

# **Mental Health First Aid England and North East Mental Health Development Unit Partnership Project**

## **Evaluation March 2011**

Dr Jo Borrill,  
University of Westminster,  
London, UK  
[j.borrill@wmin.ac.uk](mailto:j.borrill@wmin.ac.uk)

Mental Health First Aid England CIC: [www.mhfaengland.org](http://www.mhfaengland.org)  
North East Mental Health Development Unit: [www.nemhdu.org.uk](http://www.nemhdu.org.uk)

## EXECUTIVE SUMMARY

- Mental Health First Aid Training (MHFA) was delivered to 382 people across 23 venues in North-East England. Participants included religious leaders, carers, and volunteers in third sector organisations.
- The participants completed standard evaluation questionnaires after the training, providing ratings of all elements of the training content and delivery. They also provided ratings of their perceived knowledge and confidence at the start of the course compared with on completion of training.
- Median ratings of 4/5 (Very Good) were obtained for: Instructors, Presentation Slides, Video Clips, Interactive Learning Exercises, Training Manual, Structure of Sessions, Content of Sessions, Session Facilitation, and the Training Environment.
- Participants' median rating of their knowledge in supporting people with mental health problems increased from 3 (Limited) at the start of the training to 4 (Good) after completing training. This increase in ratings was highly statistically significant ( $p < .001$ ). The proportion of participants rating their knowledge as 'Good' or 'Excellent' increased from 32% to 90%.
- Participants' median rating of their confidence in helping people with mental health problems increased from 3 (Limited) at the start of the training to 4 (Good) after completing training. This increase in confidence was highly statistically significant ( $p < .001$ ). The proportion of participants rating their confidence as 'Good' or 'Excellent' increased from 27% to 89%.
- Many comments were provided on how the training had changed their attitudes to people with mental health problems. These included: better understanding; changes in feelings and attitudes ('normalisation'); reductions in fear and stigma; and motivation to improve their actions.
- When asked how they would apply their learning in practice, participants commented that they planned to: be more compassionate and supportive; provide a better service to clients with mental health problems; listen to clients more; identify the signs and symptoms of mental health problems; use the skills and specific tools acquired from the training.
- A number of participants also described how the training would help them in their personal lives, within their families, and as carers.
- The few participants who showed little self-rated change were predominantly people who had started the course with already good levels of knowledge and confidence. They nevertheless tended to rate all elements of the training positively. More information about their initial motivations for taking part in the training would be useful in understanding individual differences in response.
- Suggestions for improvement included extending the course, improving some venues, checking that slides were readable and video clips audible, removing any typing errors in the manual, increasing the number of interactive exercises and video clips, and providing longer lunch breaks. There were two requests for more discussion of gay, lesbian, bisexual or transgender issues.

- Several participants recommended that MHFA training should be extended to a wider audience, including one suggestion that it should be provided in schools. Further comments were predominantly expressions of gratitude for being able to take part.
- In order to enhance future evaluations it would be helpful to rate confidence and knowledge before commencing the training, rather than retrospectively. A follow-up of selected participants would be useful in establishing the extent to which learning has actually been applied in practice.

## 1. INTRODUCTION

Mental Health First Aid (MHFA) training originated in Australia and was first piloted in the UK in Scotland (2003/4). It was introduced in England in 2006, with funding from the National Institute for Mental Health England. MHFA is based on the same approach as first aid for physical illness or injury, namely to provide appropriate help before professional treatment or intervention is obtained. The aims of MHFA, as set out in the manual, are as follows: to preserve life where a person may be a danger to themselves or others; to prevent the mental health problem deteriorating into a more serious state; to promote recovery of good mental health; to provide comfort to a person experiencing mental health problems; to raise awareness of mental health issues in the community; and to reduce stigma and discrimination. Within the training these aims are addressed by focussing on teaching people to recognise the symptoms of mental health problems, provide initial help, and guide people towards accessing appropriate professional help.

Achieving these aims within two days of training is a challenging task, but previous evaluations have indicated very positive results. An initial evaluation was carried out in Australia using pre-post questionnaire vignettes and a six month follow-up (Kitchener & Jorm, 2002). This was followed by a randomised controlled trial (Kitchener & Jorm, 2004) which measured changes in attitude, confidence and knowledge in participants, using a waiting-list design. A further study assessed the application of knowledge to practice more than a year after training (Jorm, Kitchener, Mugford, 2005). In England, an independent evaluation by the University of Bath (Brandling & McKenna, 2010) combined standard evaluation forms with the Mental Health Problem Perception Questionnaire and selected interviews to examine the findings for 55 public sector managers and front-line staff. A brief evaluation based on the standard questionnaires was carried out for the first course for private sector employees (Borrill, 2010). To date all these evaluations have indicated that participants enjoy and appreciate the course, comment positively on the content and delivery of the training, and report increases in knowledge and confidence in helping people with mental health problems.

This report provides an analysis and interpretation of a larger sample of data collected using the current MHFA questionnaire which includes some additional questions and opportunities for participants to provide their own comments and suggestions.

## 2. METHODS AND PARTICIPANTS

Questionnaire data was collected from 382 participants who had attended training in the North-East of England. Participants included religious leaders, people working with asylum seekers, carers, and volunteers in third sector organisations. There were 24 training groups, based in a range of centres around the area, including Newcastle, Gateshead, Stockton, Durham, Darlington, Ashington, Redcar, Middlesbrough, Consett and Derby. Each training course was carried out over two days and the number of participants per group was kept relatively small, usually between 7 and 15.

The evaluation questionnaires were completed when the training finished and required participants to rate aspects of the training using a five-point likert scale. The questions included ratings of the Instructors, the content and delivery of the course, including individual training elements (presentation slides, video clips, interactive exercises, training manual), the structure of sessions and the general training environment. Participants also rated their perceived knowledge and confidence before and after the course (using retrospective ratings for pre-course) and were invited to comment on how their attitudes to people with mental health problems had changed. Finally they were asked to describe how they intended to use their learning in future practice, and had the opportunity to suggest any improvements to the training.

### 3. FINDINGS CONCERNING THE TRAINING

#### 3.1 Key aspects of the training content and delivery

The overall ratings for each element of the training are shown in Table 1. Details of median ratings, percentages, and relevant comments for each aspect of the training are provided in the subsequent sections.

**Table 1.**

	Excellent	Very Good	Good	Fair	Poor
Instructors	187 (49%)	145 (38%)	43 (11%)	7 (2%)	0
Presentation Slides	102 (27%)	181 (47%)	88 (23%)	10 (3%)	0
Video clips	103 (27%)	191 (50%)	74 (19%)	14 (4%)	0
Training Manual	147 (38%)	170 (44%)	55 (14%)	8 (2%)	2 (<1%)
Learning Exercises	133 (35%)	192 (50%)	53 (14%)	3 (<1%)	1 (<1%)
Structure of sessions	131 (34%)	182 (48%)	56 (15%)	12 (3%)	0
Content of Sessions	155 (41%)	166 (43%)	57 (15%)	4 (1%)	0
Environment	112 (29%)	176 (46%)	80 (21%)	8 (2%)	6 (2%)
Session Facilitation	150 (39%)	159 (42%)	69 (18%)	3 (<1%)	1 (<1%)

#### 3.2 Evaluation of the Instructors

Overall, the median rating for the Instructors was 4 (Very Good). As shown in Table 1, 87% of participants rated the Instructors as Very Good or Excellent and there were no Poor ratings. Ratings of Instructors were consistently high across the different groups. All groups gave their Instructors median ratings of at least Very Good, with one group rating their Instructor as Excellent.

136 participants recorded additional positive comments about the Instructors. These comments focused particularly on the Instructors' ability to explain information clearly, with further praise for engagement, approachable style, and willingness to take time out to answer personal queries. Only one participant recorded a critical comment, suggesting that the instructor should listen more to participants.

Examples of typical comments are given below:

Very easy to talk to and very interesting to listen to  
Excellent style, clear, well-paced, approachable  
Patient and inclusive  
Very helpful and entertaining, keen to answer questions  
Clear, used personal experience to illustrate points  
Very interesting and really good knowledge base  
Fantastic at encouraging and allowing debate in a safe way  
A wonderful instructor

Other spontaneous comments were made in the final 'Other Comments' section of the questionnaire, expressing thanks to the Instructors for their 'good work'.

### 3.3 Training Methods and resources

The training course used three main methods to enhance the learning sessions: slides to present and summarise information, video clips showing case study examples, and interactive exercises (for example engaging participants in a simulated voice-hearing experience). In addition all participants received a copy of the training manual which they could take away afterwards.

#### 3.3.1 Slides

The overall median rating for the presentation slides was 4 (Very Good) with 27% rating them as 5 (Excellent). There were no Poor ratings, and only 10 people (3%) rated the slides as Fair. In line with the generally high ratings, most participants who commented on the slides described them in positive terms: 'clear', 'easy to follow', 'very informative', and 'relevant'. Two enthusiastic participants described the slides as 'excellent in presenting information' and as 'a brilliant visual aid'.

A small number of participants reported that the writing on some slides was too small for them to read and a few people felt that there was too much information or too many slides compared with video clips. One person admitted 'sorry, I just don't like Powerpoint', while another suggested that handouts of the slides should be provided.

#### 3.3.2 Video clips

The overall median rating for the video clips was 4 (Very Good), with 77% of participants rating them as very good or excellent. There were no Poor ratings, and only 14 people (<4%) rated them as Fair. A couple of participants commented that they preferred video clips to slides ( see above) and several participants said that they would have liked more clips, such as one for each type of problem being discussed . The clips were described as interesting but also as 'powerful' and as 'bringing reality to the course'. Other comments focussed on how video clips helped them retain information better or changed their perspective:

Made me look at mental health in a different way  
Gave me real practical insight  
I can feel the experience too  
I took it in better seeing clips  
Helped with hearing and retaining what was learnt  
Good to see real experience

Two participant expressed difficulty in hearing what was said in the clips, perhaps related due to the background music. Another participant pointed out that all the clips showed people who had recovered, 'so they didn't show insight into actually experiencing the symptoms'.



### 3.3.3 Interactive Learning Exercises

The overall median rating of the learning Exercises was 4 (Very Good). Half of the participants rated these as Very Good with 35% rating them as Excellent. Only 4 participants recorded ratings lower than Good (1 Poor, 3 Fair).

The comments on the learning exercises focussed on two themes – the fun and enjoyment of doing interactive activities, and the way in which the exercises made them think about the issues from a different, more applied, perspective:

They got everyone thinking and interacting  
Fun and interactive; Got people taking to each other  
Helped change my perception  
Really eye-opening; It really made me think  
Enjoyed the voices exercise  
Changes you in person  
Good to take it away from academic knowledge  
Not being as confident as some, I still found I was able to join in and  
enjoy while learning

Some participants suggested that there should be more exercises, including ones more directly related to their real life situations. One person thought the exercises were 'excellent' but admitted finding them hard to follow at times; another participant noted that there was not enough room to move around. However, in line with the ratings, the majority of comments indicated considerable enthusiasm for this approach, described as a 'great way of showing what people experience'.

### 3.3.4 Training Manual

As shown in table 1, 83% of participants rated the manual as Very Good or Excellent, with a median rating of Very good. The comments made about the manual showed that participants found it to be clearly written well-presented, easy to understand, and containing a lot of useful information : The manual holds all the information I need; invaluable first aid. Several participants reported that they saw it as a useful guide for future reference and intended to read and use it after the course finished: I can read it in my own time as well; An excellent manual – it will be very useful; It pulled together all the learning ; I shall take it with me and study.

Two participants noticed that there were a few typing errors in the manual which needed correcting. One participant rated the manual was good but suggested that is should include some information about Mental Health Law (which is in fact included, in the Introduction to the manual).

### 3.4 Content and Delivery of Sessions

Participants were asked to rate the structure and content of the training sessions along with the facilitation of the sessions. The questionnaire did not provide a specific opportunity for them to comment on these aspects although some participants commented on these aspects later in the questionnaire.

Ratings of session structure, session content, and facilitation of the sessions were all rated overall as 4 (Very Good). As shown in table 1, there were very few low ratings for session content and 84% rated it as Very Good or Excellent. Facilitation of sessions also received high ratings, with only one person who rated it as poor. One comment made later in the questionnaire was that there were too many statistics, aimed at awareness-raising rather than 'first aid'. Two people noted later that they would have liked more discussion of lesbian, gay, bisexual and transgender issues.

The structure of sessions was also generally highly rated. The 12 ratings of Fair (<4%) may relate to comments made later in the questionnaire; these included one request for longer sessions, one for more use of spread-out half-day sessions, several suggestions that the course should last for three days, and two pleas for longer lunch breaks between sessions. There were also a couple of participants who felt that the introductions by Instructors could be shortened in order to provide more time for reflection. One participant recommended that clear aims and objectives should be set for each session.

### 3.5 The Training Environment

The overall median rating for Environment was 4 (Very Good), with 75% rating it as very Good or Excellent. However there were 6 ratings of Poor (<2%) and 8 of Fair (2%). While these numbers are proportionately very small, considering a sample size of 382, they indicate that a few people felt that the rooms used for training were not ideal. Examination of each of these cases indicates that there was no one training venue that was perceived as unsatisfactory. Instead there were four venues where one participant suggested that a better room should be found (Summerhill, Stockton, Middlesbrough, Newcastle), one where the room temperature needed better regulation (Butress House) and one which was reported to be not warm enough (Newton Community Centre).

## 4. WHAT DO PARTICIPANTS FEEL THEY HAVE GAINED FROM THE TRAINING?

### 4.1 Knowledge

Participants were asked to rate their level of knowledge about mental health before starting the course and after the course on a five point scale: 1 = none, 2 = poor, 3 = limited, 4 = good. 5 = excellent. The ratings are shown in Table 2 below:

**Table 2**

Level of Knowledge	Before training	End of Training
None	8 (2%)	0
Poor	69 (18%)	4 (1%)
Limited	182 (48%)	33 (9%)
Good	108 (28%)	231 (60%)
Excellent	15 (4%)	114 (30%)

These findings show that almost half the participants retrospectively rated their knowledge at the start of training as Limited (the median rating of 3). 28% of participants thought they had good knowledge at the start of the course but 18% felt their knowledge was poor and 8 said they had no knowledge at all. In contrast, the median self-rating after completing the training was 4 (Good) and the proportion of participants rating their



knowledge as good or excellent rose from 32% before training to 90% after training. The difference in ratings for the two time periods was analysed using a Wilcoxon non-parametric test and found to be highly statistically significant ( $z = 14.27$ ,  $N \text{ ties} = 92$ ,  $p < .001$ ).

#### 4.2 Confidence in helping others with mental health problems

Participants were also asked to rate their confidence in helping people with mental health problems before and after the training, as shown in Table 3 below:

**Table 3**

Level of Knowledge	Before training	End of Training
None	7 (2%)	0
Poor	69 (18%)	3 (1%)
Limited	201 (53%)	38 (10%)
Good	89 (23%)	224 (59%)
Excellent	16 (4%)	117 (31%)

As with knowledge, there was a clear increase in self-ratings of confidence across the two time periods. The median rating increased from 3 (Limited) to 4 (Good), but more impressively the percentage of those rating their confidence as good or excellent rose from 27% to 90%. 70 people said they had started the course with no confidence or poor confidence in helping people with mental health problems; this was reduced to three people by the end of the course. One of those three rated their knowledge as good and commented that they intended to do more reading. A Wilcoxon non-parametric test was used to assess the statistical significance of the difference between pre and post ratings. This was found to be highly statistically significant ( $z = 14.40$ ,  $N \text{ Ties} = 86$ ,  $p < .001$ ).

As shown in the table, there were only three participants whose self-rated confidence after training was poor. Two of these participants had nevertheless increased in self-rated knowledge. One commented that they would 'do more reading' while the other noted that they would have liked the course to be longer.

#### 4.3 Changing attitudes to people with mental health problems

Participants were invited to comment on how they thought the course had affected their attitudes to people with mental health problems. Many participants described having an improved **understanding** of the difficulties faced by people coping with mental health problems: I understand it is normal and more common than I thought. This in turn increased their confidence in their capacity to help: Better understanding and a more relaxed approach to people with mental health problems; I understand much better and believe I could help.

Another frequent comment was that their **attitudes** and **feelings** had changed: Feel more comfortable with the whole subject; A total change in attitude; a different view about people with mental health problems. This included greater **empathy** and a reduction in **fear and stigma**, as well as changes in formerly judgemental attitudes: Made me more aware, to think and not pigeon-hole people; Not scared of talking to them about

it; Would not be so fearful of a situation; less fear, more empathy. The course was also described as helping them think about people with mental health problems as **normal people**.

For some people the changes in attitude or knowledge were relevant to their **personal life**. One participant regretted the way they had previously approached family members with mental health problems. Others were optimistic about being able to address personal issues better in future: It will help me with my own social life; I know some people with these issues so it has equipped me to deal with them.

A number of participants gave examples of how changes in attitude would influence **actions**: More able to challenge prejudice in others ; Be more positive about promoting recovery ; Reinforced my desire to help people; Make clearer recommendations about local groups to contact; Give assurance that they are not alone.

There were some participants who commented that their attitudes had not changed, because they were positive at the start : I always considered myself non-judgemental; It secured what already know. Nevertheless, one person noted that the course strengthened this position : confirmed my existing attitude of respect and helped confirm my instinctive acts. Another commented that : I have a good attitude already .. but am now more able to 'myth-bust'.

#### 4.3 How do participants intend to apply their learning?

The majority of participants commented on how they planned to apply their learning in the future. Most people referred to their work roles and responsibilities, although there were also a considerable number of comments about applying what they had learnt to their personal lives, as family members and as carers. Comments included statements about being more **understanding, compassionate and supportive** towards people with mental health problems. Several people indicated that they would use it to **deliver a better service to clients**, including taking more care to **listen** to clients, being more aware of **signs and symptoms** they might present, and **knowing how to talk** to clients who present mental health issues.

Specific examples included:

It will be useful because I often work with people who are anxious, suicidal, depressed  
I will use it in my work with asylum seekers  
In my job as a volunteer mental health support worker  
I will support people from BME communities more  
Via my work as a freelance interpreter  
Working with distressed clients  
As a family support worker, dealing with patients in house  
Help and support other staff members  
Understand my own mental health and that of my family  
In my role as a carer

Participants also referred to particular skills, approaches and tools from the training that they would continue to use. Many expressed a desire to continue learning and to pass on information to others:

Give thought to the ALGEE process in dealing with service users \*  
By implementing the use of ALGEE and CPR at work  
Will keep on referring to the handouts  
Will take the manual to work and encourage my staff to read  
Reading regularly, to learn more and use it for work and everyday life  
Maybe one day I will advise somebody on this issue – or just  
understand my own mental health

\* ALGEE refers to the MHFA basic steps: Assess risk of suicide or self-harm, Listen non-judgementally, Give reassurance and information, Encourage the person to get appropriate professional help, Encourage self-help strategies.

A brief examination was made of those participants who did not choose to provide comments to this question (fewer than 1%), to check whether this omission was because they were in any way dissatisfied with the course. Their ratings across the different aspects of the training indicated that, on the contrary, all but one of these participants had rated the majority of the course elements as at least good (often excellent) and had recorded increases in confidence and/or knowledge. There was therefore just one exceptional participant, who rated the training as Fair, did not record an increase in knowledge or confidence, but offered no comments on this.

#### **4.3 Further comments and suggestions for improvement**

The suggestions for improvement made at the end of the questionnaire have been included in the relevant sections above, such as extending the training and increasing the number of videos and interactive exercises. However a number of participants added further comments which suggested a broader view of the potential of MHFA training and reinforced their positive experiences:

MHFA should be rolled out across the board  
Could be delivered in schools  
Thanks for the course – everyone should have knowledge of mental health issues  
Excellent – keep the groups small  
I will recommend it to anyone  
All very good – no need to improve  
It was great , thank-you

## 5. Conclusions

This evaluation mirrors the positive findings from earlier evaluations with smaller sample sizes (Brandling & McKenna, 2010; Borrill, 2010). The addition in this evaluation of questions encouraging participants to reflect on the application of learning has provided interesting insights as to how people plan to use the skills and knowledge they have acquired. The proportion of participants expressing any dissatisfaction remains extremely small, and critical comments were primarily suggestions for further enhancing or extending training which was highly rated. Overall there is no doubt that the vast majority of participants find this training engaging and worthwhile, with self-ratings indicating significant increases in personal knowledge and confidence. Furthermore, the high satisfaction levels were maintained across the range of different groups and instructors, with no weak links. Some further information about the background of participants and their motivations for taking part would be useful in assessing individual differences in response.

The different elements of the training all contribute to this process. Slides, while not appealing to all, are viewed as very useful in communicating information. MHFA could however take note of the comments about difficulties in reading small print, and the need to update statistical information regularly. Similarly, the course manual was viewed by almost everyone as a really useful resource, despite a couple of eagle-eyed participants noting a few typing errors. The video clips and interactive exercises were widely welcomed, and clearly stimulated a more emotional pathway for learning and understanding. Suggestions for improvement were primarily to have even more of this kind of learning – and possibly to cut down the background music in the clips. As in previous evaluations there were some calls for the training to be longer (or shorter!) and for the training to be spread out over more days. There was also feedback indicating that some people needed longer breaks between sessions. Some venues were felt to be not ideal, but these comments came from few people.

Making comparisons between pre- and post ratings is a useful way of tapping into participants' immediate reactions after the course, and the findings suggest significant positive change. However there is always the possibility that participants will be motivated to rate the experience positively afterwards because they have spent time and energy engaging in it and because they want to please the instructors who have worked closely with them. These influences may be more likely if, as here, the 'pre-training' ratings are actually provided retrospectively, at the same time as the 'post-training' ratings. It would be better in future evaluations to carry out the initial ratings when participants first arrive for training. As noted in previous evaluations, it would also be very useful to follow up participants at a future date, to assess the longer term impact of the training on personal development and practice.

## References

Borrill, J. (2010) Mental Health First Aid Training: Initial Evaluation by Private Sector Participants. Report for MHFA England.

Brandling, J & McKenna, S. (2010) Evaluating Mental Health First Aid training for Line Managers working in the public sector. Mental Health Research and Development Unit, University of Bath. Report for MHFA England.

Jorm, A.F., Kitchener, B.A., Mugford, S.K (2005) Experiences in applying skills learned in a mental health first aid training course: a qualitative study of participants' stories. *BMC Psychiatry*, 5, 43.

Kitchener, B.A & Jorm, A.F (2002) Mental Health First Aid Training for the public: Evaluation of effects on knowledge, attitudes and helping behaviour. *BMC Psychiatry*, 2, 10.

Kitchener, B.A & Jorm, A.F (2004) Mental Health First Aid Training in a workplace setting: a randomised controlled trial. *BMC Psychiatry*, 4, 23.