture of excitement and trepidation. Participants were enthusiastic although, for some, a little apprehensive of delivering the sessions. The training and resources ultimately gave staff confidence to deliver sessions and overcome any nervousness.  |
| What were your expectations of the training? | There was a clear expectation that participants would learn more about mental health issues and increase their skills. Some had a little prior knowledge of the course although were not sure entirely what it would entail.  |
| Did the training meet your expectations?  | The majority of participants felt that their expectations had been met, with a good overall impression of the course, for example; “the training was well thought, interesting, extremely informative and offers insight into mental health in a non-threatening way. I thought the training was fantastic”. While one participant did not share this perception, the majority felt it useful and informative with respect to work and home life. |
| What was good about the training, and why? | A range of examples were identified including: the use of real life experiences which helps establish empathy; key messages about mental health and mental ill health; the opportunity to explore different models of ill health; a safe and interactive environment; developing facilitation skills. |
| What could be improved? | Several potential considerations were identified including: the way the course is advertised; the use of guest speakers; more time for debate; increased sensitivity to the needs of those staff who are not experts in education, training, or mental health; more recent data; the use of challenging case studies which may upset some participants might be considered. |
| Other comments | In addition to the above, one participant felt that fitting the course in was challenging while another felt that the training was a little too simplistic with regard to mental health definitions and distinctions, and that it was informed by a medical model of health. |

**Figure 1: Overall course satisfaction (%)**

Missing n = 4

The survey also assessed participants’ attitudes concerning training needs around mental health. A high proportion indicated that they felt there was a need for training in order to help staff communicate with people with mental health issues (98.4%, n = 254). Similarly, nearly all participants (98.8%, n = 255) stated that the training provided staff with the knowledge to help identify mental health issues, while 98.1% (n = 253) agreed that the MHFA training would help them in their job.

1. *Follow up survey*

In total, 98 responses were received to the follow up survey of which we were able to match 91, representing 35.3% of the original sample. The majority of participants were female (90.1% n = 82), with a mean age of 44 (SD = 10.2). Of the 91 responses, 84% indicated the training was either useful or very useful in the work place (Figure 2) and 79% found the training useful or very useful in their everyday life (Figure 3). Participants felt the course provided confidence to communicate with people with mental health issues (100%), knowledge to identify people with potential mental health issues (99%), and 45% of participants applied the ALGEE algorithm (Assess, Listen, Give reassurance and information, Encourage appropriate professional help, Encourage self-help and other support) provided within the programme.

**Figure 2: Perceived usefulness of training at work (%)**

**Figure 3: Perceived usefulness of training to everyday life (%)**

* + 1. Changes in Participant Knowledge, Attitudes and Confidence

To test for differences in knowledge, attitudes and confidences around mental health issues, from pre-training to post-training and from post-training to six months follow-up, we performed a repeated measures ANOVA[[3]](#footnote-3). This allowed us to assess differences in mean outcome scores for each area across the three time points to determine if any changes occurred. The SPSS Statistics (v.22) package (IBM) was used for statistical analyses. A p-value of <0.05 was considered as statistically significant. A summary of the impact of the programme on participants is presented below. For the full statistical analysis outputs please refer to Appendix 7.

1. *Knowledge concerning mental health*

Following the training there was a significant reported increase of knowledge of mental health issues from pre to post training, which was also reflected from pre training to follow-up scores. However there was a slight decrease in retaining of the knowledge from post testing to follow-up.

1. *Attitudes toward mental health*

Following the training there was a significant reported increase in participants’ attitudes towards mental health from pre to post training, which was also maintained in pre training to follow-up responses. Attitudes maintained consistent from post testing to follow-up with no significant differences shown.

1. *Confidence to identify mental health issues*

Following the training there was a significant reported increase in participants’ confidence to identify mental health issues, from pre to post-training. This effect was maintained from pre-training to follow-up responses. However, there was a slight decrease in confidence from post testing to follow-up.

1. *Confidence to advise people with mental health issues*

From pre to post training there was a significant reported increase in participants’ confidence to advise those who have or may have a mental health issue. This confidence was maintained from pre-training to follow-up, although scores slightly decreased between post-testing and follow-up.

1. *Confidence to advise carers*

From pre to post training there was a significant reported increase in participants’ confidence to advise carers of those with a mental health issue. This confidence was maintained from pre-training to follow-up responses, although reported confidence slightly decreased from post-testing and follow-up.

Tables 3 and Figure 4 and present the mean outcome scores and differences from pre, post, and follow-up timeframes.

**Table 3: Mean scores - knowledge, attitudes, and confidences (pre, post, and follow-up)**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Outcome** |  | **Pre** |  | **Post** |  | **Follow-up** |
|  | **M** | **SE** |  | **M** | **SE** |  | **M** | **SE** |
|  |  |  |  |  |  |  |  |  |  |
| Knowledge |  | 3.00b,c | .08 |  | 4.57a,c | .05 |  | 3.98a,b | .07 |
| Attitudes |  | 3.86b,c | .09 |  | 4.86a,c | .04 |  | 4.67a | .07 |
| Confidence to ID  |  | 2.86b,c | .10 |  | 4.45a,c | .06 |  | 3.98a,b | .06 |
| Confidence to advise |  | 2.73b,c | .11 |  | 4.43a,c | .07 |  | 4.17a,b | .08 |
| Confidence advise carers |  | 2.70b,c | .10 |  | 4.44a,c | .07 |  | 4.11a,b | .06 |

 *Note:* a = significant difference versus pre; b = significant difference versus post; c = significant difference versus follow-up. All mean differences were significant at the *p* < .01 level.

## 4.3 Participant experiences and perceptions

A number of open-ended (qualitative) questions were included in the pre/post survey (Survey 3) in order to elicit feedback from participants concerning the experience of attending the session, things learned, and recommendations for future programmes. Numerous broad conceptual themes emerged through analysis of this data which helped unpack participant feedback. These themes were added to as the parallel process of analyzing participant interviews took place. These are summarized in Table 4.

The integration of survey data and interview data provided a composite account of participants’ overall experiences and perceptions. Four key themes emerged including knowledge & awareness, delivery style, and outcomes, and recommendations. An overview of these themes is presented in Figure 5, and include example comments provided by participants as a means of linking the themes directly to participant data from the survey (3) and participant interviews. These are outlined below.

### 4.3.1. Knowledge and awareness

The first theme, knowledge and awareness, concerned participants’ perceptions that the course had provided a deeper understanding of mental health and the issues faced by people experiencing mental health issues. While this varied between participants it was clear overall that the training had made a meaningful impact on participants; ‘*...it makes you think more, think about behaviors, changes. It gets you out of a routine so can really look at a situation*’. Three subthemes emerged via data analysis which helped explain the overall theme. These are outlined below together with example comments:

1. Educational and informative

The programme helped to improve participants’ knowledge and instilled a greater awareness of the mental health spectrum and the effects experienced by individuals with mental health issues; ‘*I realised how much I didn’t know. You don’t need to be an expert in mental health to be good at mental health, anybody can do it, you know?’* In addition to specific knowledge about mental health conditions the programme was also useful in highlighting the range and nature of wider professional services available to support people experiencing mental health issues. This knowledge provided participants with additional options to consider when providing support in a range of situations.

**Figure 4: Mean differences in knowledge, attitude and confidence**

Note: all results are statistically significant (p < .01) except attitude at follow-up.

1. Challenging perceptions and stigma

The data suggested that the programme in some way helped to challenge stigmas or misconceptions concerning mental health and instil a greater awareness of the complexity and magnitude of mental health issues. This resonated with participants who felt that mental health issues were the poor relation compared with physical health issues; ‘*I was quite open minded before, but it’s definitely changed my mind. I’m not so wary about mental health, I can go into a situation, I can be empathetic. Just because you don’t look ill, just because you can’t see it, it doesn’t mean that it isn’t having an impact on people*’. This provided a different perspective which helped participants to reflect on their own attitudes and to challenge mental health stigma within their personal and professional lives.

1. Practical skills and resources

The programme provided participants with a set of practical tools that could be readily applied in practice and other settings; ‘*It taught me things I’ve never learned from a textbook. If someone is in front of you and they’re having suicidal thoughts and are about to do something, it [a book] doesn’t tell you how to deal with it. But the course gives you practical advice and action*’. The simple steps for assessing and responding to people experiencing mental health issues together with ‘worked examples’ and the programme booklet were identified as facets which helped reinforce the learning, particularly through the group work and discussions. Opportunities to engage in small group work was highlighted by the participants in the interviews as particularly useful in helping to understand how the learning could be applied in practice.

The ALGEE algorithm (Assess, Listen, Give reassurance and information, Encourage appropriate professional help, Encourage self-help and other support) was particularly useful in providing participants with a clear and stepped approach to dealing with people experiencing mental health issues; *‘ALGEE was really good, as was the CPR. It gives you the confidence to deal with really sensitive issues, things that are really difficult to deal with. That was useful, being able to look out for certain behaviours…’*

**Figure 5: Main themes concerning participant feedback**

### 4.3.2 Delivery style

This theme related to feedback about the way the programme was delivered. Three subthemes emerged via data analysis; instructors, interaction, and content. These are outlined below together with example comments:

1. Instructors

The instructors were widely praised for their knowledge, openness and professionalism. As such, the instructors were integral to the overall success of the programme in helping to establish a productive and safe environment in which learning could take place. Some of the participants who took part in the interviews indicated a degree of trepidation prior to completing the programme in that they were unsure as to the level of prior knowledge that might be expected of them, or the types of participants they would be joining. The instructors were critical in this respect, establishing a genial and comfortable learning environment; ‘*The subject matter is quite sensitive in terms of the topic, suicide, self-harm, but they* [instructors] *manages that very well, making sure we were ok and checking to see if anybody needed time out from the sessions.*’

1. Interaction

The process of discussing the programme content with others seemingly provided a powerful means of reinforcing the learning that took place. This helped established a positive learning environment in which the course content could be further explored. It also provided a means of sharing experiences and practices between professionals from different backgrounds; ‘*It’s been a tremendous help, increasing my knowledge and understanding. The chance to discuss things with people from different backgrounds was really good, sharing experiences…’*

1. Content

It was apparent that the majority of participants were impressed by the programme content and materials which provided a variety of learning experiences. The use of slide-based presentations, videos, case studies and group work helped to bring the subject to life and gave participants a good grasp of the subject matter. Interview participants highlighted that the depth of the content covered in the programme offered all participants some form of benefit, regardless of prior knowledge and experience with respect to recognising and dealing with people experiencing mental health issues; ‘*I was fairly knowledgeable beforehand through my training and my work…but [the course] was brilliant, I really enjoyed it. It was thought provoking and the trainers were great…it surpassed my expectations*’.

### 4.3.3 Outcomes

The final theme, outcomes related to participant’s comments relating the impact of the programme. Two subthemes emerged which highlighted the impact on individuals in respect of confidence, and their ability to manage mental health.

1. Confidence

The programme had a clear impact on participants’ confidence concerning their abilities to identify and support people experiencing mental health issues. While data from the participant interviews suggested that this confidence would be perceived in different ways by participants it was evident that the programme instilled confidence to use the practical skills acquired during the programme and to speak about mental health more generally, and also to communicate with people in difficult situations; ‘*I learned that it is better to ask than not to ask. To be direct, to use words like self-harm and suicide. Don’t skirt around issues. People in crisis need to hear things in simple terms when they’re struggling with a situation’*. This created a greater sense of purpose and direction with respect to being able to deal with situations more competently than before the programme, and a capacity to better manage the situations which they were presented with.

It was clear from the survey data and participant interview that this confidence had created what might be described as a pro-active attitude with respect to identifying and dealing with mental health issues. For example, all interview participants indicated that they had applied their skills in some way following the course, whether professionally with clients, with colleagues, or with friends and family. In this sense, participant confidence was expressed in a conscious awareness of recognising traits and behaviours in others which might indicate some form of mental health issue.

1. Managing mental health

The second sub theme related to perceptions that the programme had provided knowledge participants could apply to themselves and those around them in order to better manage their own mental health, and support that of others; ‘*Since* [the programme] *I’ve had people come up and say “I’m completely worthless”, so I’ve used the training to find out actually how serious that comment is, should it be something to be concerned about. In one case I actually contacted someone’s GP for them, I spoke to them to make sure that it was ok to do that, and I made the call with them there…before the training I might not have gone so far with the situation, asked enough questions, the right questions, to help out*’. In this respect the knowledge and skills the programme had provided a mechanism for initiating potentially awkward conversations; ‘*…just to be up front about it, say what it is, say I worried about because…so giving them the opportunity to talk to you*’.

### 4.3.4 Recommendations

The final theme concerned participant feedback regarding aspects of the programme that they did not necessarily enjoy, or areas that they felt could be improved for future courses.

Some participants felt that the sessions could have been improved by providing more time for discussion, a deeper exploration of mental health issues i.e. through case studies / role play, and additional videos. In contrast, others felt that the material was at times too basic and that progress was too slow. This suggested that meeting the needs and preferences of all participants was challenging. The participant interview data indicated a range of experience in dealing with mental health issues due to the nature of professional roles and personal experiences. Some participants indicated that for those completely new to mental health, or very inexperienced, a pre-programme information package might serve to convey a basic understanding of mental health in preparation for the main MHFA programme. This would potentially provide a richer learning experience as the potential for ‘overload’ would be reduced for these participants.

During analysis of the survey data we also observed several references to the concern that the facts and figures used in the presentation were often outdated and needed renewing. This was not alluded to by the interview participants but indicates that there are aspects of the programme that may need updating or revising.

The interviews with participants highlighted two additional areas for consideration in respect of improving the impact of the programme overall. Firstly, it was generally felt that more education was needed for front line health services staff; ‘*All health professionals should go on the training, it should be mandatory to be honest. There’s so many of us coming into contact with people with mental health issues…*’ Issues of cost and time were identified as potential barriers in this respect. However, consistent with comments in the survey data, it was clear that there was a general perception that health professionals and those in other industries for example, education, should have access to programmes such as MHFA and that these should be incorporated into basic or mandatory training and supported with ongoing updates.

**Table 4: Summary of themes**

|  |  |
| --- | --- |
| ***Knowledge & awareness**** Better informed, knowing how to help
* Helped understand what service users experience
* Look at mental health in a different way
* Normalising of mental health issues and confidence given around them
* Listen non-judgmentally
* How to communicate with suicidal service users
* Recognise signs and symptoms of mental health issues, signposting
 | ***Delivery style**** Clear information presented well
* Knowledge of trainers, update attitudes towards mental health
* Very engaging trainers, knowledgeable
* Sharing experience and knowledge with others
* Relaxed environment, discussion
* Practical aspects, revisiting conditions, space to think
* Case studies helped me think how I would act
* Good combination of presenters, videos, group work
 |
| ***Outcomes**** Helped increase confidence, comfortable asking questions about suicide
* Confident to speak to young people and families
* Confidence to use tools and strategies
* Confidence to challenge misconceptions
* Mindful of own wellbeing
* Relevant to work and personal life
* Confidence to communicate with friends and family
* Enhanced practice
* Empowered to support colleagues
 | ***Participant recommendations**** More specific examples of managing conditions in workplace
* More freedom for instructors to promote local MH services
* Chance to talk to mental health specialists about their experiences, more information about referral routes
 |

##

# Discussion of results

* The findings of this evaluation demonstrated that the MHFA training had a high degree of efficacy for increasing the resilience of healthcare staff to communicate with mental health issues, and their carers. Further, the high rate of satisfaction demonstrated that the programme was generally acceptable in terms of its structure, content and relevance to practice.
* It was evident that the core principles of the programme, its practical tools, and opportunity to challenge perceptions concerning mental health helped to increase knowledge, confidence, and a greater awareness of, and confidence to, defy mental health stigmas. As such, the MHFA programme appeared to be effective in providing health professionals in the present context with the types of skills they needed to support people seeking help, as outlined by Happell, Wilson, and McNamara (2014).
* Despite a small drop off at follow up, the results concerning knowledge, attitudes, confidence to identify and advise demonstrated that the effects of the programme were generally maintained by participants in the long term. In this respect the programme was effective in supporting health professionals to maintain a higher degree of care in relation to identifying and responding to people with mental health issues following completion of the programme.
* Participant feedback concerning the usefulness of the training for their professional roles indicated that the programme provided a valuable means of supporting staff to offer consistently high quality patient care, as has been prioritised as a core healthcare objective (Public Health England, 2013). This effect appeared to be generally true across all participants, irrespective of the level of prior knowledge or experience. While we observed a general pattern with respect to positive perceptions, the few exceptions to this demonstrated how the programme impacts varied slightly between individuals, as has been shown elsewhere (Crowe & Everett, 2014). This suggests that there will be limits to the overall ability of the programme to elicit the same effects across all participants. While it is not possible to account for differences in individual attitudes, needs and preferences, opportunities to integrate feedback from participants will likely help maintain a high standard of course delivery.
* The usefulness of the programme was evident in everyday life whereby participants used skills, knowledge and confidence to support friends and family experiencing mental health issues. This suggests the programme impacts are felt beyond the specific contexts in which staff operate, and in this respect has a great deal of added value. This may be particularly important within the workplace as a means of helping colleagues to avoid burnout (Crowe & Everett, 2014).
* Participant perceptions suggested that MHFA had a potential place within broader staff training systems as a means of increasing basic knowledge and developing key skills in mental health first aid. As with research elsewhere, concerns were raised over cost and time constraints (Brunero, Jeon, & Foster, 2012). These aside, it was clear that the MHFA programme, or those of its type, were recognised as integral to staff development and professional practice. The recommendations for improvements identified by participants would only serve to improve its acceptability within the present context and underline is potential usefulness as a means of increasing the resiliency of healthcare professionals to communicate with people with mental health issues, and their carers.

# 6. Conclusions

Based on the synthesis of the data established in this evaluation, the following conclusions and implications can be drawn.

* Participants were highly satisfied with the course and applied the learning and materials to both work and everyday life.
* Following the training participants increased their knowledge and attitudes towards mental health, increased their confidence to identify mental health issues, and increased in confidence to advise people with mental health issues, and their carers.
* At follow-up, an increased attitude towards mental health was sustained.
* Participants gained knowledge and awareness that assisted them to be better informed and know how to: help service users/ clients; understand the service users’ experiences and issues more fully; improve communication with service users / clients, and recognise signs and symptoms of mental health and how to signpost to services.
* The programme assisted staff to increase confidence to: deal with sensitive issues, particularly suicide; enhance practice via early identification of mental health issues in service users, clients and staff; use practical tools and strategies to address issues immediately; empower and support colleagues, and be mindful of their own mental wellbeing.
* The delivery of the training was well presented with knowledgeable and engaging trainers. The trainers were integral for establishing a relaxed environment with opportunities for discussions, space to think, and practical application of learning with case study examples.

# 7. Recommendations

As a result of the discussion and conclusions above, which are in turn based on the synthesis of the evidence acquired in this research, we make the following recommendations:

* To explore opportunities for commissioning the MHFA programme for those working the health field and in particular those who are front line health services staff.
* Health professionals and those in other industries for example, education, should have access to mental health education training programmes, such as MHFA, which are incorporated into basic or mandatory training and supported with ongoing updates.
* For those attending the training who may be new to mental health or very inexperienced, a pre-programme information package might serve to convey a basic understanding of mental health in preparation for the main MHFA programme. This would potentially provide a richer learning experience as the potential for ‘overload’ would be reduced for these participants.
* An update to the facts and figures used within the MHFA presentation and handout materials in order to help maintain current levels of knowledge and provide engaging and relevant information.
* Provide more time for discussion during the training for a deeper exploration of mental health issues i.e. through case studies / role play, and additional videos, specific examples of managing conditions in the workplace, and an opportunity to talk with mental health specialists about their experiences and information on referral routes.
* Provide instructors delivering the MHFA training more freedom to promote local mental health services so participants are better informed of resources close by.

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# Appendices

## Survey 1 (Trainers)

Trainers survey interview questions:

1. Please, in brief, describe your experiences of communicating with people with mental health issues (and their carers) prior to MHFA training:

2. Prior to MHFA training, how did you feel about communicating with people with mental health issues (and their carers)?

3. Having completed the training, how do you now feel with respect to delivering the course to other NHS members of staff?

4. What were your expectations of the training prior to you doing it?

5. In your view, did the training meet your expectations? Please explain your answer.

6. What was good about the training, and why?

7. In your opinion, what could be improved?

8. Is there anything else you would like to comment on?

## Survey 2 (pre/post)

**HEE-NW MHFA COURSE PARTICIPANT SURVEY**

All questions contained in this questionnaire are strictly confidential. Your help is very much appreciated. Thank you in advance.

|  |  |  |  |
| --- | --- | --- | --- |
| **Name** *(Last, First):* |  | 🞎 M 🞎 F | **Your date of birth:** |
| **Your primary email:** | **Age:** |
| **Your contact number:**  |
| **How did you hear about the training?** |  | **Would you be willing to be contacted by telephone to be invited to take part in a short telephone conversation for further feedback?** 🞎 Yes 🞎 No. |

|  |
| --- |
| SECTION 1 |

|  |  |
| --- | --- |
|  | **Please circle a response** |
| **Overall, how satisfied are you with the MHFA training?**  | **Very Low** |  | **Very High** |
|  | 1. Overall, my satisfaction with the training is
 | 1 | 2 | 3 | 4 | 5 |
| **How would you rate your knowledge of mental health issues?**  | **Very poor** |  | **Very Good** |
|  | 1. My knowledge of mental health issues **before** MHFA Training was
 | 1 | 2 | 3 | 4 | 5 |
|  | 1. My knowledge of mental health issues **after** MHFA Training is
 | 1 | 2 | 3 | 4 | 5 |
| **How would you rate your attitudes toward mental health?**  | **Indifferent** |  | **Sympathetic** |
|  | 1. My attitudes toward mental health **before** MHFA Training was
 | 1 | 2 | 3 | 4 | 5 |
|  | 1. My attitudes toward mental health **after** MHFA Training is
 | 1 | 2 | 3 | 4 | 5 |
| **How would you rate your confidence to identify mental health issues?**  | **Very Low** |  | **Very High** |
|  | 1. My confidence to identify mental healthissues **before** MHFA Training was
 | 1 | 2 | 3 | 4 | 5 |
|  | 1. My confidence to identify mental healthissues **after** MHFA Training is
 | 1 | 2 | 3 | 4 | 5 |
| **How would you rate your confidence to advise and recommend support services to people who have, or might have, mental health issues?**  | **Very Low** |  | **Very High** |
|  | 1. My confidence to advise and recommend support services **before** MHFA Training was
 | 1 | 2 | 3 | 4 | 5 |
|  | 1. My confidence to advise and recommend support services **after** MHFA Training is
 | 1 | 2 | 3 | 4 | 5 |
| **How would you rate your confidence to advise and recommend support services to carers of people who have, or might have, mental health issues?**  | **Very Low** |  | **Very High** |
|  | 1. My confidence to advise and recommend support services **before** MHFA Training was
 | 1 | 2 | 3 | 4 | 5 |
|  | 1. My confidence to advise and recommend support services **after** MHFA Training is
 | 1 | 2 | 3 | 4 | 5 |

1. **In your opinion, do you think there is need for training to help staff feel more confident to communicate with people with mental health issues? (please tick a response):**

 🞎 Yes 🞎 No 🞎 Don’t know

1. **Overall, do you think the training provides staff with the knowledge to identify people with potential mental health issues? (please tick a response):**

 🞎 Yes 🞎 No 🞎 Don’t know

1. **Do you think the MHFA training will help you in your job? (please tick a response):**

 🞎 Yes 🞎 No 🞎 Don’t know

|  |
| --- |
| SECTION 2 |

1. In your opinion what are the best aspects of the MHFA training?

|  |
| --- |
|  |

1. Please outline 3 things that you will take with you/have learnt during MHFA training that you think will help you in your job.

|  |
| --- |
| **1.****2.****3.**  |

1. Please take a moment to outline any areas for improvement in the delivery of the MHFA training.

|  |
| --- |
|  |

1. Do you have any other comments about the MHFA training and how it might support you in your role?

|  |
| --- |
|  |

**Survey Ends**

**We will email you a follow up survey in 3 months to ask you about your how you have used the MHFA training. Please ensure that you have added your correct email address to the first page of this survey.**

Thank you for your time and effort in completing the survey. Your assistance is greatly appreciated.

Please feel free to contact the lead researcher for this project should you have any questions:

**Dr Colin Baker**

**University of Gloucestershire**

Phone: 01242 715198

Email: cmbaker@glos.ac.uk

## Survey 3 (follow up)

**HEE-NW MHFA Course PARTICIPANT follow up survey**

All questions contained in this questionnaire are strictly confidential. Your help is very much appreciated. Thank you in advance.

|  |  |  |  |
| --- | --- | --- | --- |
| **Name** *(Last, First):* |  | 🞎 M 🞎 F | **Your date of birth:** |
| **Your primary email:** | **Age:** |
| **Would you be willing to be contacted by telephone to be invited to take part in a short telephone conversation** **for further feedback?** (please tick):  🞎 Yes 🞎 No |

|  |
| --- |
| SECTION 1 |

|  |  |
| --- | --- |
|  | **Please circle a response** |
| **How would you rate your knowledge of mental health issues?**  | **Very Low** |  | **Very High** |
|  | 1. My knowledge of mental health issues **following** MHFA Training is
 | 1 | 2 | 3 | 4 | 5 |
| **How would you rate your attitude toward mental health in general?** | **Indifferent** |  | **Sympathetic** |
|  | 1. My attitude toward mental health **following** MHFA Training is
 | 1 | 2 | 3 | 4 | 5 |
| **How would you rate your confidence to identify mental health issues?** | **Very low** |  | **Very High** |
|  | 1. My confidence to identify mental healthissues **following** MHFA Training is
 | 1 | 2 | 3 | 4 | 5 |
| **How would you rate your confidence to advise and recommend support services to people who have, or might have, mental health issues?**  | **Very low** |  | **Very High** |
|  | 1. My confidence to advise and recommend support services **following** MHFA Training is
 | 1 | 2 | 3 | 4 | 5 |
| **How would you rate your confidence to advise and recommend support services to carers of people who have, or might have, mental health issues?**  | **Very low** |  | **Very High** |
|  | 1. My confidence to advise and recommend support services **following** MHFA Training is
 | 1 | 2 | 3 | 4 | 5 |
| **How useful has the MHFA training been?** | **Not useful at all** |  | **Very useful** |
|  | 1. In my work life the MHFA training has been
 | 1 | 2 | 3 | 4 | 5 |
|  | 1. In my everyday life the MHFA training has been
 | 1 | 2 | 3 | 4 | 5 |

1. **In your opinion, do you think there is need for training to help staff feel more confident to communicate with people with mental health issues? (please tick a response):**

 🞎 Yes 🞎 No 🞎 Don’t know

1. **Overall, do you think the training provides staff with the knowledge to identify people with potential mental health issues? (please tick a response):**

 🞎 Yes 🞎 No 🞎 Don’t know

|  |
| --- |
| SECTION 2 |

1. Have you used ALGEE at work **following** MHFA training? 🞎 Yes 🞎 No
2. If so, how often have you used it and can you provide an example?

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1. Could you describe how you have used any other knowledge and skills at work that you have learnt **following** MHFA training?

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1. Please take a moment to outline any ways in which the MHFA training has had an influence on your practice as a NHS member of staff.

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1. Do you have any other comments **following** MHFA training?

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| --- |
|  |

**Survey Ends**

**THANK YOU FOR YOUR TIME AND EFFORT IN COMPLETING THIS SURVEY, YOUR RESPONSES ARE VERY MUCH APPRECIATED.**

Please feel free to contact the lead researcher for this project should you have any questions:

**Dr Colin Baker**

**University of Gloucestershire**

Phone: 01242 715198

Email: cmbaker@glos.ac.uk

## Participant information

**Evaluation of Mental Health First Aid Health Education North West**

Dear Participant,

We would like to invite you to take part in an evaluation of Mental Health First Aid (MHFA) training within the NHS (Health Education North West). The evaluation is investigating the impact of the course on those people who have completed the training.

To help, we would like you to complete a survey on two occasions: (1) immediately after the training and (2); in 3 months’ time. It should take approximately 5 minutes to complete at each point. If happy to do so, you may also be invited to participate in a telephone interview to discuss your experiences of taking part in MHFA training, how it affected your mental health literacy, and how the delivery might be improved. Your participation in these activities is completely voluntary, and you are free to withdraw at any time.

Your responses will be kept confidential and anonymous and any data will be kept secure at all times. You will not be identified in any reports or publications resulting from the project.

The project has the full support of the Research Ethics Committee at the University of Gloucestershire. Upon request, we would be happy to supply a written report of the findings. If you would like further information about the project or if you have any concerns about your participation in the research, then please contact the operational lead, Dr Colin Baker, either by e-mail or by telephone (please see details below).

Thank you for your assistance with this evaluation.

Regards,

**Dr. Colin Baker**

School of Sport and Exercise

University of Gloucestershire

Oxstalls Campus

Oxstalls Lane

Gloucester

GL2 9HW

T: 01242 715198

 E: cmbaker@glos.ac.uk

## Informed consent

**Title of Project:**

Evaluation of the Health Education North West Mental Health First Aid Programme

**Lead Researcher:**

Dr Colin Baker

School of Sport and Exercise, University of Gloucestershire

Oxstalls Campus, Oxstalls Lane, Gloucester

GL2 9HW

T: 01242 715198

 E: cmbaker@glos.ac.uk

* I have understood the details of the research as explained to me by the researcher, and confirm to act as a participant.
* I understand that my participation is entirely voluntary, that I will not be identifiable from the data collected during the research, and that I have the right to withdraw from the project at any time without any obligation to explain my reasons for doing so.
* I further understand that the data collected may be used for analysis and subsequent publication, and provide consent that this might occur.

Print name:

Sign name:

Date:

## Qualitative interview schedule

**Telephone Interview Schedule**

**Aim**: To generate information about the experience of participants taking part in MHFA training, how it affected their mental health literacy, and how the delivery might be improved.

**1.0 Section One: Background**

1.1 Can you tell me a bit about your role at work?

**2.0 Section Two: Prior Mental Health Knowledge and Awareness**

2.1 Prior to the training, what were your general perceptions about mental health issues?

2.2 Can you tell me about your experiences of mental health issues at work prior to MHFA training? (experience of, dealing with, identifying, uncertainties, etc.)

2.3 In general, what are your opinions concerning staff’s ability to recognise and deal with peoples’ mental health issues?

2.4 Do you think staff need more support e.g. training, to develop the ability to communicate with people with mental health issues?

**3.0 Section Three: MHFA training**

3.1 Can you describe what the training was like? (process, format, style…)

3.2 How did you feel taking part in the training?

3.3 What were your expectations of the training before doing it? (expectations met?)

3.4 What did you learn about recognising and responding to peoples’ mental health issues?

3.5 Having done the training, what do you now think about mental health issues?

3.6 Could you describe some positive and negative aspects of the training process? (explain…)

3.7 How did that make you feel?

**4.0 Section Four: MHFA in practice**

4.1 In your opinion, would you describe the MHFA training as useful to you at work? (If so, why? If not, why not?)

4.2 Have you used any of the knowledge and skills that you learnt on the course at work? (provide example if possible, with details)

4.3 In your opinion, do you think you would have acted in the same way if you hadn’t done the training? (If so, how and why do you think you did something differently?)

4.4 How do you now feel about recognising and responding to patients’ mental health issues? (e.g. confident, more aware…why is that?)

4.5 Overall, what impact do you think the training had on you? (at work, elsewhere)

**5.0 Section Five: Future development**

5.1 What suggestions would you make to improve mental health awareness in the NHS?

5.2 What recommendations would you give to HEE NW to help them support staff in terms of communicating with, and responding to, people with mental health issues?

5.3 Is there anything else that you’d like to share about your experience of MHFA and its impact at work?

## Full Statistical Analysis Reporting

***Knowledge***

For knowledge, the repeated measure ANOVA yielded a significant Mauchly’s test, indicating that the assumption of sphericity had been violated, χ2(2) = 8.433, *p* = .015. As such, the degrees of freedom were corrected using Greenhouse-Geisser estimates of sphericity (ε = .92). Results show that there was a significant main effect of the training on knowledge of mental health issues *F* (1.83, 165.07) = 203.30, *p* = .00. Bonferroni pairwise comparisons reveal that immediately following training, from pre- to post-intervention, participants showed a significant increase in their knowledge of mental health issues (Mdifference pre.post = 1.57, 95% CI = [1.40, 1.75]), which endured to follow-up (Mdifference pre.follow = .98, 95% CI = [.76, 1.20]). A small but significant decrease in knowledge occurred from post training to follow-up (Mdifference post.follow = -.59, BCa 95% CI = [-.77, -.42]).

***Attitude***

For attitudes, a similar pattern of findings emerged. Here, Mauchly’s test was also violated (χ2[2] = 11.263, *p* = .004) and so the Greenhouse-Geisser correction (ε = .90) was applied to the degrees of freedom. Results show that there was a significant main effect of the training on attitudes toward mental health issues *F* (1.79, 160.88) = 70.29, *p* = .00. Bonferroni pairwise comparisons reveal that immediately following training, from pre- to post-intervention, participants showed a significant increase in their attitudes toward mental health issues (Mdifference pre.post = 1.00, 95% CI = [.79, 1.21]), which endured to follow-up (Mdifference pre.follow = .81, 95% CI = [.56, 1.07]). No significant decrease (p = .056) in attitudes toward mental health occurred from post training to follow-up (Mdifference post.follow = -.19, BCa 95% CI = [-.38, -.00]).

***Confidence to Identify Mental Health Issues***

For confidence to identify mental health issues Mauchly’s test was also violated (χ2[2] = 17.97, *p* = .00) and so the Greenhouse-Geisser correction (ε = .85) was applied to the degrees of freedom. Results show that there was a significant main effect of the training on confidence to identify mental health issues *F* (1.69, 152.18) = 148.05, *p* = .00. Bonferroni pairwise comparisons reveal that immediately following training, from pre- to post-intervention, participants showed a significant increase in their confidence in identifying mental health issues (Mdifference pre.post = 1.59, 95% CI = [1.39, 1.80]), which endured to follow-up (Mdifference pre.follow = 1.12, 95% CI = [.84, 1.40]). A small but significant decrease in confidence occurred from post training to follow-up (Mdifference post.follow = -.47, BCa 95% CI = [-.68, -.26]).

***Confidence to Advise People with Mental Health Issues***

For confidence to advise people with mental health issues Mauchly’s test was also violated (χ2[2] = 17.64, *p* = .00) and so the Greenhouse-Geisser correction (ε = .85) was applied to the degrees of freedom. Results show that there was a significant main effect of the training on confidence to advise people with mental health issues *F* (1.69, 150.64) = 162.91, *p* = .00. Bonferroni pairwise comparisons reveal that immediately following training, from pre- to post-intervention, participants showed a significant increase in their confidence in advising people with mental health issues (Mdifference pre.post = 1.70, 95% CI = [1.46, 1.93]), which endured to follow-up (Mdifference pre.follow = 1.43, 95% CI = [1.14, 1.73]). A small but significant decrease in confidence occurred from post training to follow-up (Mdifference post.follow = -.27, BCa 95% CI = [-.47, -.06]).

***Confidence to Advise Carers***

Finally, for confidence to advise carers, Mauchly’s test was also violated (χ2[2] = 16.325, *p* = .00) and so the Greenhouse-Geisser correction (ε = .86) was applied to the degrees of freedom. Results show that there was a significant main effect of the training on confidence in advising carers *F* (1.71, 154.16) = 213.47, *p* = .00. Bonferroni pairwise comparisons reveal that immediately following training, from pre- to post-intervention, participants showed a significant increase in their confidence in advising carers (Mdifference pre.post = 1.74, 95% CI = [1.53, 1.95]), which endured to follow-up (Mdifference pre.follow = 1.41, 95% CI = [1.15, 1.66]). A small but significant decrease in confidence occurred from post training to follow-up (Mdifference post.follow = -.33, BCa 95% CI = [-.51, -.15]).

**Evaluation of the Health Education England working across the North West (HEE NW) Mental Health First Aid (MHFA) training programme**

**Contact:**

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March, 2016.

1. The mean is the average of all the numbers i.e. the sum of all the numbers (ages) divided by the number of participants. [↑](#footnote-ref-1)
2. The Standard Deviation is a measure of how spread out the data are. A low standard deviation indicates that the data are close to the mean, in this instance, the mean age. [↑](#footnote-ref-2)
3. Analysis of variance (ANOVA) is a collection of statistical models used to analyse differences among means in groups of data. Repeated measures ANOVA seeks to detect any overall differences between related means and are appropriate for studies that investigate changes in mean scores over three or more time points. [↑](#footnote-ref-3)